

Facility Name & ID Number Arcola Health Care Center

0046045 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	50	Skilled (SNF)	50	18,300	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,300	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,600	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			1,572	1,572	8
9	SNF/PED					9
10	ICF	25,920	3,528		29,448	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,920	3,528	1,572	31,020	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.75%

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES

NO

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

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

YES

NO

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

Date started 11/9/1993

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

YES

Date 11/09/1993

NO

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

YES

NO

If YES, enter number of beds certified 50 and days of care provided 1,081

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	142,519	18,628		161,147		161,147	5,508	166,655		1
2	Food Purchase		153,709		153,709		153,709	(14,089)	139,620		2
3	Housekeeping	99,919	20,233		120,152		120,152	41	120,193		3
4	Laundry	55,074	9,381		64,455		64,455	2	64,457		4
5	Heat and Other Utilities			114,026	114,026		114,026	571	114,597		5
6	Maintenance	46,138	23,155	35,074	104,367		104,367	3,366	107,733		6
7	Other (specify):* Home Off. Ben. All.							1,354	1,354		7
8	TOTAL General Services	343,650	225,106	149,100	717,856		717,856	(3,247)	714,609		8
	B. Health Care and Programs										
9	Medical Director			36,800	36,800		36,800		36,800		9
10	Nursing and Medical Records	757,851	42,622	156,797	957,270		957,270	8,413	965,683		10
10a	Therapy			78,390	78,390		78,390		78,390		10a
11	Activities	57,483	176	179	57,838		57,838		57,838		11
12	Social Services	49,470			49,470		49,470		49,470		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							1,669	1,669		15
16	TOTAL Health Care and Programs	864,804	42,798	272,166	1,179,768		1,179,768	10,082	1,189,850		16
	C. General Administration										
17	Administrative	63,417			63,417		63,417	42,881	106,298		17
18	Directors Fees										18
19	Professional Services			5,105	5,105		5,105	4,840	9,945		19
20	Dues, Fees, Subscriptions & Promotions			6,561	6,561		6,561	1,178	7,739		20
21	Clerical & General Office Expenses	18,969	6,701	9,855	35,525		35,525	53,486	89,011		21
22	Employee Benefits & Payroll Taxes			269,558	269,558		269,558		269,558		22
23	Inservice Training & Education							327	327		23
24	Travel and Seminar							327	327		24
25	Other Admin. Staff Transportation			8,477	8,477		8,477	4,237	12,714		25
26	Insurance-Prop.Liab.Malpractice			22,115	22,115		22,115	258	22,373		26
27	Other (specify):* Home Off. Ben. All.							15,320	15,320		27
28	TOTAL General Administration	82,386	6,701	321,671	410,758		410,758	122,854	533,612		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,290,840	274,605	742,937	2,308,382		2,308,382	129,689	2,438,071		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

Arcola Health Care Center

#0046045

Report Period Beginning:

1/1/2008

Ending:

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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			47,582	47,582		47,582	19,782	67,364			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			174,970	174,970		174,970	4,121	179,091			32
33	Real Estate Taxes			23,661	23,661		23,661	786	24,447			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,169	10,169		10,169	670	10,839			35
36	Other (specify):*											36
37	TOTAL Ownership			256,382	256,382		256,382	25,359	281,741			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		56,488		56,488		56,488		56,488			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,900	54,900		54,900		54,900			42
43	Other (specify):* Non-allowable Cost		469	119,954	120,423		120,423	(120,423)				43
44	TOTAL Special Cost Centers		56,957	174,854	231,811		231,811	(120,423)	111,388			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,290,840	331,562	1,174,173	2,796,575		2,796,575	34,625	2,831,200			45

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

Arcola Health Care Center

ID# 0046045

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (1,681)	43	1
2	X-Rays-Part A	(2,140)	43	2
3	Disallowed Dues & Subs	(315)	20	3
4	Offset Vending Revenue	(7,216)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(325)	21	5
6	Offset Miscellaneous Nursing Supplies Revenue	(1,147)	10	6
7	Resident Flowers	(453)	43	7
8	Disallowed Special Events	(361)	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
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32				32
33				33
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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	(13,638)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 5,508	\$ 5,508	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	90	90	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	41	41	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	571	571	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,366	3,366	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,354	1,354	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	9,560	9,560	8	
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,669	1,669	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	42,881	42,881	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,840	4,840	12	
13	V							13	
14	Total		\$			\$ 69,882	\$ *	69,882	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 Prmotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,493	\$	1,493	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	53,811		53,811	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	327		327	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	327		327	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	4,237		4,237	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	258		258	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	15,320		15,320	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	5,863		5,863	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,124		4,124	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	786		786	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	670		670	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		\$			\$ 87,216	\$ *	87,216	39

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

Facility Name & ID Number

Arcola Health Care Center

0046045

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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	1,785,793	1.28	2.41	Salary	42,881	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	\$ 42,881		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Arcola Health Care Center# 0046045 Report Period Beginning: 1/1/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,413,604	69	\$ 251,260	\$ 250,687	31,020	\$ 5,508	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	31,020	90	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	31,020	41	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	31,020	2	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	31,020	571	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	31,020	3,366	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	31,020	1,354	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	31,020	9,560	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	31,020	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	31,020	1,669	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	31,020	42,881	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	31,020	4,840	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	31,020	1,493	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	31,020	53,811	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	31,020	327	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	31,020	327	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	31,020	4,237	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	31,020	258	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	31,020	15,320	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	31,020	5,863	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	31,020	4,124	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	31,020	786	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	31,020	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	31,020	670	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 157,098	25

Facility Name & ID Number

Arcola Health Care Center

0046045

Report Period Beginning:

1/1/2008

Ending:

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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	Bank of America		X	Mortgage	\$3,244 + int.	1/17/07	\$ 2,775,000	\$ 2,706,200	12/31/13	Varies	\$ 174,361	1						
2	Ford Credit		X	Van Purchase	\$639.08	11/22/04	33,217	6,241	11/17/09	0.0590	609	2						
3							Interest Income Offset				(3)	3						
4							Home Office Allocation-PHC				4,124	4						
5												5						
	Working Capital																	
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$639.08		\$ 2,808,217	\$ 2,712,441			\$ 179,091	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 2,808,217	\$ 2,712,441			\$ 179,091	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.)

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 2007 report.		\$	<u>27,000</u>	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.)		\$	<u>24,661</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(2,339)</u>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>26,000</u>	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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		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. Home Office Allocation			<u>786</u>	
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>24,447</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<u>22,534</u>	8
	2004	<u>24,341</u>	9
	2005	<u>27,991</u>	10
	2006	<u>26,064</u>	11
	2007	<u>24,661</u>	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Arcola Health Care Center COUNTY Douglas

FACILITY IDPH LICENSE NUMBER 0046045

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>01-14-09-200-00580</u>	<u>Long-Term Care Facility</u>	\$ <u>24,345.94</u>	\$ <u>24,345.95</u>
2. <u>01-14-09-200-005</u>	<u>Long-Term Care Facility</u>	\$ <u>314.60</u>	\$ <u>314.60</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>24,660.54</u>	\$ <u>24,660.55</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number Arcola Health Care Center

0046045 Report Period Beginning:

1/1/2008 Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>159,865</u>	<u>1993</u>	<u>\$ 44,078</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 44,078	3

Facility Name & ID Number Arcola Health Care Center

0046045

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	100	1995	1975	\$ 859,153	\$	35	\$ 24,547	\$ 24,547	\$ 331,384	4
5										5
6										6
7	Home Office Allocation									7
8										8
	Improvement Type**									
9	Building Improvement		1993	13,499		20	675	675	10,462	9
10	Building Improvement		1994	31,000		20	1,550	1,550	22,425	10
11	Building Improvement		1995	10,602		20	530	530	7,400	11
12	Landscaping		1997	5,593		20	280	280	3,219	12
13	Parking Lot		1997	6,500		20	325	325	3,738	13
14	Carpeting		1997	934		20	47	47	539	14
15	Door Closer		1997	1,225		20	61	61	703	15
16	Driveway Grading		1998	784		15	52	52	547	16
17	Guttering		1998	1,273		15	85	85	892	17
18	Wiring		1998	6,426		20	321	321	3,372	18
19	Windows		1998	2,330		15	155	155	1,629	19
20	Siding		1998	12,606		20	630	630	6,616	20
21	Doors		1998	765		15	51	51	536	21
22	Sink		1998	901		20	45	45	675	22
23	Garage		1998	8,286		15	552	552	5,797	23
24	Wood Flooring		1999	1,174		20	59	59	559	24
25	Asphalt Lot		1999	4,680		20	234	234	2,223	25
26	Tile		1999	6,477		20	324	324	3,076	26
27	Vinyl Siding		1999	5,600		25	224	224	2,128	27
28	Door Alarms		2000	1,593		20	80	80	679	28
29	Water Heater		2000	5,075		20	254	254	2,159	29
30	Sidewalk		2000	876		20	44	44	374	30
31	Carpeting		2000	670		20	34	34	288	31
32	Scarf Swags/Valances		2001	6,043		20	302	302	2,114	32
33	Scarf Holders		2001	1,083		20	54	54	378	33
34	Fence		2001	2,000		20	100	100	700	34
35	Replacement Wall		2001	686		20	34	34	239	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

Facility Name & ID Number Arcola Health Care Center

0046045

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Security System	2002	\$ 5,959	\$	20	\$ 298	\$ 298	\$ 1,937	37
38	Sprinkler System	2002	4,946		20	247	247	1,608	38
39	Sign	2002	1,248		20	62	62	792	39
40	Medicare Wing Expansion	2003	100,808		20	5,040	5,040	27,721	40
41	Architect Fees	2003	1,343		20	67	67	402	41
42	Patio	2003	5,858		20	293	293	1,758	42
43	Medicare Wing Expansion	2003	2,500		20	125	125	688	43
44	Medicare Wing Expansion	2003	750		20	38	38	207	44
45	Medicare Wing Expansion	2003	1,500		20	75	75	413	45
46	Medicare Wing Expansion	2003	500		20	25	25	138	46
47	Furnace	2004	2,195		20	110	110	495	47
48	Roofing	2005	2,500		20	125	125	439	48
49	Asphalt West Lot	2006	21,480		20	1,074	1,074	2,685	49
50	Door Alarm	2007	2,117		10	212	212	318	50
51	Furnace/Air Conditioner	2007	3,985		10	399	399	598	51
52	Blinds	2007	4,431		10	443	443	665	52
53	Windows	2007	19,021		20	951	951	1,427	53
54	Water Heater	2008	6,500		7	464	464	464	54
55	Boiler	2008	3,425		20	86	86	86	55
56	6 New Sprinklers	2008	5,990		25	120	120	120	56
57	Fire Alarm Repair	2008	2,899		7	207	207	207	57
58									58
59	Land Improvement Depreciation			1,871			(1,871)		59
60	Building Depreciation			23,372			(23,372)		60
61	Building Improvement Depreciation			9,081			(9,081)		61
62									62
63									63
64									64
65	2008-Home Office Allocation-Land Improvements		1,077			69	69		65
66	2008-Home Office Allocation-Building Improvements		16,091			386	386		66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,214,957	\$ 34,324		\$ 42,565	\$ 8,241	\$ 458,019	70

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

Facility Name & ID Number Arcola Health Care Center

0046045

Report Period Beginning:

 1/1/2008

Ending:

 12/31/2008

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	\$ 116,730	\$ 6,757	\$ 11,673	\$ 4,916		\$ 79,647	71
72	Current Year Purchases	12,403	899	620	(279)		620	72
73	Fully Depreciated Assets	128,973					128,973	73
74	Home Office Allocation			5,863	5,863			74
75	TOTALS	\$ 258,106	\$ 7,656	\$ 18,156	\$ 10,500		\$ 209,240	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1994 Dodge Van	1998	\$ 28,010	\$ 1,775	\$	\$ (1,775)	5	\$ 28,010	76
77	Facility	2005 Ford	2004	33,217	3,827	6,643	2,816	5	29,895	77
78										78
79										79
80	TOTALS			\$ 61,227	\$ 5,602	\$ 6,643	\$ 1,041		\$ 57,905	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)	\$ 1,578,368	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 47,582	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 67,364	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 19,782	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 725,164	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					87
88	N/A				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		Home Office Allocation						6
7	TOTAL				\$			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: \$ 10,839 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

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

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

Arcola Health Care Center

0046045

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 6,461
Dishwasher	708
Copier	3,000
Home Office Allocation	670
	<u>10,839</u>
	<u>10,839</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$		\$ 35,275	\$		\$ 35,275	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			4,520			4,520	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs			38,595			38,595	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				56,488		56,488	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$ 78,390	\$ 56,488		\$ 134,878	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Arcola Health Care Center

0046045

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 999,739	\$ 999,739	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	491,669	491,669	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,874	24,874	6
7	Other Prepaid Expenses	11,871	11,871	7
8	Accounts Receivable (owners or related parties)	2,608,147	2,608,147	8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,136,300	\$ 4,136,300	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		44,078	13
14	Buildings, at Historical Cost	941,489	875,244	14
15	Leasehold Improvements, at Historical Cost	248,056	339,713	15
16	Equipment, at Historical Cost	338,206	319,333	16
17	Accumulated Depreciation (book methods)	(678,508)	(725,164)	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)	\$ 849,243	\$ 853,204	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,985,543	\$ 4,989,504	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 511,215	\$ 511,215	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	80,437	80,437	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,136	2,136	31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,000	26,000	32
33	Accrued Interest Payable	15,941	15,941	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	25,685	25,685	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 661,414	\$ 661,414	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,241	6,241	39
40	Mortgage Payable	2,706,200	2,706,200	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,712,441	\$ 2,712,441	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,373,855	\$ 3,373,855	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,611,688	\$ 1,615,649	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,985,543	\$ 4,989,504	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,441,205	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,441,204	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	170,484	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)	\$ 170,484	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,611,688	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	\$ 2,676,360	1
2	Discounts and Allowances for all Levels	59,819	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,736,179	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	127,411	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 127,411	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	4,341	14
15	Telephone, Television and Radio	5,941	15
16	Rental of Facility Space		16
17	Sale of Drugs	68,230	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,093	20
21	Other Medical Services	3,335	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 84,940	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	1,472	28
28a	Vending Income	17,054	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,526	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,967,059	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	717,856	31
32	Health Care	1,179,768	32
33	General Administration	410,758	33
B. Capital Expense			
34	Ownership	256,382	34
C. Ancillary Expense			
35	Special Cost Centers	176,911	35
36	Provider Participation Fee	54,900	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,796,575	40
41	Income before Income Taxes (line 30 minus line 40)**	170,484	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 170,484	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 part of 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 Arcola Health Care Center

0046045

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

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	1,733	1,733	\$ 42,418	\$ 24.48	1
2	Assistant Director of Nursing	260	260	3,594	13.82	2
3	Registered Nurses	1,937	2,212	43,713	19.76	3
4	Licensed Practical Nurses	11,350	12,074	213,093	17.65	4
5	CNAs & Orderlies	38,994	40,270	403,017	10.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,359	1,449	9,075	6.26	9
10	Activity Assistants	2,462	2,470	26,919	10.90	10
11	Social Service Workers	2,080	2,080	49,470	23.78	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,724	13.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,837	14,365	113,795	7.92	15
16	Dishwashers					16
17	Maintenance Workers	4,154	4,257	46,138	10.84	17
18	Housekeepers	11,902	12,435	99,919	8.04	18
19	Laundry	6,767	6,919	55,074	7.96	19
20	Administrator	2,080	2,080	63,417	30.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,783	1,839	18,969	10.31	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 C: <u>Transportation</u>	1,949	2,069	21,489	10.39	32
33	Other(specify) <u>Care Plan Coord.</u>	2,447	2,447	52,016	21.26	33
34	TOTAL (lines 1 - 33)	107,174	111,039	\$ 1,290,840 *	\$ 11.63	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			35	
36	Medical Director	Monthly	36,800	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,100	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)		\$ 37,900		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	94	\$ 4,330	10(3)	50
51	Licensed Practical Nurses	3,450	124,697	10(3)	51
52	Certified Nurse Assistants/Aides	1,304	26,446	10(3)	52
53	TOTAL (lines 50 - 52)	4,848	\$ 155,473		53

Arcola Health Care Center

0046045

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,105

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	176
GoffWilson, P.A.	Legal	587
Ginoli & Company	Accountants	1,427
RSM McGladrey	Accountants	13
Emdeon Business Services	Computer Services	69
Advanced Answers on Demand	Computer Services	95
Access 2 Go	Computer Services	1,112
Ivans	Computer Services	328
Kemper Technology	Computer Services	170
VisionShare	Computer Services	602
Logmein	Computer Services	64
Comm Net Communiations	Computer Services	46
Charter Communications	Computer Services	17
Advanced System Designs	Computer Services	14
Consolidated Communications	Computer Services	21
Miscellaneous Vendors	Computer Services	13
Miscellaneous Vendors	Miscellaneous	86

Total (agree to Schedule V, line 19, column 8)		<u>9,945</u>
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Facility Name & ID Number Arcola Health Care Center# 0046045

Report Period Beginning:

1/1/2008

Ending:

12/31/2008**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. 3,860 -IHCA
- (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? No
- (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. \$ 5,754 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? N/A
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,900
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. \$ 14,179
- (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. \$ No
- 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? N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company 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