		FOR BHF USE					

LL1

DEPARTME
FINANCIA

I. IDPH License ID Number: 0046805

Facility Name: Tuscola Health Care Center

Address: 1203 Egyptian Trail (Number) Tuscola (City)

County: Douglas

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:

Name: Mike Kocher **Telephone Number:** (309) 689-5850

Email Address:

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE C
THAT IS NECESSARY TO ACCOMPLISH THE ST
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. I
OF THIS INFORMATION IS MANDATORY. FAII
ANY INFORMATION ON OR BEFORE THE DUE
RESULT IN CESSATION OF PROGRAM PAYMEI
HAS BEEN APPROVED BY THE FORMS MANA

2013
STATE OF ILLINOIS
ENT OF HEALTHCARE AND FAMILY SERVICES
L AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

61953
Zip Code

ERNMENTAL
State
County
Other

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to t
State of Illinois, for the period from 1/1/2013 to
and certify to the best of my knowledge and belief that the said c
are true, accurate and complete statements in accordance with
applicable instructions. Declaration of preparer (other than prov
is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any informati
in this cost report may be punishable by fine and/or imprisonme

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phon

)F INFORMATIOI
ſATUTORY
DISCLOSURE
LURE TO PROVIDI
DATE WILI
NTS. THIS FORM
GEMENT CENTER.

the
12/31/2013
contents

vider)
e.

on
nt.

(Date)

(Date)

f ( )

Y SERVICES

e # (217) 782-1630

Facility Name & ID Number Tuscola Health Care Center

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 ___

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period
1	73	Skilled (SNF)	73
2		Skilled Pediatric (SNF/PED)	
3		Intermediate (ICF)	
4		Intermediate/DD	
5		Sheltered Care (SC)	
6		ICF/DD 16 or Less	
7	73	TOTALS	73

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of P	3	4
		Medicaid Recipient	Private Pay	Other
8	SNF	10,080	8,236	820
9	SNF/PED			
10	ICF			
11	ICF/DD			
12	SC			
13	DD 16 OR LESS			
14	TOTALS	10,080	8,236	820

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.82%

STATE OF ILLINOIS

0046805 Report Period Beginning: 1/1/2013 Endi

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

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

N/A

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

4

None

Licensed Bed Days During Report Period	
26,645	1
	2
	3
	4
	5
	6
26,645	7

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 [ ]

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 8/1/2004

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

YES [X] Date 1/18/2005 NO [ ]

5 'ayment Total	
19,136	8
	9
	10
	11
	12
	13
19,136	14

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

YES [X] NO [ ] If YES, enter number of beds certified 71 and days of care provided

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: 12/31/2013 Fiscal Year: 12/31/2013

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

ng: 12/31/2013

?

638

Facility Name & ID Number **Tuscola Health Care Center**

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

	Operating Expenses	Costs Per General Ledger		
		Salary/Wage	Supplies	Other
	A. General Services	1	2	3
1	Dietary	112,976	11,545	
2	Food Purchase		103,216	
3	Housekeeping	86,332	22,025	
4	Laundry	285	10,507	
5	Heat and Other Utilities			67,774
6	Maintenance	55,044	11,328	12,812
7	Other (specify):* Home Off. Ben. All.			
8	**TOTAL General Services**	254,637	158,621	80,586
	B. Health Care and Programs			
9	Medical Director			7,000
10	Nursing and Medical Records	922,974	100,989	4,113
10a	Therapy			103,508
11	Activities	24,686	438	1,234
12	Social Services	3,508	8	
13	CNA Training			
14	Program Transportation			
15	Other (specify):* Home Off. Ben. All.			
16	**TOTAL Health Care and Programs**	951,168	101,435	115,855
	C. General Administration			
17	Administrative			131,400
18	Directors Fees			
19	Professional Services			2,729
20	Dues, Fees, Subscriptions & Promotions			6,392
21	Clerical & General Office Expenses	25,671	3,988	8,008
22	Employee Benefits & Payroll Taxes			144,556
23	Inservice Training & Education			
24	Travel and Seminar			
25	Other Admin. Staff Transportation			2,804
26	Insurance-Prop.Liab.Malpractice			27,606
27	Other (specify):* Home Off. Ben. All.			
28	**TOTAL General Administration**	25,671	3,988	323,495
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,231,476	264,044	519,936

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. B

0046805 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

)llar)

Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10
124,521		124,521	3,771	128,292		
103,216		103,216	(4,341)	98,875		
108,357		108,357	38	108,395		
10,792		10,792		10,792		
67,774		67,774	286	68,060		
79,184		79,184	1,847	81,031		
			213	213		
493,844		493,844	1,814	495,658		
7,000		7,000		7,000		
1,028,076		1,028,076	(3,314)	1,024,762		
103,508		103,508		103,508		
26,358		26,358	(7,975)	18,383		
3,516		3,516		3,516		
1,168,458		1,168,458	(11,289)	1,157,169		
131,400		131,400	(65,442)	65,958		
2,729		2,729	14,421	17,150		
6,392		6,392	2,948	9,340		
37,667		37,667	52,245	89,912		
144,556		144,556		144,556		
			75	75		
			4	4		
2,804		2,804	3,491	6,295		
27,606		27,606	674	28,280		
			4,326	4,326		
353,154		353,154	12,742	365,896		
2,015,456		2,015,456	3,267	2,018,723		

xceeds $1000.
e sure to include a detailed explanation of each reclassification.

1
2
3
4
5
6
7
8
9
10
10a
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29

Facility Name & ID Number **Tuscola Health Care Center**

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger			
	Capital Expense	**Salary/Wage**	**Supplies**	**Other**	**Total**
	D. Ownership	**1**	**2**	**3**	**4**
30	Depreciation			**46,212**	**46,212**
31	Amortization of Pre-Op. & Org.				
32	Interest			**84,745**	**84,745**
33	Real Estate Taxes			**29,739**	**29,739**
34	Rent-Facility & Grounds				
35	Rent-Equipment & Vehicles			**21,926**	**21,926**
36	Other (specify):*				
37	**TOTAL Ownership**			**182,622**	**182,622**
	Ancillary Expense				
	E. Special Cost Centers				
38	Medically Necessary Transportation				
39	Ancillary Service Centers		**44,416**		**44,416**
40	Barber and Beauty Shops				
41	Coffee and Gift Shops				
42	Provider Participation Fee			**150,800**	**150,800**
43	Other (specify):* **Non-allowable Costs**	**14,980**	**304**	**82,132**	**97,416**
44	**TOTAL Special Cost Centers**	**14,980**	**44,720**	**232,932**	**292,632**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**1,246,456**	**308,764**	**935,490**	**2,490,710**

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $100**

Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	46,212	7,295	53,507			30
						31
	84,745	50,831	135,576			32
	29,739	303	30,042			33
						34
	21,926	558	22,484			35
						36
	182,622	58,987	241,609			37
						38
	44,416		44,416			39
						40
						41
	150,800		150,800			42
	97,416	(97,416)				43
	292,632	(97,416)	195,216			44
	2,490,710	(35,162)	2,455,548			45

0.

Facility Name & ID Number Tuscola Health Care Center # 0046805

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should
In column 2 below, reference the line on which the particula

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY
1	Day Care	$		$
2	Other Care for Outpatients			
3	Governmental Sponsored Special Programs			
4	Non-Patient Meals	(4,422)	2	
5	Telephone, TV & Radio in Resident Rooms	(812)	43	
6	Rented Facility Space			
7	Sale of Supplies to Non-Patients			
8	Laundry for Non-Patients			
9	Non-Straightline Depreciation	(1,138)	30	
10	Interest and Other Investment Income	(9,488)	32	
11	Discounts, Allowances, Rebates & Refunds			
12	Non-Working Officer's or Owner's Salary			
13	Sales Tax	(186)	43	
14	Non-Care Related Interest			
15	Non-Care Related Owner's Transactions			
16	Personal Expenses (Including Transportation)			
17	Non-Care Related Fees			
18	Fines and Penalties	(25,928)	43	
19	Entertainment			
20	Contributions	(660)	43	
21	Owner or Key-Man Insurance			
22	Special Legal Fees & Legal Retainers			
23	Malpractice Insurance for Individuals			
24	Bad Debt	(35,758)	43	
25	Fund Raising, Advertising and Promotional	(21,672)	43	
26	Income Taxes and Illinois Personal Property Replacement Tax			
27	CNA Training for Non-Employees			
28	Yellow Page Advertising			
29	Other-Attach Schedule See Page 5A	(23,940)	Various	
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (124,004)		$

BHF USE ONLY								
48		49		50		51	52	

be adjusted out of Schedule V, pages 3 or 4 via column 7.
r cost was included. (See instructions.)

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)		88,842	Various	34
35	Other- Attach Schedule				35
36	SUBTOTAL (B): (sum of lines 31-35)	$	88,842		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$	(35,162)		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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			$		47

STATE OF ILLINOIS **Page 5A**

Tuscola Health Care Center

ID# **0046805**

Report Period Beginning: **1/1/2013**

Ending: **12/31/2013**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (5,979)	43	1
2	X-Rays-Part A	(559)	43	2
3	Offset Transportation Revenue	(7,975)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(38)	21	4
5	Offset Chamber of Commerce Dues	(200)	20	5
6	Offset Cable TV Revenue	(5,865)	43	6
7	Disallowed Special Events	41	43	7
8	Offset Miscellaneous Nursing Supplies Revenue	(3,327)	10	8
9	Resident Flowers	(38)	43	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**	(23,940)		49

Facility Name & ID Number **Tuscola Health Care Center**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B
	A. General Services				
1	Dietary	0	3,771	0	0
2	Food Purchase	0	81	0	0
3	Housekeeping	0	38	0	0
4	Laundry	0	0	0	0
5	Heat and Other Utilities	0	286	0	0
6	Maintenance	0	1,847	0	0
7	Other (specify):*	0	213	0	0
8	**TOTAL General Services**	0	6,236	0	0
	B. Health Care and Programs				
9	Medical Director	0	0	0	0
10	Nursing and Medical Records	(3,327)	13	0	0
10a	Therapy	0	0	0	0
11	Activities	(7,975)	0	0	0
12	Social Services	0	0	0	0
13	CNA Training	0	0	0	0
14	Program Transportation	0	0	0	0
15	Other (specify):*	0	0	0	0
16	**TOTAL Health Care and Programs**	(11,302)	13	0	0
	C. General Administration				
17	Administrative	0	(65,442)	0	0
18	Directors Fees	0	0	0	0
19	Professional Services	0	7,950	0	6,471
20	Fees, Subscriptions & Promotions	(200)	0	505	2,643
21	Clerical & General Office Expenses	(38)	0	46,732	5,551
22	Employee Benefits & Payroll Taxes	0	0	0	0
23	Inservice Training & Education	0	0	75	0
24	Travel and Seminar	0	0	4	0
25	Other Admin. Staff Transportation	0	0	3,491	0
26	Insurance-Prop.Liab.Malpractice	0	0	674	0
27	Other (specify):*	0	0	4,326	0
28	**TOTAL General Administration**	(238)	(57,492)	55,807	14,665
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,540)	(51,243)	55,807	14,665

STATE OF ILLINOIS

0046805 Report Period Beginning: 1/1/2013 Ending:

PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0

Summary A
12/31/2013

SUMMARY TOTALS (to Sch V, col.7)	
3,771	1
81	2
38	3
0	4
286	5
1,847	6
213	7
6,236	8
0	9
(3,314)	10
0	10a
(7,975)	11
0	12
0	13
0	14
0	15
(11,289)	16
(65,442)	17
0	18
14,421	19
2,948	20
52,245	21
0	22
75	23
4	24
3,491	25
674	26
4,326	27
12,742	28
7,689	29

STATE OF ILLINOIS

Facility Name & ID Number **Tuscola Health Care Center**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**
30	Depreciation	**(812)**	**0**	**3,098**	**5,335**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**
32	Interest	**0**	**0**	**5,153**	**55,166**
33	Real Estate Taxes	**0**	**0**	**303**	**0**
34	Rent-Facility & Grounds	**0**	**0**	**0**	**0**
35	Rent-Equipment & Vehicles	**0**	**0**	**558**	**0**
36	Other (specify):*	**0**	**0**	**0**	**0**
37	**TOTAL Ownership**	**(812)**	**0**	**9,112**	**60,501**
	Ancillary Expense				
	E. Special Cost Centers				
38	Medically Necessary Transportation	**0**	**0**	**0**	**0**
39	Ancillary Service Centers	**0**	**0**	**0**	**0**
40	Barber and Beauty Shops	**0**	**0**	**0**	**0**
41	Coffee and Gift Shops	**0**	**0**	**0**	**0**
42	Provider Participation Fee	**0**	**0**	**0**	**0**
43	Other (specify):*	**(14,198)**	**0**	**0**	**0**
44	**TOTAL Special Cost Centers**	**(14,198)**	**0**	**0**	**0**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(26,550)**	**(51,243)**	**64,919**	**75,166**

 # 0046805 Report Period Beginning: 1/1/2013 Ending:

PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0

Summary B
12/31/2013

SUMMARY TOTALS (to Sch V, col.7)	
7,621	30
0	31
60,319	32
303	33
0	34
558	35
0	36
68,801	37
0	38
0	39
0	40
0	41
0	42
(14,198)	43
(14,198)	44
62,292	45

Facility Name & ID Number Tuscola Health Care Center

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defin

1 OWNERS		2 RELATED NURSI
Name	Ownership %	Name
Mark B. Petersen	100	See PG6 - Supp

B. Are any costs included in this report which are a result of transactions with related organizations? management fees, purchase of supplies, and so forth. [X] YES [ ]

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in 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 Org Name of Related O
1	V	1	Dietary	$	Petersen Health Ca
2	V	2	Food		Petersen Health Ca
3	V	3	Housekeeping		Petersen Health Ca
4	V	4	Laundry		Petersen Health Ca
5	V	5	Utilities		Petersen Health Ca
6	V	6	Maintenance		Petersen Health Ca
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Ca
8	V	10	Nursing and Medical Records		Petersen Health Ca
9	V	10A	Therapy		Petersen Health Ca
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Ca
11	V	17	Administrative	131,400	Petersen Health Ca
12	V	19	Professional Services		Petersen Health Ca
13	V				
14	Total			$ 131,400	

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

ed in the instructions. Use Page 6-Supplemental as necessary.

NG HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Busine
		See PG6 - Supp		

This includes rent,
NO

accordance with

ganization	6	7	8 Difference:
rganization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
ıre, Inc.	100.00%	$ 3,771	$ 3,771
ıre, Inc.	100.00%	81	81
ıre, Inc.	100.00%	38	38
ıre, Inc.	100.00%	0	
ıre, Inc.	100.00%	286	286
ıre, Inc.	100.00%	1,847	1,847
ıre, Inc.	100.00%	213	213
ıre, Inc.	100.00%	13	13
ıre, Inc.	100.00%	0	
ıre, Inc.	100.00%	0	
ıre, Inc.	100.00%	65,958	(65,442)
ıre, Inc.	100.00%	7,950	7,950
		$ 80,157	$ * (51,243)

ess

1
2
3
4
5
6
7
8
9
10
11
12
13
14

Facility Name & ID Number Tuscola Health Care Center

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? T
management fees, purchase of supplies, and so forth. [X] YES [ ]

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Org
Schedule V		Line	Item	Amount	Name of Related O
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care
16	V	21	Clerical and General Office		Petersen Health Care
17	V	23	Inservice Training & Education		Petersen Health Care
18	V	24	Travel and Seminar		Petersen Health Care
19	V	25	Other Admin. Staff Transport.		Petersen Health Care
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care
22	V	30	Depreciation		Petersen Health Care
23	V	32	Interest		Petersen Health Care
24	V	33	Real Estate Taxes		Petersen Health Care
25	V	34	Rent-Facility and Grounds		Petersen Health Care
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care
27	V				
28	V				
29	V				
30	V				
31	V				
32	V				
33	V				
34	V				
35	V				
36	V				
37	V				
38	V				
39	Total			$	

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

TE OF ILLINOIS

0046805 Report Period Beginning: 1/1/2013 Ending:

This includes rent,

NO

accordance with

ganization	6	7	8 D
rganization	Percent of Ownership	Operating Cost of Related Organization	Adjus Relate Costs (
, Inc.	100.00%	$ 505	$
, Inc.	100.00%	46,732	
, Inc.	100.00%	75	
, Inc.	100.00%	4	
, Inc.	100.00%	3,491	
, Inc.	100.00%	674	
, Inc.	100.00%	4,326	
, Inc.	100.00%	3,098	
, Inc.	100.00%	5,153	
, Inc.	100.00%	303	
, Inc.	100.00%	0	
, Inc.	100.00%	558	
		$ 64,919	$ *

ifference: tments for d Organization (7 minus 4)	
505	15
46,732	16
75	17
4	18
3,491	19
674	20
4,326	21
3,098	22
5,153	23
303	24
	25
558	26
	27
	28
	29
	30
	31
	32
	33
	34
	35
	36
	37
	38
64,919	39

Facility Name & ID Number Tuscola Health Care Center

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? T
management fees, purchase of supplies, and so forth. [X] YES [ ]

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Org
Schedule V		Line	Item	Amount	Name of Related O
15	V	1	Dietary	$	Petersen Health Ente
16	V	2	Food		Petersen Health Ente
17	V	3	Housekeeping		Petersen Health Ente
18	V	4	Laundry		Petersen Health Ente
19	V	5	Utilities		Petersen Health Ente
20	V	6	Maintenance		Petersen Health Ente
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Ente
22	V	10	Nursing and Medical Records		Petersen Health Ente
23	V	12	Social Services		Petersen Health Ente
24	V	17	Administrative		Petersen Health Ente
25	V	19	Professional Services		Petersen Health Ente
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Ente
27	V	21	Clerical and General Office		Petersen Health Ente
28	V	22	Employee Benefits & Payroll		Petersen Health Ente
29	V	23	Inservice Training & Education		Petersen Health Ente
30	V	24	Travel and Seminar		Petersen Health Ente
31	V	25	Other Admin. Staff Transport.		Petersen Health Ente
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Ente
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Ente
34	V	30	Depreciation		Petersen Health Ente
35	V	32	Interest		Petersen Health Ente
36	V	33	Real Estate Taxes		Petersen Health Ente
37	V	34	Rent-Facility and Grounds		Petersen Health Ente
38	V	35	Rent-Equipment & Vehicles		Petersen Health Ente
39	Total			$	

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

TE OF ILLINOIS

 # 0046805 Report Period Beginning: 1/1/2013 Ending:

This includes rent,

NO

accordance with

ganization	6	7	8 D
rganization	Percent of Ownership	Operating Cost of Related Organization	Adjus Relate Costs (
rprises, LLC	100.00%	$ 0	$
rprises, LLC	100.00%	0	
rprises, LLC	100.00%	0	
rprises, LLC	100.00%	0	
rprises, LLC	100.00%	0	
rprises, LLC	100.00%	0	
rprises, LLC	100.00%	0	
rprises, LLC	100.00%	0	
rprises, LLC	100.00%	0	
rprises, LLC	100.00%	0	
rprises, LLC	100.00%	6,471	
rprises, LLC	100.00%	2,643	
rprises, LLC	100.00%	5,551	
rprises, LLC	100.00%	0	
rprises, LLC	100.00%	0	
rprises, LLC	100.00%	0	
rprises, LLC	100.00%	0	
rprises, LLC	100.00%	0	
rprises, LLC	100.00%	0	
rprises, LLC	100.00%	5,335	
rprises, LLC	100.00%	55,166	
rprises, LLC	100.00%	0	
rprises, LLC	100.00%	0	
rprises, LLC	100.00%	0	
		$ 75,166	$ *

ifference: tments for d Organization (7 minus 4)	
	15
	16
	17
	18
	19
	20
	21
	22
	23
	24
6,471	25
2,643	26
5,551	27
	28
	29
	30
	31
	32
	33
5,335	34
55,166	35
	36
	37
	38
75,166	39

Facility Name & ID Number Tuscola Health Care Center

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizat**

	1 OWNERS		2 RELATED NU
	Name	**Ownership %**	**Name**
1			Aledo Health Care Center
2			Arcola Health Care Center
3			Aspen Rehab & Health Care
4			Batavia Rehab & Health Care Cent
5			Bement Health Care Center
6			Benton Rehab & Health Care Cent
7			Bloomington Rehab & Health Care
8			Casey Health Care Center
9			Charleston Rehab & Health Care C
10			Cisne Rehab & Health Care Center
11			Countryview Care Center of Macon
12			Countryview Terrace
13			Cumberland Rehab & Health Care
14			Decatur Rehab & Health Care Cen
15			Eastside Health & Rehabilitation C
16			Eastview Terrace
17			El Paso Health Care Center
18			Enfield Rehab & Health Care Cent
19			Farmer City Rehab & Health Care
20			Flanagan Rehab & Health Care Ce
21			Flora Gardens Care Center
22			Flora Health Care Center
23			Fondulac Rehab & Health Care Ce
24			Havana Health Care Center
25			Illini Heritage Rehab & Health Car
26			Jonesboro Rehab & Health Care C
27			Kewanee Care Home
28			LaHarpe Davier Health Care Cente
29			Lebanon Care Center
30			Marigold Rehab & Health Care Ce

tions (parties) as defined in the instructions.

URSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Aledo	Petersen Companies, L	Peoria	Mgmt/Bookkeeping
	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping
	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping
ter	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping
	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping
er	Benton	Petersen Health Systen	Peoria	Mgmt/Bookkeeping
Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality
	Casey	Petersen Restaurants,	Peoria	Restaurant
Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping
	Cisne	Petersen Health Care V	Peoria	Mgmt/Bookkeeping
nb	Macomb	Petersen Health Care V	Peoria	Mgmt/Bookkeeping
	Louisville	Petersen Health Care V	Sullivan	Lessor
Center	Greenup	Petersen Health Care V	Peoria	Mgmt/Bookkeeping
ter	Decatur	Petersen Health Care X	Peoria	Lessor
enter	Pittsfield	Petersen Osage Beach,	Osage Beach. MO	Lessor
	Sullivan	Petersen West Frankfo	West Frankfort	Lessor
	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping
er	Enfield	Poplar Bluff Health Ca	Poplar Bluff, MO	Lessor
Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor
nter	Flanagan			
	Flora			
	Flora			
nter	East Peoria			
	Havana			
e	Champaign			
enter	Jonesboro			
	Kewanee			
er	LaHarpe			
	Lebanon			
nter	Galesburg			

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

Facility Name & ID Number **Tuscola Health Care Center**

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizat**

	1 OWNERS		2 RELATED NU
	Name	**Ownership %**	**Name**
1			**Mason Point**
2			**McLeansboro Rehab & Health Car**
3			**Mt. Vernon Health Care Center**
4			**Newman Rehab & Health Care Cer**
5			**Nokomis Rehab & Health Care Cer**
6			**North Aurora Care Center**
7			**Orchard View Rehab & Health Car**
8			**Palm Terrace of Mattoon**
9			**Piper City Rehab & Living Center**
10			**Pleasant View Rehab & Health Car**
11			**Polo Rehabilitation & Health Care**
12			**Prairie City Rehab & Health Care**
13			**Robings Manor Nursing Home**
14			**Rochelle Gardens**
15			**Rochelle Rehab & Health Care Cer**
16			**Rock Falls Rehab & Health Care C**
17			**Arrow Wood Independent Living**
18			**Roseville Rehab and Health Care C**
19			**Rosiclare Rehab & Health Care Ce**
20			**Royal Oaks Care Center**
21			**Sandwich Rehab & Health Care Ce**
22			**Iron Wood Independent Living**
23			**Shawnee Rose Care Center**
24			**Shelbyville Rehab & Health Care C**
25			**South Elgin Rehab & Health Care**
26			**Sugar Creek Care Center**
27			**Sullivan Health Care Center**
28			**Sunset Manor Nursing Home**
29			**Swansea Rehab & Health Care**
30			**Timbercreek Rehab & Health Cent**

tions (parties) as defined in the instructions.

URSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Sullivan			
e Center	McLeansboro			
	Mt. Vernon			
nter	Newman			
nter	Nokomis			
	North Aurora			
re Center	Princeton			
	Mattoon			
	Piper City			
e Center	Morrison			
Center	Polo			
Center	Prairie City			
	Brighton			
	Rochelle			
nter	Rochelle			
enter	Rock Falls			
	Rock Falls			
Center	Roseville			
nter	Rosiclare			
	Kewanee			
nter	Sandwich			
	Sandwich			
	Harrisburg			
Center	Shelbyville			
Center	South Elgin			
	Watseka			
	Sullivan			
	Canton			
	Swansea			
er	Pekin			

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

Facility Name & ID Number **Tuscola Health Care Center**

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizat**

	1 OWNERS		2 RELATED NU
	Name	**Ownership %**	**Name**
1			**Toulon Health Care Center**
2			**Tuscola Health Care Center**
3			**Twin Lakes Rehab & Health Care**
4			**Vandalia Rehab & Health Care Ce**
5			**Watseka Health Care Center**
6			**Westside Rehab & Care Center**
7			**Whispering Oaks**
8			**White Oak Rehab & Health Care C**
9			**Willow Rose Rehab & Health Care**
10			**Sheldon Health Care Center**
11			**Tuscola Health Care Center**
12			**Effingham Health Care Center**
13			**Collinsville Health Care Center**
14			**Ozark Rehab & Health Care Cente**
15			**South Shore Health Care, LLC**
16			**Cedargate Skilled Nursing Facility**
17			**Tarkio Rehab & Health Care Cent**
18			**Shangri-la Rehab & Living Center**
19			**Prairie Rose Care Center**
20			**Illini Heritage Rehab & Health Ce**
21			**Courtyard Estates of Kewanee**
22			**Courtyard Estates of Bradford**
23			**Courtyard Estates of Galva**
24			**Courtyard Estates of Walcott**
25			**Courtyard Village of Kewanee**
26			**Lakewood Village**
27			**Courtyard Estates of Monmouth**
28			**Riverview Estates**
29			**Simple Blessings**
30			**Courtyard Estates of Bushnell**

tions (parties) as defined in the instructions.

URSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Toulon			
	Tuscola			
Center	Paris			
nter	Vandalia			
	Watseka			
	West Frankfort			
	Rosiclare			
enter	Mt. Vernon			
Center	Jerseyville			
	Sheldon			
	Tuscola			
	Effingham			
	Collinsville			
r	Osage Beach, MO			
	Gary, IN			
	Poplar Bluff, MO			
er	Tarkio, MO			
	Blue Springs, MO			
	Pana			
nter	Champaign			
	Kewanee			
	Bradford			
	Galva			
	Walcott			
	Kewanee			
	Charleston			
	Monmouth			
	Havana			
	Casey			
	Bushnell			

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

Facility Name & ID Number **Tuscola Health Care Center**

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizat**

	1 OWNERS		2 RELATED NU
	Name	**Ownership %**	**Name**
1			**Courtyard Estates of Canton**
2			**Legacy Estates of Monmouth**
3			**Courtyard Estates of Sullivan**
4			**Courtyard Estates of Peoria**
5			**Cornerstone Health and Rehabilita**
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			

**0046805** **Report Period Beginning:** **1/1/2013** **Ending:** **12/31/2013**

ːions (parties) as defined in the instructions.

JRSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Canton			
	Monmouth			
	Sullivan			
	Peoria			
tion	Peoria			

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

STATE OF

Facility Name & ID Number Tuscola Health Care Center #

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of I

NOTE: ALL owners (even those with less than 5% ownership) and their re must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest
1				
2				
3				
4	N/A			
5				
6				
7				
8				
9				
10				
11				
12				
13				

* If the owner(s) of this facility or any other related parties listed above have receive of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE A

** This must include all forms of compensation paid by related entities and all FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FO ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RES

Board of Directors.
elatives who receive any type of compensation from this home

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
						2
						3
						4
						5
						6
						7
						8
						9
						10
						11
						12
			TOTAL	$		13

ed compensation from other nursing homes, attach a schedule detailing the name(s)
AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS

ocated to Schedule V of this report (i.e., management fees).
RMS OF COMPENSATION RECEIVED FROM THIS HOME,
ULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Tuscola Health Care Center #

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	Su All
1	1	Dietary	Resident Days	1,560,986	
2	2	Food	Resident Days	1,560,986	
3	3	Housekeeping	Resident Days	1,560,986	
4	4	Laundry	Resident Days	1,560,986	
5	5	Utilities	Resident Days	1,560,986	
6	6	Maintenance	Resident Days	1,560,986	
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	
8	10	Nursing and Medical Records	Resident Days	1,560,986	
9	10A	Therapy	Resident Days	1,560,986	
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	
11	17	Administrative	Resident Days	1,560,986	
12	19	Professional Services	Resident Days	1,560,986	
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	
14	21	Clerical and General Office	Resident Days	1,560,986	
15	23	Inservice Training & Education	Resident Days	1,560,986	
16	24	Travel and Seminar	Resident Days	1,560,986	
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	
20	30	Depreciation	Resident Days	1,560,986	
21	32	Interest	Resident Days	1,560,986	
22	33	Real Estate Taxes	Resident Days	1,560,986	
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	
25	TOTALS				

0046805 Report Period Beginning: 1/1/2013 Ending: 2/31/2013

ce

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

5 Number of ıbunits Being ocated 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
75	$ 307,592	$ 295,212	19,136	$ 3,771
75	6,577	0	19,136	81
75	3,057	0	19,136	38
75	0	0	19,136	0
75	23,338	0	19,136	286
75	150,672	97,358	19,136	1,847
75	17,394	0	19,136	213
75	1,082	0	19,136	13
75	0	0	19,136	0
75	0	0	19,136	0
75	4,578,456	4,578,456	19,136	65,958
75	648,504	0	19,136	7,950
75	41,231	0	19,136	505
75	3,812,055	3,383,297	19,136	46,732
75	6,148	0	19,136	75
75	313	0	19,136	4
75	284,745	0	19,136	3,491
75	54,993	0	19,136	674
75	352,851	0	19,136	4,326
75	252,711	0	19,136	3,098
75	420,365	0	19,136	5,153
75	24,742	0	19,136	303
75	0	0	19,136	0
75	45,546	0	19,136	558
	$ 11,032,372	$ 8,354,323		$ 145,076

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

Facility Name & ID Number Tuscola Health Care Center #

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	Su All
1	1	Dietary	Resident Days	66,460	
2	2	Food	Resident Days	66,460	
3	3	Housekeeping	Resident Days	66,460	
4	4	Laundry	Resident Days	66,460	
5	5	Utilities	Resident Days	66,460	
6	6	Maintenance	Resident Days	66,460	
7	7	Mgmt. Allocation of Benefits	Resident Days	66,460	
8	10	Nursing and Medical Records	Resident Days	66,460	
9	12	Social Services	Resident Days	66,460	
10	17	Administrative	Resident Days	66,460	
11	19	Professional Services	Resident Days	66,460	
12	20	Dues, Fees, Subs & Promotions	Resident Days	66,460	
13	21	Clerical and General Office	Resident Days	66,460	
14	22	Employee Benefits & Payroll	Resident Days	66,460	
15	23	Inservice Training & Education	Resident Days	66,460	
16	24	Travel and Seminar	Resident Days	66,460	
17	25	Other Admin. Staff Transport.	Resident Days	66,460	
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	66,460	
19	27	Mgmt. Allocation of Benefits	Resident Days	66,460	
20	30	Depreciation	Resident Days	66,460	
21	32	Interest	Resident Days	66,460	
22	33	Real Estate Taxes	Resident Days	66,460	
23	34	Rent-Facility and Grounds	Resident Days	66,460	
24	35	Rent-Equipment & Vehicles	Resident Days	66,460	
25	TOTALS				

0046805 Report Period Beginning: 1/1/2013 Ending: 2/31/2013

ce	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

5 Number of ıbunits Being ocated 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
4	$	$	19,136	$
4			19,136	
4			19,136	
4			19,136	
4			19,136	
4			19,136	
4			19,136	
4			19,136	
4			19,136	
4			19,136	
4	22,473		19,136	6,471
4	9,179		19,136	2,643
4	19,278		19,136	5,551
4			19,136	
4			19,136	
4			19,136	
4			19,136	
4			19,136	
4			19,136	
4	18,529		19,136	5,335
4	191,593		19,136	55,166
4			19,136	
4			19,136	
4			19,136	
	$ 261,052	$		$ 75,166

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

Facility Name & ID Number **Tuscola Health Care Center** **#**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required
		YES	NO		
	A. Directly Facility Related				
	Long-Term				
1	First Bank		X	Mortgage	$14,319.50
2					
3					
4					
5					
	Working Capital				
6					
7					
8					
9	TOTAL Facility Related				$14,319.50
	B. Non-Facility Related*				
10					
11					
12					
13					
14	TOTAL Non-Facility Related				
15	TOTALS (line 9+line14)				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sc

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

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

necessary.)

5	6	7	8	9	10	
Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	Original	Balance				
6/22/12	$ 1,462,500	$ 1,273,896	6/22/15	Various	$ 84,745	1
						2
						3
						4
						5
						6
						7
						8
	$ 1,462,500	$ 1,273,896			$ 84,745	9
						10
		Interest Income Offset			(9,488)	11
		Home Office Allocation-PHC			5,153	12
		Home Office Allocation-PHE			55,166	13
	$	$			$ 50,831	14
	$ 1,462,500	$ 1,273,896			$ 135,576	15

:h. V. $ _____ Line # _____

equently, page 4, col. 7.

in column 2.

Facility Name & ID Number Tuscola Health Care Center

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report. **Important, please see the next works statement and bill must accompany t**

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment cc

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the li

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other ge
(Describe appeal cost below. Attach copies of invoices to support the cost and a c

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.
TOTAL REFUND $ _____ **For** _____ **Tax Year.** **(Attach a copy of the**

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	**27,885**	**8**
	2009	**28,364**	**9**
	2010	**30,185**	**10**
	2011	**30,075**	**11**
	2012	**29,907**	**12**

Accrual based on prior year tax bill.

NOTES:

1. **Please indicate a negative number by use of brackets( ). Dec taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you mu application for real estate tax exemption unless the building This denial must be no more than four years old at**

sheet, "RE_Tax". The real estate tax the cost report.		$	30,972	1
overs more than one year, detail below.)	2012	$	29,907	2
		$	(1,065)	3
nes below.)		$	30,804	4
eneral operating costs on Schedule V, sections A, B or C. copy of the appeal filed with the county.)		$		5
Home Office Allocation real estate tax appeal board's decision.)		$	303	6
		$	30,042	7

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2012	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

duct any overaccrual of

ust attach a denial of an
is rented from a for-profit entity.
t the time the cost report is filed.

2012 LONG TERM CARE REAL ESTATE TA

FACILITY NAME Tuscola Health Care Center

FACILITY IDPH LICENSE NUMBER 0046805

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

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

Enter the tax index number and real estate tax assessed for 2012 on the lines provi
cost that applies to the operation of the nursing home in Column D. Real estate ta
home property which is vacant, rented to other organizations, or used for purposes
entered in Column D. Do not include cost for any period other than calendar year

	(A) Tax Index Number	(B) Property Description	
1.	09-08-02-100-027	Long-Term Care Facility	$
2.	09-08-02-100-029	Long-Term Care Facility	$
3.			$
4.			$
5.			$
6.			$
7.			$
8.			$
9.			$
10.			$
		TOTALS	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant prop
used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the c
(Generally the real estate tax cost must be allocated to the nursing home based upc

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this s
tax bill which is normally paid during 2013.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is
documentation . Facilities located in Cook County are required to provide
installment tax bill.

X STATEMENT

COUNTY Douglas

-8622

ded below. Enter only the portion of the
x applicable to any portion of the nursing
other than long term care must not be
2012.

(C) Total Tax	(D) Tax Applicable to Nursing Home
16,045.92	$ 16,045.92
13,861.18	$ 13,861.18
	$
	$
	$
	$
	$
	$
	$
	$
29,907.10	$ 29,907.10

erty, or property which is not directly

ost allocated to the nursing home.
on sq. ft. of space used.)

statement. Be sure to use the 2012

not considered acceptable tax bill
copies of their original **second**

Facility Name & ID Number Tuscola Health Care Center

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,274 **B. General Construction Type:**

C. Does the Operating Entity? [X] **(a) Own the Facility** [ ]

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may co

D. Does the Operating Entity? [X] **(a) Own the Equipment** [ ]

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

E. List all other business entities owned by this operating entity or related to the operat (such as, but not limited to, apartments, assisted living facilities, day training facilitie List entity name, type of business, square footage, and number of beds/units availabl

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being If so, please complete the following:

1. Total Amount Incurred:

3. Current Period Amortization:

Nature of Costs:

(Attach a complete schedule detailing the

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	Sq
1	Facility	
2		
3	TOTALS	

STATE OF ILLINOIS

0046805 Report Period Beginning: 1/1/2013 Ending:

Exterior Brick Frame Steel Number of Stories

(b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrela Organization.

mplete Schedule XI or Schedule XII-A. See instructions.)

(b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Comple Unrelated Organization.

complete Schedule XI-C or Schedule XII-B. See instructions.)

ing entity that are located on or adjacent to this nursing home's grounds
s, day care, independent living facilities, CNA training facilities, etc.)
e (where applicable).

amortized? [ ] YES [X] NO

2. Number of Years Over Which it is Being Amortized:

4. Dates Incurred:

total amount of organization and pre-operating costs.)

2	3	4	
uare Feet	Year Acquired	Cost	
187,955	2005	$ 50,000	1
			2
187,955		$ 50,000	3

1

ıted

etely

Facility Name & ID Number Tuscola Health Care Center

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.)

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	
4	73		2005	1974	$
5					
6					
7					
8					
	Improvement Type**				
9	Carpeting			2005	
10	Tiles			2005	
11	Sidewalks			2005	
12	Fire Alarm System			2006	
13	Carpeting			2007	
14	Signage			2007	
15	Parking Lot			2007	
16	Flooring			2008	
17	A/C Rooftop Unit			2010	
18	Roofing Repair			2011	
19	Sprinkler System			2012	
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30	Land Improvements Booked				
31	Building Booked				
32	Building Improvement Booked				
33					
34	2013-Home Office Allocation-Building Improvements				
35	2013-Home Office Allocation-Land Improvements				
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.

STATE OF ILLINOIS

 # 0046805 Report Period Beginning: 1/1/2013 Ending:

Round all numbers to nearest dollar.

4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	Ac De
500,000	$	30	$ 16,667	$ 16,667	$
1,286		25	51	51	
2,945		10	295	295	
3,901		15	260	260	
4,552		5			
1,152		10	115	115	
3,305		10	331	331	
2,400		15	160	160	
3,869		15	258	258	
10,833		15	722	722	
3,000		7	428	428	
75,700		25	1,514	1,514	
	420			(420)	
	16,667			(16,667)	
	5,614			(5,614)	
8,998			216	216	
840			54	54	

See Page 12A, Line 70 for total

9 cumulated preciation	
150,004	4
	5
	6
	7
	8
451	9
2,605	10
2,210	11
4,552	12
748	13
2,151	14
1,040	15
1,419	16
2,527	17
1,070	18
3,028	19
	20
	21
	22
	23
	24
	25
	26
	27
	28
	29
	30
	31
	32
	33
	34
	35
	36

Facility Name & ID Number Tuscola Health Care Center

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.)

	1 Improvement Type**	3 Year Constructed	
37			$
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49			
50			
51			
52			
53			
54			
55			
56			
57			
58			
59			
60			
61			
62			
63			
64			
65			
66			
67			
68			
69			
70	TOTAL (lines 4 thru 69)		$

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

STATE OF ILLINOIS

0046805 Report Period Beginning: 1/1/2013 Ending:

) Round all numbers to nearest dollar.

4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	Ac De
	$		$	$	$
622,781	$ 22,701		$ 21,071	$ (1,630)	$

9 ccumulated epreciation	
	37
	38
	39
	40
	41
	42
	43
	44
	45
	46
	47
	48
	49
	50
	51
	52
	53
	54
	55
	56
	57
	58
	59
	60
	61
	62
	63
	64
	65
	66
	67
	68
	69
171,805	70

Facility Name & ID Number Tuscola Health Care Center # 0046805

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost
71	Purchased in Prior Years	$ 232,769
72	Current Year Purchases	16,281
73	Fully Depreciated Assets	
74	Home Office Allocation	
75	TOTALS	$ 249,050

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost
76	Patient Care	'06 Ford Econoline	2005	$ 28,696
77				
78				
79				
80	TOTALS			$ 28,696

E. Summary of Care-Related Assets

81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4)
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B

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		$	$	$
87	N/A			
88				
89				
90				
91	TOTALS	$	$	$

Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
$ 22,254	$ 23,459	$ 1,205	5-10 yrs.	$ 197,005	71
1,257	814	(443)	10 yrs.	814	72
					73
	8,163	8,163			74
$ 23,511	$ 32,436	$ 8,925		$ 197,819	75

	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
	$				$ 28,696	76
						77
						78
						79
	$	$	$		$ 28,696	80

1 Reference	2 Amount		
+ (Pages 12B thru 12I, if applicable)	$ 950,527	81	
thru 12I, if applicable)	$ 46,212	82	
thru 12I, if applicable)	$ 53,507	83	**
thru 12I, if applicable)	$ 7,295	84	
thru 12I, if applicable)	$ 398,320	85	

4	
	86
	87
	88
	89
	90
	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, c
If NO, see instructions. ☐

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount
3	Original Building:				$
4	Additions				
5					
6					
7	TOTAL				$ **

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? ☐

16. Rental Amount for movable equipment: $ 22,484 Description: See A

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	
17			$	$
18	N/A			
19				
20				
21	TOTAL		$	$

ːolumn 4?
YES [ ] NO

5 Total Years of Lease	6 Total Years Renewal Option*	
		3
		4
		5
		6
		7

*

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.	/2014	$
13.	/2015	$
14.	/2016	$

YES [X] NO
ttached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

4 Rental Expense for this Period	
	17
	18
	19
	20
	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 **1/1/2013**
Period End **12/31/2013**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	14,900
Dishwasher		-
Laundry Equipment		-
Copier		7,026
Home Office Allocation		558
		22,484

STA

Facility Name & ID Number Tuscola Health Care Center

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a sch

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PO
IN-HOUSE PROG
IN OTHER FACII
COMMUNITY CC
HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS

			1	2	
			Facility		
			Drop-outs	Completed	
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)	$		

(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.

TE OF ILLINOIS

0046805 Report Period Beginning: 1/1/2013 Ending:

tructions.)

edule listing the facility name, address and cost per CNA trained in that facility.)

RTION:

RAM

LITY

OLLEGE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

(d)

3	4
Contract	Total
	$
	$

C. CONTRACTUAL INCOME

In the box below record the amount of inco
facility received training CNAs from other

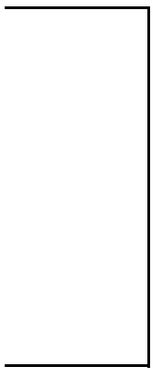
$

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	

(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.



ome your
facilities.

Facility Name & ID Number Tuscola Health Care Center

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

		1	2	
	Service	Schedule V Line & Column Reference	Staff Units of Service	
1	Licensed Occupational Therapist	10A(3)	hrs	$
2	Licensed Speech and Language Development Therapist	10A(3)	hrs	
3	Licensed Recreational Therapist		hrs	
4	Licensed Physical Therapist	10A(3)	hrs	
5	Physician Care		visits	
6	Dental Care		visits	
7	Work Related Program		hrs	
8	Habilitation		hrs	
9	Pharmacy	39(2)	# of prescrpts	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs	
11	Academic Education		hrs	
12	Other (specify):			
13	Other (specify):			
14	TOTAL			$

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitio
Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with t
on this schedule.

STATE OF ILLINOIS
0046805 Report Period Beginning: 1/1/2013 Ending:

3	4		5	6	7	
Cost	Outside Practitioner (other than consultant)			Supplies (Actual or)	Total Units	To
	Units		Cost	Allocated)	(Column 2 + 4)	(Col.
	2,809	$	42,137	$	2,809	$
	277		4,151		277	
	3,815		57,220		3,815	
				44,416		
	6,901	$	103,508	$ 44,416	6,901	$

ners. Consultant fees should be detailed on
he above activities should not be listed

8 tal Cost 3 + 5 + 6)	
42,137	1
4,151	2
	3
57,220	4
	5
	6
	7
	8
44,416	9
	10
	11
	12
	13
147,924	14

Facility Name & ID Number **Tuscola Health Care Center** **STATE #**

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of**

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	$ 3,221,941	$ 3,221,941	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 57,147)	135,718	135,718	3
4	Supply Inventory (priced at)	10,540	10,540	4
5	Short-Term Investments			5
6	Prepaid Insurance	25,706	25,706	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,393,905	$ 3,393,905	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	508,998	14
15	Leasehold Improvements, at Historical Cost	122,911	113,783	15
16	Equipment, at Historical Cost	284,143	277,746	16
17	Accumulated Depreciation (book methods)	(408,378)	(398,320)	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)**	$ 554,976	$ 552,207	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,948,881	$ 3,946,112	25

***(See in**

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 310,981	$ 310,981	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	78,261	78,261	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,171	5,171	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,804	30,804	32
33	Accrued Interest Payable	6,628	6,628	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	37,639	37,639	36
37	Accrued Management Fees	273,899	273,899	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 743,383	$ 743,383	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,273,896	1,273,896	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	369,458	369,458	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,643,354	$ 1,643,354	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,386,737	$ 2,386,737	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,562,144	$ 1,559,375	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,948,881	$ 3,946,112	48

ıstructions.)

Facility Name & ID Number **Tuscola Health Care Center** **#**

XVI. STATEMENT OF CHANGES IN EQUITY

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

1 Total		
1,631,910	1	
	2	
(1)	3	
	4	
	5	
1,631,909	6	
(69,765)	7	
	8	
	9	
	10	
	11	
	12	
)	13	
	14	
	15	
	16	
(69,765)	17	
	18	
	19	
	20	
	21	
	22	
	23	
1,562,144	24	*

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

STATE OF ILLINOI

Facility Name & ID Number Tuscola Health Care Center # 0046805

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this sched
classifications of revenue and expense must be provided on this form, even if financial statem
Note: This schedule should show gross revenue and expenses. Do not net revenue

		1		
	I. Revenue	**Amount**		
	A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	$ 2,330,966	1	31
2	Discounts and Allowances for all Levels	(206,875)	2	32
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,124,091	3	33
	B. Ancillary Revenue			
4	Day Care		4	34
5	Other Care for Outpatients		5	
6	Therapy	184,592	6	35
7	Oxygen	1,515	7	36
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 186,107	8	
	C. Other Operating Revenue			37
9	Payments for Education		9	38
10	Other Government Grants		10	39
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop		12	40
13	Barber and Beauty Care		13	
14	Non-Patient Meals	4,422	14	41
15	Telephone, Television and Radio	5,865	15	
16	Rental of Facility Space		16	42
17	Sale of Drugs	74,147	17	
18	Sale of Supplies to Non-Patients		18	43
19	Laboratory		19	
20	Radiology and X-Ray	2,490	20	
21	Other Medical Services	2,995	21	44
22	Laundry		22	45
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 89,919	23	46
	D. Non-Operating Revenue			47
24	Contributions		24	48
25	Interest and Other Investment Income***	9,488	25	49
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,488	26	
	E. Other Revenue (specify):**			*
27	**Settlement Income (Insurance, Legal, Etc.)**		27	**
28	**Miscellaneous Revenue**	3,365	28	
28a	**Transportation Revenue**	7,975	28a	***
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,340	29	
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,420,945	30	****]

Report Period Beginning: 1/1/2013 **Ending:** 12/31/2013

ule to Schedules V and VI.) All required
ents are attached.
e against expense.

	2	
II. Expenses	**Amount**	
A. Operating Expenses		
General Services	**493,844**	**31**
Health Care	**1,168,458**	**32**
General Administration	**353,154**	**33**
B. Capital Expense		
Ownership	**182,622**	**34**
C. Ancillary Expense		
Special Cost Centers	**141,832**	**35**
Provider Participation Fee	**150,800**	**36**
D. Other Expenses (specify):		
		37
		38
		39
TOTAL EXPENSES (sum of lines 31 thru 39)*	**$ 2,490,710**	**40**
Income before Income Taxes (line 30 minus line 40)**	**(69,765)**	**41**
Income Taxes		**42**
NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	**$ (69,765)**	**43**

III. Net Inpatient Revenue detailed by Payer Source		
Medicaid - Net Inpatient Revenue	**$ 992,584**	**44**
Private Pay - Net Inpatient Revenue	**1,063,982**	**45**
Medicare - Net Inpatient Revenue	**67,525**	**46**
Other-(specify)		**47**
Other-(specify)		**48**
TOTAL Inpatient Care Revenue (This total must agree to Line 3)	**$ 2,124,091**	**49**

This must agree with page 4, line 45, column 4.
Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.
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 #

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	2,080	2,080	$ 60,434	$ 29.05
2	Assistant Director of Nursing	2,699	2,867	63,578	22.18
3	Registered Nurses	5,000	5,090	127,220	24.99
4	Licensed Practical Nurses	10,129	10,468	229,248	21.90
5	CNAs & Orderlies	37,624	35,950	416,240	11.58
6	CNA Trainees				
7	Licensed Therapist				
8	Rehab/Therapy Aides				
9	Activity Director	1,783	1,851	20,649	11.16
10	Activity Assistants				
11	Social Service Workers	221	229	3,508	15.32
12	Dietician				
13	Food Service Supervisor	2,080	2,080	22,923	11.02
14	Head Cook				
15	Cook Helpers/Assistants	10,510	10,590	90,053	8.50
16	Dishwashers				
17	Maintenance Workers	3,989	4,017	55,044	13.70
18	Housekeepers	7,848	8,250	86,332	10.46
19	Laundry	34	34	285	8.38
20	Administrator	2,080	2,080	65,958	31.71
21	Assistant Administrator				
22	Other Administrative				
23	Office Manager	1,478	1,551	25,671	16.55
24	Clerical				
25	Vocational Instruction				
26	Academic Instruction				
27	Medical Director				
28	Qualified MR Prof. (QMRP)				
29	Resident Services Coordinator				
30	Habilitation Aides (DD Homes)				
31	Medical Records				
32	Other Health Care(specify)				
33	Other(specify) See PG20A	2,436	2,508	45,271	18.05
34	TOTAL (lines 1 - 33)	89,991	89,645	$ 1,312,414 *	$ 14.64

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

** See instructions.

STATE OF ILLINOIS

0046805 Report Period Beginning: 1/1/2013 Ending:

B. CONSULTANT SERVICES

			1	2
			Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period
35	Dietary Consultant		$	
36	Medical Director	Monthly		7,000
37	Medical Records Consultant			
38	Nurse Consultant			
39	Pharmacist Consultant	Monthly		3,867
40	Physical Therapy Consultant			
41	Occupational Therapy Consultant			
42	Respiratory Therapy Consultant			
43	Speech Therapy Consultant			
44	Activity Consultant			
45	Social Service Consultant			
46	Other(specify)			
47				
48				
49	TOTAL (lines 35 - 48)		$	10,867

C. CONTRACT NURSES

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

3	
Schedule V Line & Column Reference	
	35
L9, C3	36
	37
	38
L10, C3	39
	40
	41
	42
	43
	44
	45
	46
	47
	48
	49

3	
Schedule V Line & Column Reference	
	50
	51
	52
	53

Tuscola Health Care Center
0046805
Period Beginning **1/1/2013**
Period End **12/31/2013**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator		1,034	1,082	26,254	24.26
Transportation		441	441	4,037	9.15
Marketing		961	985	14,980	15.21
	TOTAL	2,436	2,508	45,271	

Facility Name & ID Number Tuscola Health Care Center

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Alison Cler	Administrator	0	$ 20,417
Tom Stephenson	Administrator	0	45,541

TOTAL (agree to Schedule V, line 17, col. 1)
(List each licensed administrator separately.) $ 65,958

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 131,400

TOTAL (agree to Schedule V, line 17, col. 3) $ 131,400
(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
Mediacom	Computer Services	$ 1,551
Douglas Co. Circuit Clerk	Filing Fees	20
Honkamp Krueger & Co.	Accounting Services	1,158

TOTAL (agree to Schedule V, line 19, column 3)
(If total legal fees exceed $5,000, attach copy of invoices.) $ 2,729

STATE OF ILLINOIS

0046805 Report Period Beginning: 1/1/2013

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,612
Unemployment Compensation Insurance	40,326
FICA Taxes	93,424
Employee Health Insurance	(25,323)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	3,724
Employee Retirement	793
TOTAL (agree to Schedule V, line 22, col.8)	$ 144,556

F. Dues, Fees, Subscriptions and P

Description
IDPH License Fee
Advertising: Employee Recruitme
Health Care Worker Background
(Indicate # of checks performed
Patient Background Checks
Miscellaneous Licenses & Permits
Miscellaneous Dues & Subscriptior
Home Office Allocation
Less: Public Relations Expense
Non-allowable advertising
Yellow page advertising
TOTAL (agree to Sch. line 20, col. 8)

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

G. Schedule of Travel and Semina

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

* Attach copy of IMRF notifications

**See instructions.

Ending: 12/31/2013

'romotions

		Amount
	$	3,980
nt		1,111
Check		
)		
91		916
		185
ıs		200
		3,148
		(200)
	(	)
	(	)
. V,	$	9,340

r**

		Amount
	$	
		4
	(	)
	$	4

Tuscola Health Care Center
0046805
Period Beginning **1/1/2013**
Period End **12/31/2013**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	**Type**	**Amount**
Total (agree to Schedule V, line 19, column 3)		2,729
Home Office Allocation		
SmithAmundsen	Legal	473
Cole, Schotz, Meisel	Legal	260
Black, Hedin, Ballard	Legal	24
Ginoli & Company	Accountants	4873
Allpayer Exchange	Computer Services	299
Miscellaneous	Computer Services	75
Odessian LLC	Computer Services	37
CCH	Computer Services	11
Lexis-Nexis	Computer Services	4
Ipanema Solutions	Computer Services	10
Macquarie Technology Services	Computer Services	67
Advanced Answers on Demand	Computer Services	3499
TeamViewer	Computer Services	11
Stratus Networks	Computer Services	282
Kemper Technology	Computer Services	218
AT&T	Computer Services	4
Medifax	Computer Services	32
Vision Share/Ability Network	Computer Services	479
Barracuda	Computer Services	86
CIAN	Computer Services	115
Comcast	Computer Services	26
Emdeon	Computer Services	38
Marotta Gund Budd & Dzera	Other Prof Fees	1071
David Budde	Other Prof Fees	22
Pharmacy Price Mangement	Other Prof Fees	88
All Scripts	Other Prof Fees	158
U.S. Bank	Other Prof Fees	2,159
Total (agree to Schedule V, line 19, column 8)		17,150

STATE OF IL

Facility Name & ID Number Tuscola Health Care Center #

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in S
(See instructions.)

	1	2	3	4	5	6	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	
1			$		$	$	$
2							
3							
4	N/A						
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20	TOTALS		$		$	$	$

ch. V, line 6, col. 3).

7	8	9	10	11	12	13
	Amount of Expense Amortized Per Year					
FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
	$	$	$	$	$	$
	$	$	$	$	$	$

Facility Name & ID Number **Tuscola Health Care Center**

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? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,684** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **150,800**
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. $ **4,422**

(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? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **7,975**

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? **Yes**

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Company**

(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? **No**
Attach invoices and a summary of services for all architect and appraisal fees.