



Facility Name & ID Number The Henry and Jane Vonderlieth Living Center# 0019976 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

## 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	90	Skilled (SNF)	90	32,940	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,940	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		536		536	8
9	SNF/PED					9
10	ICF	11,852	15,384		27,236	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,852	15,920		27,772	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.31%D. How many bed-hold days during this year were paid by the Department? 30 (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)

NoneF. Does the facility maintain a daily midnight census? YesG. 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 10/21/1973J. 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 90 and days of care provided 2,579Medicare Intermediary Mutual of Omaha Medicare

## IV. ACCOUNTING BASIS

ACCRUAL  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

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Facility Name &amp; ID Number The Henry and Jane Vonderlieth Living Cen # 0019976 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

## 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	237,376	17,234	6,590	261,200	(34,114)	227,086		227,086		1
2	Food Purchase		200,741		200,741	(31,960)	168,781	(4,772)	164,009		2
3	Housekeeping	68,194	23,584		91,778		91,778		91,778		3
4	Laundry	55,391	15,441		70,832		70,832		70,832		4
5	Heat and Other Utilities			130,221	130,221		130,221	(6,535)	123,686		5
6	Maintenance	74,914	15,435	30,576	120,925		120,925	83	121,008		6
7	Other (specify):* SEE PAGE 24			2,533	2,533		2,533		2,533		7
8	<b>TOTAL General Services</b>	435,875	272,435	169,920	878,230	(66,074)	812,156	(11,224)	800,932		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,428,697	116,585	6,625	1,551,907		1,551,907		1,551,907		10
10a	Therapy	43,398		2,808	46,206		46,206		46,206		10a
11	Activities	34,223	2,674	53	36,950		36,950		36,950		11
12	Social Services	24,724		4,153	28,877		28,877		28,877		12
13	CNA Training										13
14	Program Transportation			1,606	1,606		1,606		1,606		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,531,042	119,259	15,245	1,665,546		1,665,546		1,665,546		16
	<b>C. General Administration</b>										
17	Administrative	67,558		1,560	69,118	(200)	68,918	(1,273)	67,645		17
18	Directors Fees			3,159	3,159		3,159		3,159		18
19	Professional Services			14,842	14,842		14,842		14,842		19
20	Dues, Fees, Subscriptions & Promotions			14,760	14,760	1,096	15,856	(130)	15,726		20
21	Clerical & General Office Expenses	77,551	10,109	15,983	103,643		103,643		103,643		21
22	Employee Benefits & Payroll Taxes			352,047	352,047	65,178	417,225		417,225		22
23	Inservice Training & Education			1,352	1,352		1,352		1,352		23
24	Travel and Seminar			430	430		430		430		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			96,863	96,863		96,863		96,863		26
27	Other (specify):* SEE PAGE 24			4,257	4,257		4,257	(3,639)	618		27
28	<b>TOTAL General Administration</b>	145,109	10,109	505,253	660,471	66,074	726,545	(5,042)	721,503		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,112,026	401,803	690,418	3,204,247		3,204,247	(16,266)	3,187,981		29

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

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

Facility Name & ID Number      The Henry and Jane Vonderlieth Living Center      #0019976      Report Period Beginning:      01/01/2005      Ending:      12/31/2005

## 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			213,588	213,588	(51,636)	161,952	7,062	169,014			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			213,588	213,588	(51,636)	161,952	7,062	169,014			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			9,507	9,507		9,507		9,507			38
39	Ancillary Service Centers		65,470	195,713	261,183		261,183		261,183			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,275	49,275		49,275		49,275			42
43	Other (specify):* <b>SEE PAGE 24</b>		667	23,447	24,114	51,636	75,750	(75,750)				43
44	<b>TOTAL Special Cost Centers</b>		66,137	277,942	344,079	51,636	395,715	(75,750)	319,965			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,112,026	467,940	1,181,948	3,761,914		3,761,914	(84,954)	3,676,960			45

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

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center

# 0019976

Report Period Beginning: 01/01/2005

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**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	(4,772)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,535)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,062	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				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	(65)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,639)	27		24
25	Fund Raising, Advertising and Promotional	(65)	20		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	(76,940)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (84,954)		\$	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>	\$ (84,954)		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.		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	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

The Henry and Jane Vonderlieth Living Center

ID# 0019976

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Write off current year deferred maint depreciation	\$ 3,444	6	1
2	Apartment expenses	(75,750)	43	2
3	Flowers	(591)	17	3
4	Current year deferred maintenance items	(3,361)	6	4
5	Apartment resident expense	(682)	17	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>	(76,940)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center# 0019976 Report Period Beginning:

01/01/2005

Ending: 12/31/2005

## 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	(4,772)	0	0	0	0	0	0	0	0	0	0	(4,772)	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	(6,535)	0	0	0	0	0	0	0	0	0	0	(6,535)	5
6	Maintenance	83	0	0	0	0	0	0	0	0	0	0	83	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(11,224)</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>(11,224)</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	0	0	0	0	0	0	0	0	0	0	0	0	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>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>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(1,273)	0	0	0	0	0	0	0	0	0	0	(1,273)	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	(130)	0	0	0	0	0	0	0	0	0	0	(130)	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):*	(3,639)	0	0	0	0	0	0	0	0	0	0	(3,639)	27
28	<b>TOTAL General Administration</b>	<b>(5,042)</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>(5,042)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(16,266)</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>(16,266)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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

	Capital Expense	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>D. Ownership</b>												
30	Depreciation	7,062	0	0	0	0	0	0	0	0	0	0	7,062 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>7,062</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>7,062 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(75,750)	0	0	0	0	0	0	0	0	0	0	(75,750) 43
44	<b>TOTAL Special Cost Centers</b>	<b>(75,750)</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>(75,750) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(84,954)</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>(84,954) 45</b>

**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
None						

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

Facility Name & ID Number      The Henry and Jane Vonderlieth Living Cer      #      0019976      Report Period Beginning:      01/01/2005      Ending:      12/31/2005

## 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	None								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

**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

Facility Name & ID Number The Henry and Jane Vonderlieth Living Cent # 0019976 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense
		YES	NO				Original	Balance			
	<b>A. Directly Facility Related</b>										
	<b>Long-Term</b>										
1							\$	\$			\$
2											
3											
4											
5											
	<b>Working Capital</b>										
6											
7											
8											
9	<b>TOTAL Facility Related</b>						\$	\$		\$	
	<b>B. Non-Facility Related*</b>										
10											
11											
12											
13											
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$	
15	<b>TOTALS (line 9+line14)</b>						\$	\$		\$	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

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

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

**B. Real Estate Taxes**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2004 report.		\$	1																								
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																								
3. Under or (over) accrual (line 2 minus line 1).		\$	3																								
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																								
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5																								
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																								
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2000</td><td>8</td></tr> <tr><td>2001</td><td>9</td></tr> <tr><td>2002</td><td>10</td></tr> <tr><td>2003</td><td>11</td></tr> <tr><td>2004</td><td>12</td></tr> </table>	2000	8	2001	9	2002	10	2003	11	2004	12	<table border="1"> <tr><td colspan="2"><b>FOR OHF USE ONLY</b></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2004 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>		<b>FOR OHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2004 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2000	8																										
2001	9																										
2002	10																										
2003	11																										
2004	12																										
<b>FOR OHF USE ONLY</b>																											
13	FROM R. E. TAX STATEMENT FOR 2004 \$	13																									
14	PLUS APPEAL COST FROM LINE 5 \$	14																									
15	LESS REFUND FROM LINE 6 \$	15																									
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																									

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 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 The Henry and Jane Vonderlieth Living Cente COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0019976

CONTACT PERSON REGARDING THIS REPORT Cindy Russell

TELEPHONE (217) 792-3218 FAX #: (217) 792-3210

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

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 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. <u>N/A - tax exempt</u>	<u></u>	\$ <u></u>	\$ <u></u>
2. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
<b>TOTALS</b>		\$ <u></u>	\$ <u></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 & ID Number The Henry and Jane Vonderlieth Living Center# 0019976 Report Period Beginning:01/01/2005 Ending: 12/31/2005**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 37,140 B. General Construction Type: Exterior Brick Frame Steel 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)

25 apartments owned by corporationF. 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	<u>Buildings and grounds</u>	<u>2,163,000</u>	<u>1971</u>	<u>\$ 55,924</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<u>2,163,000</u>		<u>\$ 55,924</u>	<u>3</u>

Facility Name &amp; ID Number The Henry and Jane Vonderlieth Living Center

# 0019976

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

**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	60	1973	1973	\$ 1,172,276	\$ 29,307	35	\$ 33,494	\$ 4,187	\$ 1,032,203	4
5	30	1977	1977	441,636	11,041	35	12,618	1,577	354,093	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Heating system		1979	3,848		20			3,848	9
10	Conversion		1979	11,345	344	33	344		9,110	10
11	Medicine room		1981	474		20			474	11
12	Sidewalks		1981	1,209		20			1,209	12
13	Shower room		1982	1,175	34	35	34		796	13
14	Blacktopping		1983	5,095		20			5,095	14
15	Landscaping		1984	1,000		10			1,000	15
16	Remodeling		1984	3,117		20			3,117	16
17	Parking lot		1985	36,890		15			36,890	17
18	Fire hydrant		1985	1,308		15			1,308	18
19	Building improvement		1985	5,201	173	30	173		3,524	19
20	Energy management system		1985	9,381	334	20	334		9,509	20
21	Blacktopping		1986	3,885	194	20	194		3,767	21
22	Shrubs		1986	583		10			583	22
23	Sewer lift station		1986	40,129	2,006	20	2,006		38,281	23
24	Sewer lift station		1987	15,420	771	20	771		14,585	24
25	Windows Improvement:		1988	4,721		5			4,721	25
26	Fan		1988	1,743		5			1,743	26
27	Office remodeling		1988	1,580		15				27
28	Patio door		1990	985	50	15	50		985	28
29	Trees		1990	700		10			700	29
30	Air conditioner		1991	53,731	3,582	15	3,582		52,238	30
31	Building improvements (ceilings, lift station, temperature controls)		1991	16,133		10			16,133	31
32	Building improvements (kitchen floor, sprinklers, fire doors)		1991	43,767	2,918	15	2,918		42,700	32
33	Fire alarm panels		1992	4,622	308	15	308		4,261	33
34	Water softner		1992	7,887		10			7,887	34
35	Walk-in cooler		1992	12,469	623	20	623		8,151	35
36	Door monitor system		1992	1,700		10			1,700	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number The Henry and Jane Vonderlieth Living Center

# 0019976

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

## 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	30 Heating units	1992	\$ 9,810	\$ 491	20	\$ 491		\$ 6,751	37
38	Blacktopping	1992	2,859		10			2,859	38
39	Library paneling	1993	3,900	195	20	195		2,454	39
40	Convection units	1993	3,270	164	20	164		2,077	40
41	Computer room - drywall	1994	2,244		10			2,244	41
42	Pump	1994	3,439	28	10	28		3,439	42
43	Roof	1995	324,374	12,975	25	12,975		141,443	43
44	Room size heater	1995	1,604	17	10	17		1,604	44
45	Heating system units	1995	9,772	653	20	489	(164)	5,216	45
46	Garage doors	1996	1,550	155	10	155		1,460	46
47	80 Gallon water heater	1996	7,611	761	10	761		7,103	47
48	Exhaust fan	1997	1,691	169	10	169		1,352	48
49	Therapy, activity, administration offices, and additional storage	1998	796,976	22,770	35	22,770		176,468	49
50	Additional finish costs (line 49 above)	1998	4,715	135	35	135		1,046	50
51	Dampers and motor actuator	1998	3,293	165	20	165		1,306	51
52	Chiller	1998	14,853	743	20	743		5,882	52
53	Moveable wall	1998	9,830	393	25	393		2,849	53
54	Boiler programmer	1998	2,570	129	20	129		1,021	54
55	80 Gallon water heater	1998	5,287	529	10	529		4,100	55
56	Chain link fence	1999	1,019	68	15	68		442	56
57	Lowered "one head"	2000	2,087	209	10	209		1,132	57
58	8 Steel universal access doors 24"x24"	2000	437	44	10	44		238	58
59	11 Smoke & fire dampers	2000	21,450	2,145	10	2,145		11,083	59
60	Card zone expander installed	2000	3,185	319	10	319		1,648	60
61	Floor tile for center corridor & dining room	2000	6,290	419	15	419		2,121	61
62	Blacktopping drive (from def maint per IDPH review 2000 report)	2000	7,309		5	1,462	1,462	5,848	62
63	Boiler	2001	64,480	3,224	20	3,224		13,433	63
64	4" wall base in corridors & dining room	2001	19,200	1,280	15	1,280		5,227	64
65	12 time delayed locks on outside doors	2002	23,618	2,362	10	2,362		7,873	65
66	Boiler room hollow steel door	2002	1,233	35	35	35		134	66
67	Garage	2002	71,872	2,053	35	2,053		6,313	67
68	Driveway entrance sign	2003	1,967	131	15	131		306	68
69	West chain link fence 800'	2003	6,800	453	15	453		1,019	69
70	TOTAL (lines 4 thru 69)		\$ 3,344,605	\$ 104,899		\$ 111,961	\$ 7,062	\$ 2,088,102	70

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

Facility Name &amp; ID Number The Henry and Jane Vonderlieth Living Center

# 0019976

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

## 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		
1	Totals from Page 12A, Carried Forward	\$ 3,344,605	\$ 104,899		\$ 111,961	\$ 7,062	\$ 2,088,102		1
2	Compressor for chiller	2003 7,126	713	10	713		1,604		2
3	Sidewalks	2004 10,150	677	15	677		959		3
4	Asphalt near dumpster	2004 648	130	5	130		141		4
5	Asphalt and sealcoat	2004 13,303	2,661	5	2,661		3,104		5
6	Front entry doors	2004 5,405	270	20	270		518		6
7	Breaker box	2004 581	39	15	39		55		7
8	Receptacles in dining room	2004 1,950	78	25	78		111		8
9	Ceiling tile	2004 3,318	166	20	166		304		9
10									10
11									11
12	16 red LED exit signs	2005 886	49	15	49		49		12
13	Door and wall protection coverings	2005 3,993	44	15	44		44		13
14	Tile - south hall	2005 8,600	108	20	108		108		14
15	Vinyl - 4 south rooms	2005 7,245	60	20	60		60		15
16	Carpet - living room and front entry	2005 9,300	78	10	78		78		16
17	Gazebo roof	2005 3,312	97	20	97		97		17
18	Kitchen air handler	2005 1,449	121	10	121		121		18
19	Fan coil installed	2005 1,996	150	10	150		150		19
20	HVAC units	2005 6,612	386	10	386		386		20
21	Parking lot lights	2005 3,295	18	15	18		18		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	TOTAL (lines 1 thru 33)	\$ 3,433,774	\$ 110,744		\$ 117,806	\$ 7,062	\$ 2,096,009		34

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

Facility Name & ID Number    The Henry and Jane Vonderlieth Living Center    #    0019976    Report Period Beginning:    01/01/2005    Ending:    12/31/2005

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	\$ 434,295	\$ 37,295	\$ 37,295	\$	5-15 yrs	\$ 306,837	71
72	Current Year Purchases	13,526	1,178	1,178		5-10 yrs	1,178	72
73	Fully Depreciated Assets	331,305	2,580	2,580		5-15 yrs	331,305	73
74								74
75	TOTALS	\$ 779,126	\$ 41,053	\$ 41,053	\$		\$ 639,320	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient transport	2000 Chev. Supreme Bus	1999	\$ 43,000	\$ 5,373	\$ 5,373	\$	6	\$ 43,000	76
77	Patient transport	2002 Olds Silhouette	2001	28,690	4,782	4,782		6	20,323	77
78										78
79										79
80	TOTALS			\$ 71,690	\$ 10,155	\$ 10,155	\$		\$ 63,323	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)	\$ 4,340,514 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 161,952 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 169,014 83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,062 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,798,652 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	Apartment land improvements	\$ 89,457	\$ 6,985	\$ 67,271	86
87	Apartments	1,445,154	41,267	763,523	87
88	Portraits	6,000			88
89	Equipment	30,740	3,384	19,989	89
90					90
91	TOTALS	\$ 1,571,351	\$ 51,636	\$ 850,783	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: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES  NO

If NO, see instructions.

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_

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

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

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

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

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

10. Effective dates of current rental agreement:  
Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	_____/2006	\$ _____
13.	_____/2007	\$ _____
14.	_____/2008	\$ _____

\* 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.

**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><u>Training was not necessary because this organization had a very low turnover rate of aides this year.</u></p>	<p>2. <b>CLASSROOM PORTION:</b></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. <b>CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

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



Facility Name &amp; ID Number    The Henry and Jane Vonderlieth Living Center

#    0019976

Report Period Beginning:    01/01/2005

Ending:

12/31/2005

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of    12/31/2005

(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	\$ 347,548	\$	1
2	Cash-Patient Deposits	4,806		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	267,886		3
4	Supply Inventory (priced at FIFO cost )	16,346		4
5	Short-Term Investments	3,830,750		5
6	Prepaid Insurance	18,230		6
7	Other Prepaid Expenses	486		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest Receivable</u>	1,461		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,487,513	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	55,924		13
14	Buildings, at Historical Cost	4,725,355		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	887,556		16
17	Accumulated Depreciation (book methods)	(3,497,092)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Land Improvements, at historical</u>	227,764		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,399,507	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,887,020	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 77,981	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,806		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	161,672		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Patient Care Prepayments</u>	4,378		36
37	<u>Employee Benefits Withheld</u>	8,548		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 257,385	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Apartment Resident Deposits</u>	1,247,063		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,247,063	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,504,448	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 5,382,572	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 6,887,020	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>5,230,395</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>5,230,395</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>152,177</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>152,177</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>5,382,572</b>	<b>24</b> *

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

STATE OF ILLINOIS

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center # 0019976

Report Period Beginning: 01/01/2005

Page 19  
Ending: 12/31/2005

**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	\$ 3,489,215	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,489,215	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,008	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		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>	\$ 2,008	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	146,190	24
25	Interest and Other Investment Income***	156,211	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 302,401	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>SEE PAGE 25</u>	120,467	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 120,467	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,914,091	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	878,230	31
32	Health Care	1,665,546	32
33	General Administration	660,471	33
<b>B. Capital Expense</b>			
34	Ownership	213,588	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	270,690	35
36	Provider Participation Fee	49,275	36
<b>D. Other Expenses (specify):</b>			
37	Apartment expenses	24,114	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,761,914	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	152,177	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 152,177	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 &amp; ID Number The Henry and Jane Vonderlieth Living Center

# 0019976

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,896	2,081	\$ 59,466	\$ 28.58	1
2	Assistant Director of Nursing	1,904	2,081	54,228	26.06	2
3	Registered Nurses	4,473	4,768	100,794	21.14	3
4	Licensed Practical Nurses	26,181	28,199	529,260	18.77	4
5	CNAs & Orderlies	58,929	63,247	609,374	9.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,275	3,744	43,398	11.59	8
9	Activity Director	1,722	1,866	18,200	9.75	9
10	Activity Assistants	2,277	2,428	16,023	6.60	10
11	Social Service Workers	1,927	2,031	24,724	12.17	11
12	Dietician					12
13	Food Service Supervisor	1,983	2,105	29,570	14.05	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,469	23,055	207,806	9.01	15
16	Dishwashers					16
17	Maintenance Workers	3,832	4,378	74,914	17.11	17
18	Housekeepers	8,712	9,317	68,194	7.32	18
19	Laundry	5,778	6,275	55,391	8.83	19
20	Administrator	1,968	2,081	67,558	32.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,804	2,055	33,978	16.53	23
24	Clerical	3,346	3,522	43,573	12.37	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	5,076	5,587	75,575	13.53	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	156,552	168,820	\$ 2,112,026 *	\$ 12.51	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	152	\$ 6,590	1(3)	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	600	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	75	4,153	12(3)	45
46	Other(specify)				46
47	Restorative Program Consultant	51	2,808	10a(3)	47
48					48
49	TOTAL (lines 35 - 48)	290	\$ 14,151		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			52
53	TOTAL (lines 50 - 52)	\$		53

Facility Name & ID Number **The Henry and Jane Vonderlieth Living Center**

# **0019976**

Report Period Beginning: **01/01/2005**

Ending: **12/31/2005**

**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			
Cindy Russell	Administrator	0	\$ 67,558	Workers' Compensation Insurance	\$ 85,885	IDPH License Fee	\$ 0			
				Unemployment Compensation Insurance	0	Advertising: Employee Recruitment	9,568			
				FICA Taxes	155,053	Health Care Worker Background Check (Indicate # of checks performed <u>56</u> )	896			
				Employee Health Insurance	99,727	Facility Advertising	65			
				Employee Meals	66,074	Life Services Network of IL dues	5,062			
				Illinois Municipal Retirement Fund (IMRF)*	0	INHAA membership fee	100			
				Employee Physicals	2,243	Administrator license	100			
				Employee Awards	7,521					
				Vacation pay to former employee	722					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 67,558	TOTAL (agree to Schedule V, line 22, col.8)			\$ 417,225	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 15,726
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount		
SEE PAGE 25			\$ 1,560				Out-of-State Travel	\$		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,560				In-State Travel			
C. Professional Services										
Vendor/Payee	Type	Amount								
Helen M. Meagher, C.P.A.	Audit, cost report & 990	\$ 7,100								
Helen M. Meagher, C.P.A.	Workman's comp insurance fmd	189								
Helen M. Meagher, C.P.A.	Depreciation schedule spreadshe	1,000								
RSM McGladrey	review IDPA reports & rates	496								
Duane Morris, LLP	Legal services	1,642								
Attschuler, Melvoin, & Glasser, LLP	2004 Medicare cost report	4,415								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 14,842	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 430

\* Attach copy of IMRF notifications

\*\*See instructions.



**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. Life Services Network of IL - \$5,062
- (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? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32,613 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. \_\_\_\_\_
- (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. \$ 49,275  
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 benefit: on Schedule V. \$ 66,074 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,008
- (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. \$ 6,391  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? Yes  
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? Yes  
**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.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Helen M. Meagher, C.P.A. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? 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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

V. COST CENTER EXPENSES

V. RECLASSIFICATOINS

A. General Services		Other		Description	To Line	From Line	Amount
Line 7 Other:							
Hazardous Waste Removal		2,533		1 Employee Meal Costs	22		\$ 66,074
						1	(34,114)
		\$ 2,533				2	(31,960)
				2 Apartment Depreciation	43		51,636
C. General Administration						30	(51,636)
				3 Employee Background Checks	20		896
Line 27 Other:						22	(896)
Reimburse residents for damaged property		121		4 Administrator license fee	20		100
Bad debts		3,639				17	(100)
Loss on disposal of capital assets		497		5 INHAA membership fee	20		100
						17	(100)
		\$ 4,257					
E. Special Cost Centers							
Line 43 Other:							
Supplies, column 2							
Supplies for apartments		\$ 667					
Other, column 3							
Apartment Expenses:							
Maintenance		10,258					
Utilities		446					
Trash Removal		1,225					
Cable		3,477					
Insurance		8,041					
Auto mileage reimbursement		-					
		\$ 23,447					



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