		FOR BHF USE					

LL1

2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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.

I. IDPH License ID Number: 0046805

Facility Name: Tuscola Health Care Center

Address: 1203 Egyptian Trail (Number) Tuscola (City) 61953 (Zip Code)

County: Douglas

Telephone Number: (217) 253-4791 **Fax #** (217) 253-3754

HFS ID Number: 200349783003

Date of Initial License for Current Owners: 1/18/2005

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2009 to 12/31/2009 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) (Date)
	(Type or Print Name) Mark B. Petersen
	(Title) Chief Executive Officer
Paid Preparer	(Signed) (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (309) 691-8113
Email Address:

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

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	21	Skilled (SNF)	21	7,665	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	18,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	73	TOTALS	73	26,645	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			1,130	1,130	8
9	SNF/PED					9
10	ICF	12,681	8,233	77	20,991	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,681	8,233	1,207	22,121	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.02%

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 [X] 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 [X]

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 [X] Date 1/18/05 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 21 and days of care provided 1,130

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	121,631	10,881		132,512		132,512	3,868	136,380			1
2	Food Purchase		121,403		121,403		121,403	(1,433)	119,970			2
3	Housekeeping	106,682	13,248		119,930		119,930	36	119,966			3
4	Laundry	2,157	7,537		9,694		9,694		9,694			4
5	Heat and Other Utilities			73,942	73,942		73,942	382	74,324			5
6	Maintenance	27,549	11,075	14,924	53,548		53,548	1,874	55,422			6
7	Other (specify):* Home Off. Ben. All.							699	699			7
8	**TOTAL General Services**	258,019	164,144	88,866	511,029		511,029	5,426	516,455			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	834,068	71,161	5,429	910,658		910,658	2,189	912,847			10
10a	Therapy			126,096	126,096		126,096		126,096			10a
11	Activities	22,493	59	236	22,788		22,788	(26)	22,762			11
12	Social Services	28,631			28,631		28,631		28,631			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.							288	288			15
16	**TOTAL Health Care and Programs**	885,192	71,220	140,161	1,096,573		1,096,573	2,451	1,099,024			16
	C. General Administration											
17	Administrative	14,375		96,000	110,375		110,375	(49,569)	60,806			17
18	Directors Fees											18
19	Professional Services			5,696	5,696		5,696	7,884	13,580			19
20	Dues, Fees, Subscriptions & Promotions			7,205	7,205		7,205	3,885	11,090			20
21	Clerical & General Office Expenses	33,212	4,299	9,527	47,038		47,038	45,741	92,779			21
22	Employee Benefits & Payroll Taxes			154,079	154,079		154,079	342	154,421			22
23	Inservice Training & Education							403	403			23
24	Travel and Seminar							124	124			24
25	Other Admin. Staff Transportation			3,122	3,122		3,122	1,944	5,066			25
26	Insurance-Prop.Liab.Malpractice			23,895	23,895		23,895	806	24,701			26
27	Other (specify):* Home Off. Ben. All.							10,588	10,588			27
28	**TOTAL General Administration**	47,587	4,299	299,524	351,410		351,410	22,148	373,558			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,190,798	239,663	528,551	1,959,012		1,959,012	30,025	1,989,037			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: 1/1/2009 Ending: 12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			50,168	50,168		50,168	7,120	57,288			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,594	44,594		44,594	23,680	68,274			32
33	Real Estate Taxes			28,585	28,585		28,585	490	29,075			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,189	3,189		3,189	469	3,658			35
36	Other (specify):*											36
37	TOTAL Ownership			126,536	126,536		126,536	31,759	158,295			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		44,584		44,584		44,584		44,584			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,968	39,968		39,968		39,968			42
43	Other (specify):* Non-allowable Cost		308	44,248	44,556		44,556	(44,556)				43
44	TOTAL Special Cost Centers		44,892	84,216	129,108		129,108	(44,556)	84,552			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,190,798	284,555	739,303	2,214,656		2,214,656	17,228	2,231,884			45

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

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,520)	2		4
5	Telephone, TV & Radio in Resident Rooms	(305)	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	(129)	30		9
10	Interest and Other Investment Income	(1,344)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(87)	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	(2,029)	43		18
19	Entertainment				19
20	Contributions	(250)	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	(28,599)	43		24
25	Fund Raising, Advertising and Promotional	(7,262)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(6,425)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (47,950)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	65,178	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 65,178		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 17,228		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Tuscola Health Care Center

ID# 0046805

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (1,538)	43	1
2	X-Rays-Part A	(3,841)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(152)	10	3
4	Offset Miscellaneous Office Supplies Revenue	(23)	21	4
5	Offset Chamber of Commerce Dues	(200)	20	5
6	Resident Flower	(472)	43	6
7	Disallowed Special Events	(173)	43	7
8	To offset Transportation Revenue	(26)	11	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(6,425)		49

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 3,868	$ 3,868	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	87	87	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	36	36	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	382	382	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,874	1,874	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	699	699	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	2,341	2,341	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%	288	288	10
11	V	17	Administrative	96,000	Petersen Health Care, Inc.	100.00%	46,431	(49,569)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	5,424	5,424	12
13	V								13
14	Total			$ 96,000			$ 61,430	$ * (34,570)	14

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

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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. [X] 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%	$ 1,512	$ 1,512	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	39,446	39,446	16
17	V	23	Inservice Training and Education		Petersen Health Care, Inc.	100.00%	403	403	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	124	124	18
19	V	25	Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,944	1,944	19
20	V	26	Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	806	806	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	10,588	10,588	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,188	3,188	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	4,904	4,904	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	490	490	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%	469	469	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			$			$ 63,874	$ * 63,874	39

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

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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. [X] 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%	0		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%	2,460	2,460	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Enterprises, LLC	100.00%	2,573	2,573	26
27	V	21	Clerical and General Office		Petersen Health Enterprises, LLC	100.00%	6,318	6,318	27
28	V	22	Employee Benefits & Payroll		Petersen Health Enterprises, LLC	100.00%	342	342	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%	0		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%	4,061	4,061	34
35	V	32	Interest		Petersen Health Enterprises, LLC	100.00%	20,120	20,120	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			$			$ 35,874	$ * 35,874	39

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

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Mark Petersen	President	Administrative	65.00	156,598	0.86	1.44	Salary	$ 2,515	L17, C7	1
2	Jifi C. Jacob	Owner	Administrative	10.00				N/A		N/A	2
3	Jacque Whitley	Owner	Administrative	10.00	103,785	0.89	1.48	Salary	1,667	L10, C7	3
4	Cindy White	Owner	Administrative	10.00	110,958	0.86	1.44	Salary	1,782	L21, C7	4
5	David Petersen	Owner	Administrative	5.00				N/A		N/A	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 5,964		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: 1/1/2009 Ending: 2/31/2009

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,493,044	75	$ 261,102	$ 259,584	22,121	$ 3,868	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	22,121	87	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	22,121	36	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	22,121	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	22,121	382	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	22,121	1,874	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	22,121	699	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	22,121	2,341	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	22,121	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	22,121	288	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	22,121	46,431	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	22,121	5,424	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	22,121	1,512	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	22,121	39,446	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	22,121	403	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	22,121	124	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	22,121	1,944	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	22,121	806	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	22,121	10,588	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	22,121	3,188	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	22,121	4,904	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	22,121	490	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	22,121	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	22,121	469	24
25	TOTALS					$ 8,639,461	$ 6,088,287		$ 125,304	25

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 2/31/2009

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	93,320	5	$	$	22,121	$	1
2	2	Food	Resident Days	93,320	5			22,121		2
3	3	Housekeeping	Resident Days	93,320	5			22,121		3
4	4	Laundry	Resident Days	93,320	5			22,121		4
5	5	Utilities	Resident Days	93,320	5			22,121		5
6	6	Maintenance	Resident Days	93,320	5			22,121		6
7	7	Mgmt. Allocation of Benefits	Resident Days	93,320	5			22,121		7
8	10	Nursing and Medical Records	Resident Days	93,320	5			22,121		8
9	15	Mgmt. Allocation of Benefits	Resident Days	93,320	5			22,121		9
10	17	Administrative	Resident Days	93,320	5			22,121		10
11	19	Professional Services	Resident Days	93,320	5	10,378		22,121	2,460	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	93,320	5	10,855		22,121	2,573	12
13	21	Clerical and General Office	Resident Days	93,320	5	26,653		22,121	6,318	13
14	22	Employee Benefits & Payroll	Resident Days	93,320	5	1,442		22,121	342	14
15	23	Inservice Training & Education	Resident Days	93,320	5			22,121		15
16	24	Travel and Seminar	Resident Days	93,320	5			22,121		16
17	25	Other Admin. Staff Transport.	Resident Days	93,320	5			22,121		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	93,320	5			22,121		18
19	27	Mgmt. Allocation of Benefits	Resident Days	93,320	5			22,121		19
20	30	Depreciation	Resident Days	93,320	5	17,132		22,121	4,061	20
21	32	Interest	Resident Days	93,320	5	84,878		22,121	20,120	21
22	33	Real Estate Taxes	Resident Days	93,320	5			22,121		22
23	34	Rent-Facility and Grounds	Resident Days	93,320	5			22,121		23
24	35	Rent-Equipment & Vehicles	Resident Days	93,320	5			22,121		24
25	TOTALS					$ 151,338	$		$ 35,874	25

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	F & M Bank of Galesburg, IL		X	Mortgage	$5,744.00	5/6/2008	$ 708,120	$ 630,308	5/6/2011	0.0695	$ 44,008	1
2	F & M Bank of Galesburg, IL		X	Purchase Van	$566.00	9/30/2005	28,696	4,966	9/30/2010	0.0675	586	2
3							Interest Income Offset				(1,344)	3
4							Home Office Allocation-PHC				4,904	4
5							Home Office Allocation-PHE				20,120	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$6,310.00		$ 736,816	$ 635,274			$ 68,274	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 736,816	$ 635,274			$ 68,274	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.)

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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

1. Real Estate Tax accrual used on 2008 report.		$ 28,000	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.)	2008	$ 27,885	2
3. Under or (over) accrual (line 2 minus line 1).		$ (115)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 28,700	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	490	
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.		$ 29,075	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2004	27,332	8
2005	28,191	9
2006	28,151	10
2007	27,035	11
2008	27,885	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2008	$	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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 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) 691-8113

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

Enter the tax index number and real estate tax assessed for 2008 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 2008.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-08-02-100-027	Long-Term Care Facility	14,960.34	14,960.34
2.	09-08-02-100-029	Long-Term Care Facility	12,924.28	12,924.28
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 27,884.62	$ 27,884.62

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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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: 1/1/2009 Ending: 12/31/2009

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? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	187,955	2005	$ 50,000	1
2					2
3	TOTALS	187,955		$ 50,000	3

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	73		2005	1974	$ 500,000	$	30	$ 16,667	$ 16,667	$ 83,336	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpeting			2005	1,286		25	51	51	247	9
10	Tiles			2005	2,945		10	295	295	1,425	10
11	Sidewalks			2005	3,901		15	260	260	1,170	11
12	Fire Alarm System			2006	4,552		5	910	910	3,185	12
13	Carpeting			2007	1,152		10	115	115	288	13
14	Signage			2007	3,305		10	331	331	827	14
15	Parking Lot			2007	2,400		15	160	160	400	15
16	Flooring			2008	3,869		15	258	258	387	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27	Land Improvements Booked					420			(420)		27
28	Building Booked					16,667			(16,667)		28
29	Building Improvement Booked					1,679			(1,679)		29
30											30
31											31
32	2009-Home Office Allocation-Land Improvements				728			46	46		32
33	2009-Home Office Allocation-Building Improvements				10,875			261	261		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

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		$ 535,013	$ 18,766		$ 19,354	$ 588	$ 91,265	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: 1/1/2009 Ending: 12/31/2009

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	$ 216,214	$ 25,490	$ 23,109	$ (2,381)	5-10 yrs.	$ 101,105	71
72	Current Year Purchases	2,422	173	121	(52)	10 yrs.	121	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			8,965	8,965			74
75	TOTALS	$ 218,636	$ 25,663	$ 32,195	$ 6,532		$ 101,226	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	$ 24,391	76
77										77
78										78
79										79
80	TOTALS			$ 28,696	$ 5,739	$ 5,739	$		$ 24,391	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)	$ 832,345	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 50,168	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 57,288	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,120	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 216,882	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.

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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: _____ *

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.	/2010	$
13.	/2011	$
14.	/2012	$

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: $ 3,658 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

* 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 1/1/2009
Period End 12/31/2009

Schedule 14A

XII. Rental Costs
B. Equipment
16. Description of rental amount for movable equipment

Medical Equipment	$	561
Copier		2,628
Home Office Allocation		469
		3,658

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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

		1	2	3	4	5	6	7	8	
	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	$	3,887	$ 58,310	$	3,887	$ 58,310	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		168	2,514		168	2,514	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		4,351	65,272		4,351	65,272	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 prescrpts				44,584		44,584	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			$	8,406	$ 126,096	$ 44,584	8,406	$ 170,680	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 Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2009 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,342,349	$ 1,342,349	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance N/A)	256,626	256,626	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,390	36,390	6
7	Other Prepaid Expenses	10,540	10,540	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Prepaid Mgmt. Fees	46,000	46,000	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,691,905	$ 1,691,905	10
	B. Long-Term Assets			
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	510,875	14
15	Leasehold Improvements, at Historical Cost	13,805	24,138	15
16	Equipment, at Historical Cost	250,637	247,332	16
17	Accumulated Depreciation (book methods)	(223,655)	(216,882)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 597,087	$ 615,463	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,288,992	$ 2,307,368	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 314,493	$ 314,493	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	77,498	77,498	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,793	1,793	31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,700	28,700	32
33	Accrued Interest Payable	3,040	3,040	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	63,678	63,678	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 489,202	$ 489,202	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,966	4,966	39
40	Mortgage Payable	630,308	630,308	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)**	$ 635,274	$ 635,274	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,124,476	$ 1,124,476	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,164,516	$ 1,182,892	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,288,992	$ 2,307,368	48

*(See instructions.)

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 744,655	1
2	Restatements (describe):		2
3	2008 Bad Debt Allowance Entered After CR Completion	(10,000)	3
4	Rounding	2	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 734,657	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	429,859	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)**	$ 429,859	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,164,516	24 *

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

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,373,671	1
2	Discounts and Allowances for all Levels	(31,910)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,341,761	3
	B. Ancillary Revenue		
4	Day Care	4,973	4
5	Other Care for Outpatients		5
6	Therapy	220,431	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 225,404	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	1,520	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	69,142	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,967	20
21	Other Medical Services	2,176	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 75,805	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,344	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,344	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	201	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 201	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,644,515	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	511,029	31
32	Health Care	1,096,573	32
33	General Administration	351,410	33
	B. Capital Expense		
34	Ownership	126,536	34
	C. Ancillary Expense		
35	Special Cost Centers	89,140	35
36	Provider Participation Fee	39,968	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,214,656	40
41	**Income before Income Taxes (line 30 minus line 40)****	429,859	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 429,859	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 a larger entity

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

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

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,008	$ 47,873	$ 23.84	1
2	Assistant Director of Nursing	1,973	2,197	49,407	22.49	2
3	Registered Nurses	5,713	6,010	139,180	23.16	3
4	Licensed Practical Nurses	9,874	10,122	206,538	20.40	4
5	CNAs & Orderlies	35,597	37,114	388,388	10.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,760	1,912	16,450	8.60	9
10	Activity Assistants					10
11	Social Service Workers	2040	2,040	28,631	14.03	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,029	13.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,266	11,354	93,602	8.24	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	27,549	13.24	17
18	Housekeepers	10,469	10,945	106,682	9.75	18
19	Laundry	83	195	2,157	11.06	19
20	Administrator	2,080	2,080	58,291	28.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,828	2,020	33,212	16.44	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Home Health Nurs	328	328	2,682	8.18	32
33	Other(specify) Transportation	740	740	6,043	8.17	33
34	TOTAL (lines 1 - 33)	89,911	93,225	$ 1,234,714 *	$ 13.24	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	8,400	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 9,000		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

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas Stephenson	Administrator	0	$ 58,291
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 58,291

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 96,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 96,000

C. Professional Services

Vendor/Payee	Type	Amount
Mediacom	Computer Services	$ 1,215
E-Health Data Solutions	Computer Services	2,700
LTC Solutions	Computer Services	1,700
SimpleLTC, Inc.	Computer Services	81
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 5,696

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,197
Unemployment Compensation Insurance	17,007
FICA Taxes	89,339
Employee Health Insurance	5,450
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	2,150
Employee Retirement	278
TOTAL (agree to Schedule V, line 22, col.8)	$ 154,421

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	3,895
Health Care Worker Background Check (Indicate # of checks performed ____)	
Patient Background Checks 48	480
Miscellaneous Licenses & Permits	85
Miscellaneous Dues & Subscriptions	250
IHCA Dues	1,500
Home Office Allocation	4,085
Less: Public Relations Expense	(200)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,090

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	124
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 124

**See instructions.

Tuscola Health Care Center
0046805
Period Beginning 1/1/2009
Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,696
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	35
GoffWilson, P.A.	Legal	49
Jackson Lewis	Legal	389
Peter Gartelos	Legal	38
Misc.	Legal	33
Ginoli & Company	Accountants	3,323
Miscellaneous Vendors	Computer Services	36
Emdeon Business Services	Computer Services	16
Advanced Answers on Demand	Computer Services	2,084
Access 2 Go	Computer Services	200
Ivans	Computer Services	24
Kemper Technology	Computer Services	566
VisionShare	Computer Services	176
MediFax	Computer Services	72
Logmeln	Computer Services	31
Charter Communications	Computer Services	1
Simple LTC	Computer Services	481
Miscellaneous Vendors	Miscellaneous	330
Total (agree to Schedule V, line 19, column 8)		13,580

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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. **1,500** **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. $ **17,689** 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. $ **39,968**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,520**

(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. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.