



Facility Name & ID Number Auburn Nursing & Rehab Center# 0047076 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

## 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	<u>67</u>	Skilled (SNF)	<u>67</u>	<u>24,455</u>	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	<u>67</u>	TOTALS	<u>67</u>	<u>24,455</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
		8	SNF	<u>11,503</u>		<u>8,990</u>
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,503</u>	<u>8,990</u>	<u>2,134</u>	<u>22,627</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 92.53%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)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 5/16/2005J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 5/16/2005 NO K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number  
of beds certified 67 and days of care provided 2,134Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Auburn Nursing & Rehab Center # 0047076 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

**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	105,588	11,067	6,576	123,231		123,231	(3,137)	120,094		1
2	Food Purchase		105,331		105,331		105,331	(483)	104,848		2
3	Housekeeping	39,959	10,390		50,349		50,349		50,349		3
4	Laundry	29,512	8,343		37,855		37,855		37,855		4
5	Heat and Other Utilities			56,303	56,303		56,303		56,303		5
6	Maintenance	36,849	10,388	25,301	72,538		72,538		72,538		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>211,908</b>	<b>145,519</b>	<b>88,180</b>	<b>445,607</b>		<b>445,607</b>	<b>(3,620)</b>	<b>441,987</b>		<b>8</b>
<b>B. Health Care and Programs</b>											
9	Medical Director			7,020	7,020		7,020		7,020		9
10	Nursing and Medical Records	793,450	53,198	341	846,989		846,989		846,989		10
10a	Therapy		317	132,165	132,482		132,482		132,482		10a
11	Activities	23,393	373	4,067	27,833		27,833		27,833		11
12	Social Services	54,145	827	2,595	57,567		57,567		57,567		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>870,988</b>	<b>54,715</b>	<b>146,188</b>	<b>1,071,891</b>		<b>1,071,891</b>		<b>1,071,891</b>		<b>16</b>
<b>C. General Administration</b>											
17	Administrative	57,316			57,316		57,316		57,316		17
18	Directors Fees										18
19	Professional Services			244,416	244,416		244,416		244,416		19
20	Dues, Fees, Subscriptions & Promotions			19,961	19,961		19,961	(8,191)	11,770		20
21	Clerical & General Office Expenses	60,841	19,734	104,900	185,475		185,475	(86,381)	99,094		21
22	Employee Benefits & Payroll Taxes			219,657	219,657		219,657		219,657		22
23	Inservice Training & Education			887	887		887		887		23
24	Travel and Seminar			5,145	5,145		5,145		5,145		24
25	Other Admin. Staff Transportation			5,960	5,960		5,960		5,960		25
26	Insurance-Prop.Liab.Malpractice			49,670	49,670		49,670		49,670		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>118,157</b>	<b>19,734</b>	<b>650,596</b>	<b>788,487</b>		<b>788,487</b>	<b>(94,572)</b>	<b>693,915</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,201,053</b>	<b>219,968</b>	<b>884,964</b>	<b>2,305,985</b>		<b>2,305,985</b>	<b>(98,192)</b>	<b>2,207,793</b>		<b>29</b>

\*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 &amp; ID Number

Auburn Nursing &amp; Rehab Center

#0047076

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

## 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			2,786	2,786		2,786		2,786			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,910	15,910		15,910	(330)	15,580			32
33	Real Estate Taxes			16,927	16,927		16,927		16,927			33
34	Rent-Facility & Grounds			221,120	221,120		221,120	4,968	226,088			34
35	Rent-Equipment & Vehicles			4,439	4,439		4,439	2,303	6,742			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			261,182	261,182		261,182	6,941	268,123			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		53,158	20,225	73,383		73,383		73,383			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,325	38,325		38,325		38,325			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		53,158	58,550	111,708		111,708		111,708			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,201,053	273,126	1,204,696	2,678,875		2,678,875	(91,251)	2,587,624			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 Auburn Nursing & Rehab Center

# 0047076

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

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	(3,137)	1		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	(330)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(483)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,525)	21		18
19	Entertainment				19
20	Contributions	(56)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,990)	21		24
25	Fund Raising, Advertising and Promotional	(8,191)	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	(517)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (29,229)</b>		<b>\$</b>	<b>30</b>

BHF USE ONLY						
48		49	50	51	52	

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

		1	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)	(62,022)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (62,022)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (91,251)</b>		<b>37</b>

\*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>			<b>\$</b>		<b>47</b>

Auburn Nursing & Rehab Center

ID# 0047076

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Miscellaneous Income	\$ (517)	21	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				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	<b>Total</b>	(517)		48
49				49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Auburn Nursing &amp; Rehab Center

# 0047076 Report Period Beginning:

1/1/2006

Ending: 12/31/2006

## 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	(3,137)	0	0	0	0	0	0	0	0	0	0	(3,137)	1
2	Food Purchase	(483)	0	0	0	0	0	0	0	0	0	0	(483)	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>(3,620)</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>(3,620)</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	0	0	0	0	0	0	0	0	0	0	0	0	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	(8,191)	0	0	0	0	0	0	0	0	0	0	(8,191)	20
21	Clerical & General Office Expenses	(17,088)	(69,293)	0	0	0	0	0	0	0	0	0	(86,381)	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>(25,279)</b>	<b>(69,293)</b>	<b>0</b>	<b>(94,572)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(28,899)</b>	<b>(69,293)</b>	<b>0</b>	<b>(98,192)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Auburn Nursing & Rehab Center# 0047076

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

## 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	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(330)	0	0	0	0	0	0	0	0	0	0	(330) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	4,968	0	0	0	0	0	0	0	0	0	4,968 34
35	Rent-Equipment & Vehicles	0	2,303	0	0	0	0	0	0	0	0	0	2,303 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>(330)</b>	<b>7,271</b>	<b>0</b>	<b>6,941 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):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</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 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(29,229)</b>	<b>(62,022)</b>	<b>0</b>	<b>(91,251) 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
Tutera Health Care Services, LLC	100					

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	34 Building & Fixtures	\$	Tutera Health Care Services, LLC	100.00%	\$ 4,968	\$ 4,968	1
2	V	35 Moveable Equipment		Tutera Health Care Services, LLC	100.00%	2,303	2,303	2
3	V	21 Non-Capital	179,571	Tutera Health Care Services, LLC	100.00%	110,278	(69,293)	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		\$ 179,571			\$ 117,549	\$ * (62,022)	14

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

Facility Name & ID Number Auburn Nursing & Rehab Center # 0047076 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

## 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	N/A								\$	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 Auburn Nursing & Rehab Center # 0047076 Report Period Beginning: 1/1/2006 Ending: 2/31/2006

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 Tutera Health Care Services, LLC  
 Street Address 7611 State Line Rd, Suite 301  
 City / State / Zip Code Kansas City, MO 64114  
 Phone Number ( 816-444-0900  
 Fax Number ( 816-822-1723

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21 Non-Capital	Direct Costs	97,645,359	12	\$ 4,929,488	\$	2,184,403	\$ 110,276	1
2	34 Capital Building	Direct Costs	97,645,359	12	222,080		2,184,403	4,968	2
3	35 Capital Equipment	Direct Costs	97,645,359	12	102,951		2,184,403	2,303	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	TOTALS				\$ 5,254,519	\$		\$ 117,547	25

Facility Name & ID Number Auburn Nursing & Rehab Center # 0047076 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

**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	Notes Payable	X		Capital			\$ 165,692	\$			\$ 15,910	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6	Interest Income		X								(330)	6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$ 165,692	\$			\$ 15,580	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ 165,692	\$			\$ 15,580	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.)

\*\* 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 2005 report.		\$ 10,602	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.)		\$ 10,602	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$	3																																	
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 16,927	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.		\$ 16,927	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td>12,996</td><td>8</td></tr> <tr><td>2002</td><td>13,012</td><td>9</td></tr> <tr><td>2003</td><td>13,012</td><td>10</td></tr> <tr><td>2004</td><td>13,402</td><td>11</td></tr> <tr><td>2005</td><td>10,602</td><td>12</td></tr> </table>	2001	12,996	8	2002	13,012	9	2003	13,012	10	2004	13,402	11	2005	10,602	12	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	<b>FOR BHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2005	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2001	12,996	8																																		
2002	13,012	9																																		
2003	13,012	10																																		
2004	13,402	11																																		
2005	10,602	12																																		
<b>FOR BHF USE ONLY</b>																																				
13	FROM R. E. TAX STATEMENT FOR 2005	\$	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: 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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,

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Auburn Nursing & Rehab Center COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0047076

CONTACT PERSON REGARDING THIS REPORT Junior Foster, THCSLLC, Mgmt Co.

TELEPHONE 816-444-0900 FAX #: 816-822-1723

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. <u>34-10.0-205-020</u>	<u>Nursing Facility</u>	<u>\$ 14,837.06</u>	<u>\$ 14,837.06</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<b>\$ <u>14,837.06</u></b>	<b>\$ <u>14,837.06</u></b>

**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   X   NO

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

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,312 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Auburn Nursing & Rehab Center

# 0047076

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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	67			\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Drywall	2006		1,200	70	10	70		70
10	Doors for laundry room	2006		1,372	40	20	40		40
11	Repair leak on two skylights	2006		3,850	229	7	229		229
12	Wrought railing	2006		1,280	91	7	91		91
13	Excavation & concrete work	2006		1,673	65	15	65		65
14	Parking lot repairs	2006		8,805	550	8	550		550
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
37		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70	TOTAL (lines 4 thru 69)	\$ 18,180	\$ 1,045		\$ 1,045	\$	\$ 1,045

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

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	\$ 4,660	\$ 1,291	\$ 1,291	\$		\$ 1,859	71
72	Current Year Purchases	8,694	449	449			449	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 13,354	\$ 1,740	\$ 1,740	\$		\$ 2,308	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)	\$ 31,534	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 2,785	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 2,785	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)	\$ 3,353	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	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: Ellsworth F. O'Sullivan

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: <u>1966</u>	<u>70</u>	<u>12/15/80</u>	\$ <u>123,986</u>	<u>25</u>		3
4	Additions						4
5							5
6							6
7	<b>TOTAL</b>	<b>70</b>		\$ <b>123,986</b>			7

10. Effective dates of current rental agreement:

Beginning 12/15/80  
Ending 12/31/05

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

Fiscal Year Ending      Annual Rent

12. 2007 \$ \_\_\_\_\_  
13. 2008 \$ \_\_\_\_\_  
14. 2009 \$ \_\_\_\_\_

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 \_\_\_\_\_.

None  
N/A

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

\* 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?</p> <p style="text-align: right;"> <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. <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.

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	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a,3	hrs	\$	640	\$	40,983	\$	640	\$	40,983	1		
2	Licensed Speech and Language Development Therapist	10a,3	hrs		204		13,609		204		13,609	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	10a,3	hrs		1,212		77,573		1,212		77,573	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	<b>TOTAL</b>			\$	2,056	\$	132,165	\$	2,056	\$	132,165	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.

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Auburn Nursing &amp; Rehab Center

# 0047076

Report Period Beginning: 1/1/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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	\$ 8,267	\$	1
2	Cash-Patient Deposits	3,597		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	349,949		3
4	Supply Inventory (priced at )	9,906		4
5	Short-Term Investments			5
6	Prepaid Insurance	13,195		6
7	Other Prepaid Expenses	1,285		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due to/from LOC Lendor</u>	5,384		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 391,583	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	7,712		14
15	Leasehold Improvements, at Historical Cost	10,478		15
16	Equipment, at Historical Cost	13,354		16
17	Accumulated Depreciation (book methods)	(3,363)		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>Fixed Asset Adjustment</u>	(276)		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 27,905	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 419,488	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 49,339	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,597		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	50,390		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,116		31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,927		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>Other Accrued Expenses</u>	17,517		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 156,886	\$	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				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 156,886	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 262,602	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 419,488	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 178,841	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 178,841	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	83,761	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 83,761	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)	\$ 262,602	24 *

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

STATE OF ILLINOIS

Facility Name & ID Number Auburn Nursing & Rehab Center

# 0047076

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

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

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

1			
	Revenue	Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,734,014	1
2	Discounts and Allowances for all Levels	(395,942)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,338,072	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	277,300	6
7	Oxygen	1,285	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 278,585	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	3,137	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	102,568	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,635	19
20	Radiology and X-Ray		20
21	Other Medical Services	28,793	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 145,133	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	330	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 330	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Miscellaneous Income</b>	517	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 517	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,762,637	30

2			
	Expenses	Amount	
<b>A. Operating Expenses</b>			
31	General Services	445,607	31
32	Health Care	1,071,892	32
33	General Administration	788,487	33
<b>B. Capital Expense</b>			
34	Ownership	261,182	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	73,383	35
36	Provider Participation Fee	38,325	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,678,876	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	83,761	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 83,761	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

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

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

Facility Name &amp; ID Number Auburn Nursing &amp; Rehab Center

# 0047076

Report Period Beginning: 1/1/2006

Ending:

12/31/2006

## 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	2,664	2,747	\$ 101,069	\$ 36.79	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,331	3,275	99,811	30.48	3
4	Licensed Practical Nurses	7,894	8,067	204,215	25.31	4
5	CNAs & Orderlies	22,394	22,633	354,742	15.67	5
6	CNA Trainees	1,540	1,580	26,789	16.96	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,851	2,018	23,393	11.59	10
11	Social Service Workers	2,359	2,441	54,145	22.18	11
12	Dietician	7,207	7,264	105,588	14.54	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,934	1,982	36,849	18.59	17
18	Housekeepers	3,290	3,343	39,959	11.95	18
19	Laundry	2,274	2,322	29,512	12.71	19
20	Administrator	1,240	1,272	68,052	53.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,310	2,377	48,826	20.54	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	612	675	8,102	12.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	60,900	61,996	\$ 1,201,052 *	\$ 19.37	34

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

\*\* See instructions.

## B. CONSULTANT SERVICES

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





XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. N/A
- (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? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 590 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES        NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 38,325  
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. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 3,137
- (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? 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?  
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? N/A  
Firm Name:        The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain.
- (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? NO  
Attach invoices and a summary of services for all architect and appraisal fees.