

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0046706</u></p> <p>Facility Name: <u>El Paso Health Care Center</u></p> <p>Address: <u>850 East 2nd Street</u> <u>El Paso</u> <u>61738</u> Number City Zip Code</p> <p>County: <u>Woodford</u></p> <p>Telephone Number: <u>(309) 527-2700</u> Fax # <u>(309) 527-2725</u></p> <p>HFS ID Number: <u>20-1032291001</u></p> <p>Date of Initial License for Current Owners: <u>10/20/2004</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2008</u> to <u>12/31/2008</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mark B. Petersen</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) () _____ Fax # () _____</td> <td></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Mark B. Petersen</u>			(Title) <u>Chief Executive Officer</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () _____ Fax # () _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
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	(Firm Name & Address) _____																																									
	(Telephone) () _____ Fax # () _____																																									
<p>In the event there are further questions about this report, please contact: Name: <u>Larry Templin</u> Telephone Number: <u>(309) 691-8113</u> Email Address: _____</p>	<p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>																																									

Facility Name & ID Number El Paso Health Care Center

0046706 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	123	Skilled (SNF)	123	45,018	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	45,018	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total	
8	SNF	36,836	971	3,767	41,574	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,836	971	3,767	41,574	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.35%

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

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

YES NO

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

Date started 10/20/2004

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

YES Date 10/20/2004 NO

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

YES NO If YES, enter number of beds certified 123 and days of care provided 731

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number El Paso Health Care Center # 0046706 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	153,808	24,217	440	178,465		178,465	7,390	185,855		1
2	Food Purchase		212,603		212,603		212,603	(870)	211,733		2
3	Housekeeping	103,978	20,065		124,043		124,043	55	124,098		3
4	Laundry	52,003	10,383		62,386		62,386	3	62,389		4
5	Heat and Other Utilities			162,399	162,399		162,399	766	163,165		5
6	Maintenance	50,034	7,298	28,277	85,609		85,609	4,516	90,125		6
7	Other (specify):* Home Off. Ben. All.							1,817	1,817		7
8	TOTAL General Services	359,823	274,566	191,116	825,505		825,505	13,677	839,182		8
	B. Health Care and Programs										
9	Medical Director			12,960	12,960		12,960		12,960		9
10	Nursing and Medical Records	1,085,370	45,532	3,615	1,134,517		1,134,517	11,817	1,146,334		10
10a	Therapy			106,062	106,062		106,062		106,062		10a
11	Activities	54,029	611	103	54,743		54,743	(3,814)	50,929		11
12	Social Services	129,937			129,937		129,937		129,937		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							2,239	2,239		15
16	TOTAL Health Care and Programs	1,269,336	46,143	122,740	1,438,219		1,438,219	10,242	1,448,461		16
	C. General Administration										
17	Administrative	68,250			68,250		68,250	57,526	125,776		17
18	Directors Fees										18
19	Professional Services			5,006	5,006		5,006	10,705	15,711		19
20	Dues, Fees, Subscriptions & Promotions			7,153	7,153		7,153	2,697	9,850		20
21	Clerical & General Office Expenses	28,709	4,489	12,251	45,449		45,449	78,617	124,066		21
22	Employee Benefits & Payroll Taxes			333,581	333,581		333,581		333,581		22
23	Inservice Training & Education							568	568		23
24	Travel and Seminar			400	400		400	439	839		24
25	Other Admin. Staff Transportation			14,775	14,775		14,775	7,117	21,892		25
26	Insurance-Prop.Liab.Malpractice			24,258	24,258		24,258	539	24,797		26
27	Other (specify):* Home Off. Ben. All.							20,552	20,552		27
28	TOTAL General Administration	96,959	4,489	397,424	498,872		498,872	178,760	677,632		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,726,118	325,198	711,280	2,762,596		2,762,596	202,679	2,965,275		29

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

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

Facility Name & ID Number El Paso Health Care Center

#0046706

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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			86,563	86,563		86,563	(6,297)	80,266			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			291,570	291,570		291,570	24,280	315,850			32
33	Real Estate Taxes			84,378	84,378		84,378	1,055	85,433			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,553	22,553		22,553	1,006	23,559			35
36	Other (specify):*											36
37	TOTAL Ownership			485,064	485,064		485,064	20,044	505,108			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		163,923		163,923		163,923		163,923			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,529	67,529		67,529		67,529			42
43	Other (specify):* Non-allowable Cost		48	65,758	65,806		65,806	(65,806)				43
44	TOTAL Special Cost Centers		163,971	133,287	297,258		297,258	(65,806)	231,452			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,726,118	489,169	1,329,631	3,544,918		3,544,918	156,917	3,701,835			45

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

El Paso Health Care Center

ID# 0046706

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (1,806)	43	1
2	X-Rays-Part A	(586)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(1,008)	10	3
4	Offset Transportation Revenue	(3,814)	11	4
5	Disallow Resident Flowers	(235)	43	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(7,449)		49

Facility Name & ID Number

El Paso Health Care Center

0046706

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 7,390	\$ 7,390	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	121	121	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	55	55	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	3	3	4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	766	766	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	4,516	4,516	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,817	1,817	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	12,825	12,825	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%	2,239	2,239	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	57,526	57,526	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	6,493	6,493	12	
13	V							13	
14	Total		\$			\$ 93,751	\$ *	93,751	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 <u>Dues, Fees, Subs and Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 2,003	\$	2,003	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	72,190		72,190	16
17	V	23 <u>Inservice Training and Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	439		439	17
18	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	439		439	18
19	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	5,684		5,684	19
20	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Health Care, Inc.</u>	100.00%	346		346	20
21	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	20,552		20,552	21
22	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	7,865		7,865	22
23	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	5,532		5,532	23
24	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,055		1,055	24
25	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			25
26	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	899		899	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		\$			\$ 117,004	\$ *	117,004	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Companies, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Companies, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Companies, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Companies, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Companies, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Companies, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Companies, LLC	100.00%	0		22	
23	V	10A Therapy		Petersen Companies, LLC	100.00%	0		23	
24	V	15 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		24	
25	V	17 Administrative		Petersen Companies, LLC	100.00%	0		25	
26	V	19 Professional Services		Petersen Companies, LLC	100.00%	4,212	4,212	26	
27	V	20 Dues, Fees, Subs & Promotions		Petersen Companies, LLC	100.00%	694	694	27	
28	V	21 Clerical and General Office		Petersen Companies, LLC	100.00%	6,427	6,427	28	
29	V	23 Inservice Training & Education		Petersen Companies, LLC	100.00%	129	129	29	
30	V	24 Travel and Seminar		Petersen Companies, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Companies, LLC	100.00%	1,433	1,433	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Companies, LLC	100.00%	193	193	32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Companies, LLC	100.00%	2,090	2,090	34	
35	V	32 Interest		Petersen Companies, LLC	100.00%	18,763	18,763	35	
36	V	33 Real Estate Taxes		Petersen Companies, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Companies, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Companies, LLC	100.00%	107	107	38	
39	Total		\$			\$ 34,048	\$ *	34,048	39

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

Facility Name & ID Number

El Paso Health Care Center

#

0046706

Report Period Beginning:

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	1,771,148	1.73	2.88	Salary	57,526	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	\$ 57,526		13

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

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

Facility Name & ID Number El Paso Health Care Center

0046706 Report Period Beginning: 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

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	1,413,604	69	251,260	250,687	41,574	\$ 7,390	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	41,574	121	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	41,574	55	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	41,574	3	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	41,574	766	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	41,574	4,516	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	41,574	1,817	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	41,574	12,825	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	41,574	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	41,574	2,239	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	41,574	57,526	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	41,574	6,493	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	41,574	2,003	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	41,574	72,190	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	41,574	439	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	41,574	439	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	41,574	5,684	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	41,574	346	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	41,574	20,552	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	41,574	7,865	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	41,574	5,532	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	41,574	1,055	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	41,574	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	41,574	899	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 210,755	25

Facility Name & ID Number El Paso Health Care Center# 0046706 Report Period Beginning: 1/1/2008Ending: 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

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

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	227,342	13	\$	41,574	\$	1
2	2	Food	Resident Days	227,342	13		41,574		2
3	3	Housekeeping	Resident Days	227,342	13		41,574		3
4	4	Laundry	Resident Days	227,342	13		41,574		4
5	5	Utilities	Resident Days	227,342	13		41,574		5
6	6	Maintenance	Resident Days	227,342	13		41,574		6
7	7	Mgmt. Allocation of Benefits	Resident Days	227,342	13		41,574		7
8	10	Nursing and Medical Records	Resident Days	227,342	13		41,574		8
9	10A	Therapy	Resident Days	227,342	13		41,574		9
10	15	Mgmt. Allocation of Benefits	Resident Days	227,342	13		41,574		10
11	17	Administrative	Resident Days	227,342	13		41,574		11
12	19	Professional Services	Resident Days	227,342	13	23,031	41,574	4,212	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	227,342	13	3,794	41,574	694	13
14	21	Clerical and General Office	Resident Days	227,342	13	35,146	41,574	6,427	14
15	23	Inservice Training & Education	Resident Days	227,342	13	706	41,574	129	15
16	24	Travel and Seminar	Resident Days	227,342	13		41,574		16
17	25	Other Admin. Staff Transport.	Resident Days	227,342	13	7,835	41,574	1,433	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	227,342	13	1,053	41,574	193	18
19	27	Mgmt. Allocation of Benefits	Resident Days	227,342	13		41,574		19
20	30	Depreciation	Resident Days	227,342	13	11,428	41,574	2,090	20
21	32	Interest	Resident Days	227,342	13	102,603	41,574	18,763	21
22	33	Real Estate Taxes	Resident Days	227,342	13		41,574		22
23	34	Rent-Facility and Grounds	Resident Days	227,342	13		41,574		23
24	35	Rent-Equipment & Vehicles	Resident Days	227,342	13	585	41,574	107	24
25	TOTALS					\$ 186,181	\$	\$ 34,048	25

Facility Name & ID Number

El Paso Health Care Center

0046706

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Associated Bank		X	Mortgage	\$36,061.00	10/20/04	\$ 3,680,000	\$ 3,274,349	1/5/09	0.0830	\$ 283,097	1					
2												2					
3							Interest Income Offset				(15)	3					
4							Home Office Allocation-PHC				5,532	4					
5							Home Office Allocation-PC				18,763	5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related				\$36,061.00		\$ 3,680,000	\$ 3,274,349			\$ 307,377	9					
B. Non-Facility Related*																	
10												10					
11							Amorization Expense				8,473	11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ 8,473	14					
15	TOTALS (line 9+line14)						\$ 3,680,000	\$ 3,274,349			\$ 315,850	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.		\$	85,000	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.)	2007	\$	83,378	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,622)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	86,000	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		\$	1,055	
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.		\$	85,433	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	_____	8
	2004	_____	9
	2005	_____	10
	2006	81,650	11
	2007	83,378	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 El Paso Health Care Center COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0046706

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>16-04-302-017</u>	<u>Long-Term Care Facility</u>	\$ <u>80,927.10</u>	\$ <u>80,927.10</u>
2. <u>16-04-301-024</u>	<u>Long-Term Care Facility</u>	\$ <u>2,451.16</u>	\$ <u>2,451.16</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>83,378.26</u>	\$ <u>83,378.26</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 El Paso Health Care Center

0046706

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,300 B. General Construction Type: Exterior Brick & Block Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>202,500</u>	<u>2004</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	202,500		\$ 50,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	123	2004	1974	\$ 934,850	\$	35	\$ 26,710	\$ 26,710	\$ 111,292
5									
6									
7									
8									
Improvement Type**									
9	Sidewalks		2006	7,230		15	482	482	1,205
10	Windows		2006	7,500		25	300	300	750
11	Generator		2007	17,756		15	1,184	1,184	1,776
12	Office air conditioner repair		2008	3,125		15	104	104	104
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28	Building Booked				37,457			(37,457)	
29	Building Improvement Booked				5,401			(5,401)	
30									
31									
32	2008-Home Office Allocation-Land Improvements			1,444			93	93	
33	2008-Home Office Allocation-Building Improvements			21,586			518	518	
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 993,491	\$ 42,858		\$ 29,391	\$ (13,467)	\$ 115,127	70

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

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	\$ 297,098	\$ 43,523	\$ 41,435	\$ (2,088)	5-10	\$ 152,537	71
72	Current Year Purchases	1,913	182	96	(86)	10	96	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			9,344	9,344			74
75	TOTALS	\$ 299,011	\$ 43,705	\$ 50,875	\$ 7,170		\$ 152,633	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,342,502	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 86,563	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 80,266	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,297)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 267,760	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								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: \$ 6,403 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	Facility	2006 Ford E250	571.88	17,156	18
19					19
20					20
21	TOTAL		\$ 571.88	\$ 17,156	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.

EI Paso Health Care Center

0046706

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	\$ 4,164
Dishwasher	763
Maintenance Equipment	35
Copier	435
Home Office Allocation	1,006
	<u>6,403</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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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	\$	2,823	\$ 42,349	\$	2,823	\$ 42,349	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		31	459		31	459	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		4,217	63,254		4,217	63,254	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				163,923		163,923	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			\$	7,071	\$ 106,062	\$ 163,923	7,071	\$ 269,985	14

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

Facility Name & ID Number El Paso Health Care Center

0046706

Report Period Beginning: 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	\$ 4,383,017	\$ 4,383,017	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	815,058	815,058	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,597	30,597	6
7	Other Prepaid Expenses	14,410	14,410	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee loans</u>	437	437	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,243,519	\$ 5,243,519	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost	992,080	956,436	14
15	Leasehold Improvements, at Historical Cost	28,381	37,055	15
16	Equipment, at Historical Cost	299,011	299,011	16
17	Accumulated Depreciation (book methods)	(335,192)	(267,760)	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): <u>Due from Prior Owner</u>	1,438	1,438	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 985,718	\$ 1,076,180	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,229,237	\$ 6,319,699	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 527,394	\$ 527,394	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	114,344	114,344	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,039	4,039	31
32	Accrued Real Estate Taxes(Sch.IX-B)	86,000	86,000	32
33	Accrued Interest Payable	20,383	20,383	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	33,805	33,805	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 785,965	\$ 785,965	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,274,349	3,274,349	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,274,349	\$ 3,274,349	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,060,314	\$ 4,060,314	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,168,923	\$ 2,259,385	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,229,237	\$ 6,319,699	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,229,580	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,229,580	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	939,343	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)	\$ 939,343	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)	\$ 2,168,923	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	\$ 4,221,313	1
2	Discounts and Allowances for all Levels	58,757	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,280,070	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	157,401	6
7	Oxygen	8,237	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 165,638	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	991	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	30,245	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,950	20
21	Other Medical Services	530	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 33,716	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	1,008	28
28a	Transportation Revenue	3,814	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,822	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,484,261	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	825,505	31
32	Health Care	1,438,219	32
33	General Administration	498,872	33
	B. Capital Expense		
34	Ownership	485,064	34
	C. Ancillary Expense		
35	Special Cost Centers	229,729	35
36	Provider Participation Fee	67,529	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,544,918	40
41	Income before Income Taxes (line 30 minus line 40)**	939,343	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 939,343	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 El Paso Health Care Center

0046706

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	1,947	\$ 56,693	\$ 29.12	1
2	Assistant Director of Nursing	1,907	49,500	25.96	2
3	Registered Nurses	1,207	27,691	22.94	3
4	Licensed Practical Nurses	19,563	408,278	20.53	4
5	CNAs & Orderlies	42,613	499,073	11.28	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	796	8,429	10.05	9
10	Activity Assistants	5,957	45,600	7.65	10
11	Social Service Workers	8,871	129,937	14.39	11
12	Dietician				12
13	Food Service Supervisor	1,796	26,959	15.01	13
14	Head Cook				14
15	Cook Helpers/Assistants	15,204	126,849	8.17	15
16	Dishwashers				16
17	Maintenance Workers	3,750	50,034	12.46	17
18	Housekeepers	11,983	103,978	8.52	18
19	Laundry	6,520	52,003	7.80	19
20	Administrator	2,080	68,250	32.81	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager	2,080	28,709	13.80	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>Care Plan Coord.</u>	2,167	44,135	20.00	33
34	TOTAL (lines 1 - 33)	128,441	\$ 1,726,118 *	\$ 13.11	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	8	\$ 440	1(3) 35
36	Medical Director	Monthly	12,960	9(3) 36
37	Medical Records Consultant	Monthly	1,440	10(3) 37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly	1,230	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)	8	\$ 16,070	49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
<u>Ruth Swift</u>	<u>Administrator</u>	<u>0</u>	\$ <u>68,250</u>	<u>Workers' Compensation Insurance</u>	\$ <u>34,789</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>		
				<u>Unemployment Compensation Insurance</u>	<u>31,319</u>	<u>Advertising: Employee Recruitment</u>	<u>1,932</u>		
				<u>FICA Taxes</u>	<u>129,096</u>	<u>Health Care Worker Background Check</u>			
				<u>Employee Health Insurance</u>	<u>135,376</u>	(Indicate # of checks performed)			
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>174</u> <u>1,746</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses & Permits</u>	<u>315</u>		
				<u>Employee Relations</u>	<u>2,198</u>	<u>Miscellaneous Dues & Subscriptions</u>			
				<u>Employee Retirement</u>	<u>803</u>	<u>IHCA Dues</u>	<u>1,170</u>		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>68,250</u>			<u>Home Office Allocation</u>	<u>2,697</u>		
(List each licensed administrator separately.)									
B. Administrative - Other									
Description			Amount						
			\$						
<u>N/A</u>									
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ <u>333,581</u>	TOTAL (agree to Sch. V, line 20, col. 8) \$ <u>9,850</u>	
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
<u>E-Health Data Solutions</u>	<u>Computer Services</u>		\$ <u>3,045</u>				<u>Out-of-State Travel</u>	\$	
<u>Fairpoint Communications</u>	<u>Computer Services</u>		<u>361</u>						
<u>LTC Solutions</u>	<u>Computer Services</u>		<u>1,600</u>				<u>In-State Travel</u>		
				<u>N/A</u>					
							<u>Seminar Expense</u>	<u>400</u>	
							<u>Home Office Allocation</u>	<u>439</u>	
							<u>Entertainment Expense</u>	()	
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>5,006</u>	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8) \$ <u>839</u>		
(If total legal fees exceed \$5,000, attach copy of invoices.)									

* Attach copy of IMRF notifications

**See instructions.

El Paso Health Care Center

0046706

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)		5,006

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	236
GoffWilson, P.A.	Legal	788
Ginoli & Company	Accountants	6,127
RSM McGladrey	Accountants	18
Miscellaneous Vendors	Computer Services	92
Emdeon Business Services	Computer Services	127
Advanced Answers on Demand	Computer Services	1,492
Access 2 Go	Computer Services	440
Ivans	Computer Services	229
Kemper Technology	Computer Services	808
VisionShare	Computer Services	86
Logmein	Computer Services	62
Comm Net Communiations	Computer Services	23
Charter Communications	Computer Services	19
Advanced System Designs	Computer Services	29
Consolidated Communications	Computer Services	17
Miscellaneous Vendors	Miscellaneous	112

Total (agree to Schedule V, line 19, column 8)	<u>15,711</u>
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El Paso Health Care Center

0046706

Period Beginning 1/1/2008

Period End 12/31/2008

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

<u>Name</u>	<u>Function</u>	<u>Ownership %</u>	<u>Amount</u>
Ruth Swift	Administrator	0	68,250
	Total		<u>68,250</u>

Facility Name & ID Number El Paso Health Care Center

0046706

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. 1,170 -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. \$ N/A Line N/A
- (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. \$ 67,529
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. \$ 991
- (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? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees