



Facility Name & ID Number Elizabeth Nursing Home

# 0008300 Report Period Beginning: 01/01/05 Ending: 12/31/05

**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	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,885	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF	5,719	10,277		15,996	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,719	10,277		15,996	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.44%

D. How many bed-hold days during this year were paid by the Department? 0 (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)  
Assisted Living Facility

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 07/08/1968

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

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

Medicare Intermediary n/a

**IV. ACCOUNTING BASIS**

ACCURAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

STATE OF ILLINOIS

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	135,034	6,339	4,385	145,758	(35,027)	110,731	110,731			1
2	Food Purchase		83,180		83,180		83,180	(1,847)	81,333		2
3	Housekeeping	44,378	11,124		55,502		55,502		55,502		3
4	Laundry	28,739	5,230		33,969		33,969		33,969		4
5	Heat and Other Utilities										5
6	Maintenance	26,393	17,384	48,502	92,279		92,279		92,279		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	234,544	123,257	52,887	410,688	(35,027)	375,661	(1,847)	373,814		8
<b>B. Health Care and Programs</b>											
9	Medical Director										9
10	Nursing and Medical Records	579,356	29,887	32,676	641,919		641,919		641,919		10
10a	Therapy										10a
11	Activities	31,803	2,947	488	35,238		35,238	(2,712)	32,526		11
12	Social Services	27,722		488	28,210		28,210		28,210		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	638,881	32,834	33,652	705,367		705,367	(2,712)	702,655		16
<b>C. General Administration</b>											
17	Administrative	80,942	20,407	43,023	144,372	(1,229)	143,143	(715)	142,428		17
18	Directors Fees			6,800	6,800		6,800		6,800		18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses										21
22	Employee Benefits & Payroll Taxes			225,235	225,235	(24,485)	200,750		200,750		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			70,198	70,198	(14,040)	56,158		56,158		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	80,942	20,407	345,256	446,605	(39,754)	406,851	(715)	406,136		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	954,367	176,498	431,795	1,562,660	(74,781)	1,487,879	(5,274)	1,482,605		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number

Elizabeth Nursing Home

#0008300

Report Period Beginning:

01/01/05

Ending:

12/31/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			57,697	57,697	(30,453)	27,244		27,244			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4	4		4	(4)				32
33	Real Estate Taxes			26,229	26,229	(14,105)	12,124		12,124			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			83,930	83,930	(44,558)	39,372	(4)	39,368			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):* <b>Assisted Living</b>	119,541	28,082	16,177	163,800	119,339	283,139		283,139			43
44	<b>TOTAL Special Cost Centers</b>	119,541	28,082	16,177	163,800	119,339	283,139		283,139			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,073,908	204,580	531,902	1,810,390		1,810,390	(5,278)	1,805,112			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL** A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,847)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(715)	17		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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	(2,716)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (5,278)		\$	30

OHF 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	2	
		Amount	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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (5,278)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Elizabeth Nursing Home

ID# 0008300

Report Period Beginning: 01/01/05

Ending: 12/31/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending Machine Revenue	\$ (2,712)	11	1
2	Interest income to extent of interest expense	(4)	32	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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	<b>Total</b>	(2,716)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning:

01/01/05

Ending:

12/31/05

## 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	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,847)	0	0	0	0	0	0	0	0	0	0	(1,847)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,847)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,847)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,712)	0	0	0	0	0	0	0	0	0	0	(2,712)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(2,712)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,712)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(715)	0	0	0	0	0	0	0	0	0	0	(715)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(715)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(715)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(5,274)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(5,274)</b>	<b>29</b>



Facility Name & ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning: 01/01/05

Ending: 12/31/05

**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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Elizabeth Nursing Home      #      0008300      Report Period Beginning:      01/01/05      Ending:      12/31/05

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Darlene Read	Shareholder	Board Member	0.04	0	1.5	0.04	Dir. Fees	\$ 1,200	1
2	Penny Heidenreich	Shareholder	Board Member	0.01	0	1.5	0.04	Dir. Fees	450	2
3	Nancy Walker	Shareholder	Board Member	0.01	0	1.5	0.04	Dir. Fees	1,100	3
4	Jack Graves	Shareholder	Board Member	0.03	0	1.5	0.04	Dir. Fees	50	4
5	Marvin Wurster	Shareholder	Board Member	0.04	0	1.5	0.04	Dir. Fees	800	5
6	Ken Haas	Shareholder	Board Member	0.01	0	1.5	0.04	Dir. Fees	550	6
7	Ted Krohmer	Shareholder	Board Member	0.01	0	1.5	0.04	Dir. Fees	600	7
8	Wayne Trost	Shareholder	Board Member	0.01	0	1.5	0.04	Dir. Fees	550	8
9	Carol Rayhorn	Shareholder	Board Member	0.03	0	1.5	0.04	Dir. Fees	600	9
10	Donald Brudi	Shareholder	Board Member	0.01	0	1.5	0.04	Dir. Fees	300	10
11	James Harkness	Administrator	Administrator	0.00	0	40	100.00	Dir. Fees	600	11
12	James Harkness	Administrator	Administrator	0.00	0	40	100.00	Compensation	58,513	12
13								TOTAL	\$ 65,313	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/05 Ending: 12/31/05

**VIII. ALLOCATION OF INDIRECT COSTS**

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/05 Ending: 12/31/05

**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
		Related**					Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Alliant Energy Loan		x	Energy Efficient Lights in NH	\$332.00	02/25/00	\$ 18,471	\$	03/31/05	0.0310	\$ 4	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>				\$332.00		\$ 18,471	\$			\$ 4	9
	<b>B. Non-Facility Related*</b>											
10	Assisted Living Apartments		x	Financing 1998 Addition	\$16,732.00	05/02/03	387,759		02/01/10	0.0575	16,177	10
11	Shareholder Loans	x		Assisted Living Expansion	Various	08/01/05	1,055,000	1,055,000	08/01/20	0.0590	Capitalized	11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>				\$16,732.00		\$ 1,442,759	\$ 1,055,000			\$ 16,177	14
15	<b>TOTALS (line 9+line14)</b>						\$ 1,461,230	\$ 1,055,000			\$ 16,181	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)



**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 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,

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Elizabeth Nursing Home COUNTY JoDaviess

FACILITY IDPH LICENSE NUMBER 0008300

CONTACT PERSON REGARDING THIS REPORT James Harkness

TELEPHONE (815) 858-2275 FAX #: (815) 858-2596

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

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of total 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. 07-002-348-06	S25 T27 R2E PT NE NE	\$ 26,230.00	\$ 12,125.00
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>26,230.00</u>	\$ <u>12,125.00</u>

**B. Real Estate Tax Cost Allocation:**

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  NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005

Facility Name &amp; ID Number Elizabeth Nursing Home

# 0008300 Report Period Beginning:

01/01/05 Ending:

12/31/05

**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 25,048 B. General Construction Type: Exterior Masonry Frame \_\_\_\_\_ Number of Stories 1C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (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)

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1967	\$ 1,055	1
2			1985		2
3	TOTALS			\$ 1,055	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning:

01/01/05

Ending:

12/31/05

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	49			\$	\$		\$	\$	\$	4
5										5
6		1985	1985	151,186					151,186	6
7										7
8										8
<b>Improvement Type**</b>										
9	Improvements		1973	1,937					1,937	9
10	Improvements		1968	90,793					90,793	10
11	Improvements		1969	1,546					1,546	11
12	Improvements		1975	2,644					2,644	12
13	Improvements		1976	2,481					2,481	13
14	Improvements		1977	7,295					7,295	14
15	Improvements		1978	7,159					7,159	15
16	Improvements		1980	6,261					6,261	16
17	Land Improvements		1986	3,143	114	19	114		3,143	17
18	Land Improvements		1988	850					850	18
19	Smoke detectors		1981	603					603	19
20	Roof		1982	11,431					11,431	20
21	Windows		1983	5,131					5,131	21
22	Windows		1984	9,124					9,124	22
23	Vent Control		1985	3,837					3,837	23
24	Door/Wall guards		1986	1,817	21	19	21		1,817	24
25	Roof Htr & AC		1987	5,473	174	31.5	174		3,178	25
26	Land Improvements		1990	5,345	253	15	253		5,345	26
27	Windows/Service Door		1988	13,338	423	31.5	423		7,397	27
28	Roof Htr & AC		1989	8,448	268	31.5	268		4,320	28
29	Roof (East, West & North)		1990	49,329	1,566	31.5	1,566		23,621	29
30	Roof Well Decks		1992	8,194	260	31.5	260		3,511	30
31	Remodel Computer Room		1992	5,872	186	31.5	186		2,514	31
32	Center structure roof		1996	7,950	204	39	204		1,869	32
33	So. Wing Htg. & AC Unit		1997	4,160					4,160	33
34	Kitchen Remodeling		1997	22,802	577	39.5	577		4,910	34
35	Exterior Remodeling		1997	20,031	507	39.5	507		4,311	35
36	26 Toilets		1997	8,443					8,443	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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	New Nursing Hm hand rail	1998	\$ 8,483	\$ 215	39.5	\$ 215	\$	\$ 1,610	37
38	Cast Iron tub base	1998	1,482	38	39.5	38		282	38
39	Nursing Hm Addition (Lndry & Bus. Office)	1998	97,742	2,474	39.5	2,474		18,558	39
40	Land Improvements - NH	1998	2,258	133	15	133		1,258	40
41	Landscaping - NH	1999	1,185	70	15	70		590	41
42	Screen door system	1999	425	11	39.5	11		69	42
43	Install 14M BTU Htg & AC roof top unit	2000	3,824	98	39	98		535	43
44	Energy Efficient Lighting - NH	2000	12,431	319	39	319		1,740	44
45	Outside Lighting - NH	2000	1,190	31	39	31		167	45
46	Land Improvements - NH	2001	2,290	153	15	153		687	46
47	Koehler Utility Sink	2002	667	83	7	83		459	47
48	Tile Project (Nursing Home Dining Area)	2003	2,113	67	31.5	67		168	48
49	AO Smith Holding Tank	2004	1,324	324	7	324		513	49
50	Ceiling Lights - N.H.	2004	484	15	31.5	15		16	50
51	Flooring - Nurses station area	2004	2,322	74	31.5	74		77	51
52	Suspended Ceiling - N.H. Hallway	2004	4,765	151	31.5	151		158	52
53	Carpet/Flooring Work - NH	2005	1,972	55	31.5	55		55	53
54	Sign	2005	551	79	7	79		79	54
55	Kitchen Fire Supression System	2005	1,200	14	31.5	14		14	55
56	Telephone Wiring	2005	678	8	31.5	8		8	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)		\$ 614,009	\$ 8,965		\$ 8,965	\$	\$ 407,860	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 97,311	\$ 14,571	\$ 14,571	\$		\$ 59,826	71
72	Current Year Purchases	30,367	2,923	2,923			2,923	72
73	Fully Depreciated Assets	261,615	1,640	1,640			261,615	73
74								74
75	TOTALS	\$ 389,293	\$ 19,134	\$ 19,134	\$		\$ 324,364	75

D. Vehicle Depreciation (See instructions.)\*

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

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,004,357	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 28,099	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 28,099	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 732,224	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	Building Imp - Assisted Living	\$ 1,088,446	\$ 27,556	\$ 213,556	86
87	Land Imp - Assisted Living	5,150	304	2,869	87
88	Appliances/Furn. - Assisted Living	24,331	1,738	24,331	88
89					89
90					90
91	TOTALS	\$ 1,117,927	\$ 29,598	\$ 240,756	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A  
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
 If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.  
 This amount was calculated by dividing the total amount to be amortized  
 by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
 (Attach a schedule detailing the breakdown of movable equipment)

\* 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.

**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					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
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.

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	

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$		\$						1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescripts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$		\$		\$		\$		\$		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.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning: 01/01/05

Ending:

12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 28,768	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	70,391		3
4	Supply Inventory (priced at )	5,162		4
5	Short-Term Investments	409,956		5
6	Prepaid Insurance	14,828		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Deferred income tax bene.</u>	14,035		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 543,140	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,275		13
14	Buildings, at Historical Cost	2,410,866		14
15	Leasehold Improvements, at Historical Cost	170,463		15
16	Equipment, at Historical Cost	413,624		16
17	Accumulated Depreciation (book methods)	(972,977)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,027,251	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,570,391	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 162,538	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	50,000		29
30	Accrued Salaries Payable	80,848		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,035		31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,800		32
33	Accrued Interest Payable	26,506		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Income Taxes Payable</u>	32,271		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 387,998	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,005,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Deferred Income Taxes</u>	15,811		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,020,811	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,408,809	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,161,582	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,570,391	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,059,155	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,059,155	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	113,527	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	(11,100)	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)	\$ 102,427	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,161,582	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning: 01/01/05

Ending:

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12/31/05

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,957,324	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,957,324	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,712	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,847	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	2,456	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 7,015	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	1,970	24
25	Interest and Other Investment Income***	6,155	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 8,125	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,972,464	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	409,891	31
32	Health Care	705,367	32
33	General Administration	446,609	33
<b>B. Capital Expense</b>			
34	Ownership	83,926	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37		163,800	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,809,593	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	162,871	41
42	<b>Income Taxes</b>	(49,344)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 113,527	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.

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

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

Facility Name & ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	\$ 38,336	\$ 18.43	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,440	5,764	87,234	15.13	3
4	Licensed Practical Nurses	9,112	9,713	130,906	13.48	4
5	CNAs & Orderlies	35,792	37,379	335,181	8.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,245	2,413	21,343	8.85	9
10	Activity Assistants	1,386	1,448	11,974	8.27	10
11	Social Service Workers	2,107	2,275	23,658	10.40	11
12	Dietician					12
13	Food Service Supervisor	2,334	2,502	29,032	11.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,452	12,084	99,692	8.25	15
16	Dishwashers					16
17	Maintenance Workers	2,672	2,840	27,417	9.65	17
18	Housekeepers	4,440	4,691	41,261	8.80	18
19	Laundry	2,900	3,068	25,457	8.30	19
20	Administrator	2,080	2,080	58,513	28.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,627	1,753	20,670	11.79	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) ALU	12,169	12,713	123,234	9.69	33
34	TOTAL (lines 1 - 33)	97,836	102,803	\$ 1,073,908 *	\$ 10.45	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	96	\$ 4,747	35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant	9	576	38
39	Pharmacist Consultant	63	3,825	39
40	Physical Therapy Consultant	20	570	40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	8	588	44
45	Social Service Consultant	8	588	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	204	\$ 10,894	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			51
52	Certified Nurse Assistants/Aides	710	16,667	52
53	TOTAL (lines 50 - 52)	710	\$ 16,667	53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning: 01/01/05

Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
			\$	Workers' Compensation Insurance		\$	IDPH License Fee	\$
				Unemployment Compensation Insurance			Advertising: Employee Recruitment	
				FICA Taxes			Health Care Worker Background Check	
				Employee Health Insurance			(Indicate # of checks performed _____)	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount				Less: Public Relations Expense ( )	
			\$				Non-allowable advertising ( )	
							Yellow page advertising ( )	
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Entertainment Expense ( )	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			TOTAL	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$				\$	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**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										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	
2			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
3														
4														
5														
6														
7														
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9														
10														
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12														
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14														
15														
16														
17														
18														
19														
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Elizabeth Nursing Home

# 0008300

Report Period Beginning: 01/01/05

Ending: 12/31/05

**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. IHCA dues of \$2,705
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (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? \_\_\_\_\_
- (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? 8.10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? 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  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 26,828  
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? Yes 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? \_\_\_\_\_
- (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? \_\_\_\_\_ 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 benefit: on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,847
- (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. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
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? No**  
**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? Yes  
Firm Name: Eide Bailly LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, 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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

Elizabeth Nursing Home  
Book - Tax Reconciliation  
12/31/2005

Income before income taxes (page 19)	162,871
Accrued Vacation Adjustment	376
Contributions Received	(1,970)
Depreciation Adjustment	(20,358)
State Income Taxes (2003 & 2004)	<u>(14,094)</u>
 Federal Taxable Income per tax return	 <u>126,825</u>