



Facility Name & ID Number Tuscola Health Care Center

# 0046805 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	<u>21</u>	Skilled (SNF)	<u>21</u>	<u>7,686</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>52</u>	Intermediate (ICF)	<u>52</u>	<u>19,032</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>73</u>	TOTALS	<u>73</u>	<u>26,718</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>2,627</u>	<u>2,627</u>	8
9	SNF/PED					9
10	ICF	<u>11,788</u>	<u>7,528</u>		<u>19,316</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,788</u>	<u>7,528</u>	<u>2,627</u>	<u>21,943</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.13%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 8/01/04

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 1/18/05 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 21 and days of care provided 2,627

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 Tuscola Health Care Center # 0046805 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
	<b>A. General Services</b>										
1	Dietary	103,423	13,848	440	117,711		117,711	3,900	121,611		1
2	Food Purchase		108,650		108,650		108,650	(1,664)	106,986		2
3	Housekeeping	85,886	10,915		96,801		96,801	29	96,830		3
4	Laundry	21,550	7,977		29,527		29,527	2	29,529		4
5	Heat and Other Utilities			80,651	80,651		80,651	404	81,055		5
6	Maintenance	27,695	11,393	14,376	53,464		53,464	2,519	55,983		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							959	959		7
8	<b>TOTAL General Services</b>	238,554	152,783	95,467	486,804		486,804	6,149	492,953		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	786,597	79,428	2,220	868,245		868,245	4,495	872,740		10
10a	Therapy			173,677	173,677		173,677		173,677		10a
11	Activities	23,318	394	3,510	27,222		27,222		27,222		11
12	Social Services	28,046			28,046		28,046		28,046		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							1,182	1,182		15
16	<b>TOTAL Health Care and Programs</b>	837,961	79,822	187,807	1,105,590		1,105,590	5,677	1,111,267		16
	<b>C. General Administration</b>										
17	Administrative	57,500		102,000	159,500		159,500	(71,638)	87,862		17
18	Directors Fees										18
19	Professional Services			5,499	5,499		5,499	8,658	14,157		19
20	Dues, Fees, Subscriptions & Promotions			6,939	6,939		6,939	955	7,894		20
21	Clerical & General Office Expenses	33,439	5,608	8,324	47,371		47,371	42,933	90,304		21
22	Employee Benefits & Payroll Taxes			182,789	182,789		182,789	7,374	190,163		22
23	Inservice Training & Education			183	183		183	232	415		23
24	Travel and Seminar			45	45		45	232	277		24
25	Other Admin. Staff Transportation			5,267	5,267		5,267	3,069	8,336		25
26	Insurance-Prop.Liab.Malpractice			14,233	14,233		14,233	183	14,416		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							10,847	10,847		27
28	<b>TOTAL General Administration</b>	90,939	5,608	325,279	421,826		421,826	2,845	424,671		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,167,454	238,213	608,553	2,014,220		2,014,220	14,671	2,028,891		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 Tuscola Health Care Center

#0046805

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	
	<b>D. Ownership</b>											
30	Depreciation			49,394	49,394		49,394	4,270	53,664			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			60,060	60,060		60,060	18,577	78,637			32
33	Real Estate Taxes			26,035	26,035		26,035	557	26,592			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			(6,784)	(6,784)		(6,784)	475	(6,309)			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			128,705	128,705		128,705	23,879	152,584			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		94,302		94,302		94,302		94,302			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,080	40,080		40,080		40,080			42
43	Other (specify):* <b>Non-allowable Cost</b>		9	28,380	28,389		28,389	(28,389)				43
44	<b>TOTAL Special Cost Centers</b>		94,311	68,460	162,771		162,771	(28,389)	134,382			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,167,454	332,524	805,718	2,305,696		2,305,696	10,161	2,315,857			45

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

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,728)	2		4
5	Telephone, TV & Radio in Resident Rooms	(271)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,821)	30		9
10	Interest and Other Investment Income	(9)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(121)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,551)	43		18
19	Entertainment				19
20	Contributions	(300)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,198)	43		24
25	Fund Raising, Advertising and Promotional	(7,795)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Pg. 5A</u>	(10,660)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (34,454)		\$	30

<b>BHF USE ONLY</b>							
48		49		50		51	

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	44,615	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 44,615		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 10,161		37

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

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

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

Tuscola Health Care Center

ID# 0046805

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (5,847)	43	1
2	X-Rays-Part A	(1,682)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(2,274)	10	3
4	Offset Miscellaneous Office Supplies Revenue	(33)	21	4
5	Offset Chamber of Commerce Dues	(200)	20	5
6	Resident Flower	(624)	43	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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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(10,660)		49

Facility Name & ID Number

Tuscola Health Care Center

# 0046805

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	65	See Attached Schedule 6E		See Attached Sch 6E		
Jifi Jacob	10					
Jacque Whitley	10					
Cindy White	10					
David Petersen	5					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,900	\$ 3,900	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	64	64	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	29	29	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	404	404	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,384	2,384	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	959	959	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	6,769	6,769	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%	1,182	1,182	10
11	V	17 Administrative	102,000	Petersen Health Care, Inc.	100.00%	30,362	(71,638)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,427	3,427	12
13	V							13
14	Total					\$ 49,482	\$ * (52,518)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,057	\$	1,057	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	38,102		38,102	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	232		232	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	232		232	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	3,000		3,000	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	183		183	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	10,847		10,847	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,151		4,151	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,920		2,920	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	557		557	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%	475		475	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		\$			\$ 61,756	\$ *	61,756	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 Health Enterprises, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Enterprises, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Enterprises, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Enterprises, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Enterprises, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Enterprises, LLC	100.00%	135	135	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Enterprises, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Enterprises, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Enterprises, LLC	100.00%	5,231	5,231	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Enterprises, LLC	100.00%	98	98	26	
27	V	21 Clerical and General Office		Petersen Health Enterprises, LLC	100.00%	4,864	4,864	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Enterprises, LLC	100.00%	7,374	7,374	28	
29	V	23 Inservice Training & Education		Petersen Health Enterprises, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Enterprises, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Enterprises, LLC	100.00%	69	69	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Enterprises, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Enterprises, LLC	100.00%	1,940	1,940	34	
35	V	32 Interest		Petersen Health Enterprises, LLC	100.00%	15,666	15,666	35	
36	V	33 Real Estate Taxes		Petersen Health Enterprises, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Enterprises, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Enterprises, LLC	100.00%	0		38	
39	Total		\$			\$ 35,377	\$ *	35,377	39

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

Facility Name &amp; ID Number

Tuscola Health Care Center

# 0046805

Report Period Beginning:

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	65.00	1,798,312	0.91	1.52	Salary	30,362	L17, C7	1
2	Jifi C. Jacob	Owner	Administrative	10.00	0	N/A	N/A	N/A	0	N/A	2
3	Jacque Whitley	Owner	Administrative	10.00	94,007	0.93	1.55	Salary	1,587	L10, C7	3
4	Cindy White	Owner	Administrative	10.00	104,888	0.93	1.55	Salary	1,771	L21, C7	4
5	David Petersen	Owner	Administrative	5.00	0	N/A	N/A	N/A	0	N/A	5
6											6
7											7
8											8
9											9
10		See Attached on Schedule 7A									10
11											11
12											12
13								TOTAL	\$ 33,720		13

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

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

Facility Name & ID Number Tuscola Health Care Center# 0046805 Report Period Beginning: 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	21,943	\$ 3,900	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	21,943	64	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	21,943	29	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	21,943	2	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	21,943	404	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	21,943	2,384	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	21,943	959	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	21,943	6,769	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	21,943	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	21,943	1,182	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	21,943	30,362	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	21,943	3,427	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	21,943	1,057	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	21,943	38,102	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	21,943	232	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	21,943	232	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	21,943	3,000	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	21,943	183	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	21,943	10,847	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	21,943	4,151	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	21,943	2,920	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	21,943	557	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	21,943	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	21,943	475	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 111,238	25

Facility Name & ID Number Tuscola Health Care Center

# 0046805

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	95,327	5	\$	21,943	\$	1
2	2	Food	Resident Days	95,327	5		21,943		2
3	3	Housekeeping	Resident Days	95,327	5		21,943		3
4	4	Laundry	Resident Days	95,327	5		21,943		4
5	5	Utilities	Resident Days	95,327	5		21,943		5
6	6	Maintenance	Resident Days	95,327	5	585	21,943	135	6
7	7	Mgmt. Allocation of Benefits	Resident Days	95,327	5		21,943		7
8	10	Nursing and Medical Records	Resident Days	95,327	5		21,943		8
9	15	Mgmt. Allocation of Benefits	Resident Days	95,327	5		21,943		9
10	17	Administrative	Resident Days	95,327	5		21,943		10
11	19	Professional Services	Resident Days	95,327	5	22,726	21,943	5,231	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	95,327	5	427	21,943	98	12
13	21	Clerical and General Office	Resident Days	95,327	5	21,132	21,943	4,864	13
14	22	Employee Benefits & Payroll	Resident Days	95,327	5	32,035	21,943	7,374	14
15	23	Inservice Training & Education	Resident Days	95,327	5		21,943		15
16	24	Travel and Seminar	Resident Days	95,327	5		21,943		16
17	25	Other Admin. Staff Transport.	Resident Days	95,327	5	301	21,943	69	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	95,327	5		21,943		18
19	27	Mgmt. Allocation of Benefits	Resident Days	95,327	5		21,943		19
20	30	Depreciation	Resident Days	95,327	5	8,430	21,943	1,940	20
21	32	Interest	Resident Days	95,327	5	68,058	21,943	15,666	21
22	33	Real Estate Taxes	Resident Days	95,327	5		21,943		22
23	34	Rent-Facility and Grounds	Resident Days	95,327	5		21,943		23
24	35	Rent-Equipment & Vehicles	Resident Days	95,327	5		21,943		24
25	TOTALS					\$ 153,694	\$	\$ 35,377	25

Facility Name &amp; ID Number

Tuscola Health Care Center

# 0046805

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**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1	F & M Bank of Galesburg, IL		X	Mortgage	\$5,744.00	5/6/2008	\$ 708,120	\$ 651,825	5/6/2011	0.0695	\$ 53,073	1						
2	F & M Bank of Galesburg, IL		X	Purchase Van	\$566.00	9/30/2005	28,696	11,173	9/30/2010	0.0675	969	2						
3							Interest Income Offset				(9)	3						
4							Home Office Allocation-PHC				2,920	4						
5							Home Office Allocation-PHE				15,666	5						
	<b>Working Capital</b>																	
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$6,310.00		\$ 736,816	\$ 662,998			\$ 72,619	9						
	<b>B. Non-Facility Related*</b>																	
10												10						
11							Amortization of Mortgage Costs				6,018	11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 6,018	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 736,816	\$ 662,998			\$ 78,637	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.		\$	<b>29,000</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2007	\$	<b>27,035</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(1,965)</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>28,000</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>Home Office Allocation</b>			<b>557</b>	
<b>TOTAL REFUND</b> \$ _____ For _____ Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>26,592</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<b>25,933</b>	8
	2004	<b>27,332</b>	9
	2005	<b>28,191</b>	10
	2006	<b>28,151</b>	11
	2007	<b>27,035</b>	12

Accrual based on prior year tax bill.

<b>FOR BHF USE ONLY</b>			
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 Tuscola Health Care Center COUNTY Douglas

FACILITY IDPH LICENSE NUMBER 0046805

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

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

Enter the tax index number and real estate tax assessed for 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>09-08-02-100-027</u>	<u>Long-Term Care Facility</u>	\$ <u>14,504.42</u>	\$ <u>14,504.42</u>
2. <u>09-08-02-100-029</u>	<u>Long-Term Care Facility</u>	\$ <u>12,530.78</u>	\$ <u>12,530.78</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>27,035.20</u>	\$ <u>27,035.20</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 Tuscola Health Care Center

# 0046805

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 21,274 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>187,955</u>	<u>2005</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>187,955</b>		<b>\$ 50,000</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	73	2005	1974	\$ 500,000	\$	30	\$ 16,667	\$ 16,667	\$ 66,669	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Carpeting		2005	1,286		25	51	51	196	9
10	Tiles		2005	2,945		10	295	295	1,130	10
11	Sidewalks		2005	3,901		15	260	260	910	11
12	Fire Alarm System		2006	4,552		5	910	910	2,275	12
13	Carpeting		2007	1,152		10	115	115	173	13
14	Signage		2007	3,305		10	331	331	496	14
15	Parking Lot		2007	2,400		15	160	160	240	15
16	Flooring		2008	3,869		15	129	129	129	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

\*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			16,667			(16,667)		46
47			1,927			(1,927)		47
48								48
49								49
50		762			49	49		50
51		11,393			273	273		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		\$ 535,565	\$ 18,594		\$ 19,240	\$ 646	\$ 72,218	70

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

Facility Name & ID Number Tuscola Health Care Center

# 0046805

Report Period Beginning:

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	\$ 205,918	\$ 24,019	\$ 22,079	\$ (1,940)	5-10 yrs.	\$ 77,481	71
72	Current Year Purchases		1,042	515	(527)	10 yrs.	515	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			6,091	6,091			74
75	TOTALS	\$ 205,918	\$ 25,061	\$ 28,685	\$ 3,624		\$ 77,996	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	'06 Ford Econoline	2005	\$ 28,696	\$ 5,739	\$ 5,739	\$	5	\$ 18,652	76
77										77
78										78
79										79
80	TOTALS			\$ 28,696	\$ 5,739	\$ 5,739	\$		\$ 18,652	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)	\$ 820,179	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 49,394	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 53,664	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,270	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 168,866	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?  YES  NO

If NO, see instructions.

		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: \$ (6,309) 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.

**Tuscola Health Care Center**

**0046805**

**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	\$ (9,769)
Copier	2,985
Home Office Allocation	474
	<u>(6,309)</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>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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	5,376	\$ 80,645	\$	5,376	\$ 80,645	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		348	5,224		348	5,224	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		5,854	87,808		5,854	87,808	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				94,302		94,302	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	<b>TOTAL</b>			\$	11,578	\$ 173,677	\$ 94,302	11,578	\$ 267,979	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 &amp; ID Number Tuscola Health Care Center

# 0046805

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 585,315	\$ 585,315	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	760,336	760,336	3
4	Supply Inventory (priced at <u>                    </u> )			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,113	18,113	6
7	Other Prepaid Expenses	8,980	8,980	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Advances</u>	350	350	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,373,094	\$ 1,373,094	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	56,300	50,000	13
14	Buildings, at Historical Cost	500,000	511,393	14
15	Leasehold Improvements, at Historical Cost	13,805	24,172	15
16	Equipment, at Historical Cost	248,214	234,614	16
17	Accumulated Depreciation (book methods)	(173,487)	(168,866)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): <u>                    </u>			22
23	Other(specify): <u>                    </u>			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 644,832	\$ 651,313	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,017,926	\$ 2,024,407	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 477,191	\$ 477,191	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	75,334	75,334	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,149	2,149	31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,000	28,000	32
33	Accrued Interest Payable	4,150	4,150	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	23,449	23,449	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 610,273	\$ 610,273	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	11,173	11,173	39
40	Mortgage Payable	651,825	651,825	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 662,998	\$ 662,998	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,273,271	\$ 1,273,271	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 744,655	\$ 751,136	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,017,926	\$ 2,024,407	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>157,979</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<u>Rounding</u>	<u>1</u>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>157,980</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>586,675</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>586,675</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>744,655</b>	<b>24</b> *

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

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,332,407	1
2	Discounts and Allowances for all Levels	42,826	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,375,233	3
	<b>B. Ancillary Revenue</b>		
4	Day Care	8,658	4
5	Other Care for Outpatients		5
6	Therapy	337,983	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 346,641	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,728	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	156,678	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,605	20
21	Other Medical Services	3,170	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 168,181	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	9	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 9	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Revenue</u>	2,307	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,307	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,892,371	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	486,804	31
32	Health Care	1,105,590	32
33	General Administration	421,826	33
	<b>B. Capital Expense</b>		
34	Ownership	128,705	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	122,691	35
36	Provider Participation Fee	40,080	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,305,696	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	586,675	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 586,675	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 Tuscola Health Care Center

# 0046805

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	1,868	\$ 44,768	\$ 23.97	1
2	Assistant Director of Nursing	261	6,267	22.62	2
3	Registered Nurses	7,969	184,419	21.64	3
4	Licensed Practical Nurses	7,438	138,003	17.79	4
5	CNAs & Orderlies	34,650	368,271	10.24	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,748	16,049	8.59	9
10	Activity Assistants				10
11	Social Service Workers	2,080	28,046	13.48	11
12	Dietician				12
13	Food Service Supervisor	2,080	27,115	13.04	13
14	Head Cook				14
15	Cook Helpers/Assistants	8,471	76,308	8.12	15
16	Dishwashers				16
17	Maintenance Workers	2,159	27,695	12.83	17
18	Housekeepers	8,280	85,886	9.97	18
19	Laundry	1,821	21,550	10.83	19
20	Administrator	2,080	57,500	27.64	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager	1,861	33,439	15.95	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)	3,219	52,138	15.38	33
34	TOTAL (lines 1 - 33)	85,985	\$ 1,167,454 *	\$ 12.95	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 hrs.	\$ 440	1(3)	35
36	Medical Director	Monthly	8,400	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	550	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)		\$ 9,390		49

**C. CONTRACT NURSES**

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

Tuscola Health Care Center  
 0046805  
 Period Beginning 1/1/2008  
 Period End 12/31/2008

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Director of Nursing				
Assistant Director of Nsg.				
Registered Nurses				
Licensed Practical Nurses				
Nurse Aides & Orderlies				
Nurse Aide Trainees				
Licensed Therapist				
Activity Director				
Activity Assistants				
Social Service Workers				
Dietician				
Food Service Supervisor				
Head Cook				
Cook Helpers/Assistants				
Dishwashers				
Maintenance Workers				
Housekeepers				
Laundry				
Administrator				
Assistant Administrator				
Other Administrative				
Office Manager				
Clerical				
Vocational Instruction				
Academic Instruction				
Medical Director				
Qualified Mental Retard.Prof.				
Resident Services Coordinator				
Habilitation Aides				
Medical Records				
Care Plan Coordinator	1,649	1,821	39,269	21.56
Marketing				
Transportation	872	872	7,269	8.34
Unit Aide				
Home Health Nurse	698	698	5,600	8.02
Marketing				
<b>TOTAL (lines 1 - 35)</b>	<b>3,219</b>	<b>3,391</b>	<b>52,138</b>	

**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	
Thomas Stephenson	Administrator	0	\$ 57,500	Workers' Compensation Insurance	\$ 58,222	IDPH License Fee	\$	
				Unemployment Compensation Insurance	19,803	Advertising: Employee Recruitment	774	
				FICA Taxes	87,945	Health Care Worker Background Check		
				Employee Health Insurance	12,593	(Indicate # of checks performed )		
				Employee Meals		Patient Background Checks	46	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	235	
				Employee Relations	10,315	Miscellaneous Dues & Subscriptions	200	
				Employee Retirement	1,285	IHCA Dues	5,270	
				Employee Life Insurance		Home Office Allocation	1,155	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 57,500					
B. Administrative - Other								
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 102,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 102,000					
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
Mediacom	Computer Services		\$ 1,199				Out-of-State Travel	\$
E-Health Data Solutions	Computer Services		2,700					
LTC Solutions	Computer Services		1,600				In-State Travel	
				N/A				
							Seminar Expense	45
							Home Office Allocation	232
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 5,499	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 277

\* Attach copy of IMRF notifications

\*\*See instructions.

**Tuscola Health Care Center**

**0046805**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		5,499

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	125
GoffWilson, P.A.	Legal	416
Ginoli & Company	Accountants	6,242
RSM McGladrey	Accountants	9
Miscellaneous Vendors	Computer Services	49
Emdeon Business Services	Computer Services	67
Advanced Answers on Demand	Computer Services	787
Access 2 Go	Computer Services	232
Ivans	Computer Services	121
Kemper Technology	Computer Services	426
VisionShare	Computer Services	46
Logmein	Computer Services	33
Comm Net Communiations	Computer Services	12
Charter Communications	Computer Services	10
Advanced System Designs	Computer Services	15
Consolidated Communications	Computer Services	9
Miscellaneous Vendors	Miscellaneous	59

Total (agree to Schedule V, line 19, column 8)		<u>14,157</u>
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Facility Name &amp; ID Number Tuscola Health Care Center

# 0046805

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. 5,270 -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. \$ 28,762 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. \$ 40,080  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,728
- (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