

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039149

Facility Name: BJORKLUND HOUSE

Address: 15841 TERRACE DRIVE OAK FOREST 60452
 Number City Zip Code

County: COOK

Telephone Number: (708) 687-2038 **Fax #** (708) 687-2762

HFS ID Number: 36-3731196001

Date of Initial License for Current Owners: 1/24/1994

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501 c (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: NAWARA FINANCIAL ADVISORS **Telephone Number:** (708) 448-7100

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2005 to 06/30/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	(Title) _____
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>MARK MERMAN</u> <u>CPA</u>	
	(Firm Name & Address) <u>NAWARA FINANCIAL ADVISORS, INC</u> <u>7420 WEST COLLEGE DRIVE - 2E, PALOS HEIGHTS, IL</u>	
	(Telephone) <u>(708) 448-7100</u> Fax # <u>(708) 448-5521</u>	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BJORKLUND HOUSE# 0039149 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>16</u>	Intermediate (ICF)	<u>16</u>	<u>5,840</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	<u>5,579</u>			<u>5,579</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>5,579</u>			<u>5,579</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.53%

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

208 (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? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 01/12/1994

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

YES Date 11/1993 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 06/30/2006 Fiscal Year: 06/30/2006

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

Facility Name & ID Number **BJORKLUND HOUSE** # **0039149** Report Period Beginning: **07/01/2005** Ending: **06/30/2006**

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

	Operating Expenses	Costs 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
	A. General Services										
1	Dietary	22,047		6,060	28,107		28,107	28,107			1
2	Food Purchase		42,452		42,452		42,452	42,452			2
3	Housekeeping		5,566	17,013	22,579		22,579	22,579			3
4	Laundry										4
5	Heat and Other Utilities			13,718	13,718		13,718	13,718			5
6	Maintenance	5,553	3,929	9,980	19,462		19,462	19,462			6
7	Other (specify):*										7
8	TOTAL General Services	27,600	51,947	46,771	126,318		126,318	126,318			8
	B. Health Care and Programs										
9	Medical Director			4,848	4,848	(4,848)					9
10	Nursing and Medical Records	321,679	4,629	46,122	372,430	(2,040)	370,390	370,390			10
10a	Therapy			8,615	8,615		8,615	8,615			10a
11	Activities	23,812	2,548	10,126	36,486		36,486	36,486			11
12	Social Services	25,022		1,283	26,305		26,305	26,305			12
13	CNA Training					2,040	2,040	2,040			13
14	Program Transportation			10,542	10,542	(10,542)					14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	370,513	7,177	81,536	459,226	(15,390)	443,836	443,836			16
	C. General Administration										
17	Administrative	54,865		5,948	60,813		60,813	60,813			17
18	Directors Fees										18
19	Professional Services			17,808	17,808		17,808	17,808			19
20	Dues, Fees, Subscriptions & Promotions			5,829	5,829	288	6,117	(2,529)	3,588		20
21	Clerical & General Office Expenses	48,325	10,494	11,389	70,208		70,208	70,208			21
22	Employee Benefits & Payroll Taxes			156,213	156,213	(288)	155,925	155,925			22
23	Inservice Training & Education			796	796		796	796			23
24	Travel and Seminar			3,711	3,711		3,711	3,711			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			(18,019)	(18,019)	19,472	1,453	1,453			26
27	Other (specify):*										27
28	TOTAL General Administration	103,190	10,494	183,675	297,359	19,472	316,831	(2,529)	314,302		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	501,303	69,618	311,982	882,903	4,082	886,985	(2,529)	884,456		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 **BJORKLUND HOUSE**

#0039149

Report Period Beginning: 07/01/2005 Ending: 06/30/2006

06/30/2006

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	
	D. Ownership											
30	Depreciation			24,513	24,513		24,513	(2,100)	22,413			30
31	Amortization of Pre-Op. & Org.			60	60	(60)						31
32	Interest			12,733	12,733	60	12,793	(2,702)	10,091			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			37,306	37,306		37,306	(4,802)	32,504			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					(4,082)	(4,082)		(4,082)			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,416	51,416		51,416		51,416			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			51,416	51,416	(4,082)	47,334		47,334			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	501,303	69,618	400,704	971,625		971,625	(7,331)	964,294			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 **BJORKLUND HOUSE**

0039149

Report Period Beginning: **07/01/2005**

Ending: **06/30/2006**

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				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	2,702	L32		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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	2,529	L20		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 DT Vehicle Depreciation	2,100	L30		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 7,331		\$	30

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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 7,331		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

BJORKLUND HOUSE

ID# 0039149

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
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			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Facility Name & ID Number BJORKLUND HOUSE

0039149

Report Period Beginning: 07/01/2005 Ending: 06/30/2006

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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

BJORKLUND HOUSE

#

0039149

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

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									\$		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 BJORKLUND HOUSE

0039149 Report Period Beginning: 07/01/2005

Ending: 6/30/2006

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 _____
 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	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	National Covenant Properties		X	Mortgage	\$2,676.00	2/1/1999	\$ 343,919	\$ 177,098	9/30/2013	0.0700	\$ 12,733	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$2,676.00		\$ 343,919	\$ 177,098			\$ 12,733	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 343,919	\$ 177,098			\$ 12,733	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE Line # N/A

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

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

Facility Name & ID Number **BJORKLUND HOUSE**

0039149 Report Period Beginning: **07/01/2005** Ending: **06/30/2006**

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2006 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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2001	_____	8		
2002	_____	9		
2003	_____	10		
2004	_____	11		
2005	_____	12		
			FOR BHF USE ONLY	
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, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BJORKLUND HOUSE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0039149

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

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

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant 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 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.

Facility Name & ID Number BJORKLUND HOUSE

0039149

Report Period Beginning:

07/01/2005 Ending:

06/30/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 9,000 B. General Construction Type: Exterior BRICK Frame WOOD 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 grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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	<u>16-BED ICF/DD</u>	<u>24,568</u>	<u>1993</u>	<u>\$ 60,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	24,568		\$ 60,000	3

Facility Name & ID Number BJORKLUND HOUSE

0039149

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

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	16		1993	1993	\$ 428,233	\$ 10,706	40	\$ 10,706		\$ 133,193	4
5			2006	2006	462,246	483	40	483		483	5
6											6
7											7
8											8
	Improvement Type**										
9		PLUMBING		1994	250	17	15	17		208	9
10		SHELVING		1994	157		8			157	10
11		SURFACE KNOX-BOX		1994	138		8			138	11
12		LOCKS		1994	152		8			152	12
13		BADFGER - 5		1994	149		8			149	13
14		INSULATION		1994	1,800	120	15	120		1,489	14
15		SPRINKLERS		1994	150	10	15	10		124	15
16		STAIRWAY LIGHTING		1994	345	23	15	23		283	16
17		DRYWALL		1994	264	18	15	18		214	17
18		GARAGE		1994	8,421	421	20	421		4,928	18
19		WATER HEATER		1995	3,736	249	15	249		2,860	19
20		DOORKNOBS AND LOCKS		1996	915		8			915	20
21		VALVE/WATER HEATER		1996	1,900		8			1,900	21
22		LAUNDRY TUB		1996	1,985		8			1,985	22
23		ENCLOSE PORCH		1996	1,606		8			1,606	23
24		SEPTIC SYSTEM		1997	2,268		8			2,268	24
25		STEEL DOOR FRAMES		1997	3,840	240	8	240		3,840	25
26		SPRINKLER SYSTEM		2000	2,880	192	15	192		1,056	26
27		CARPETING		2001	4,050	506	8	506		2,784	27
28		CURTAINS		2001	1,968	246	8	246		1,353	28
29		PAINTING		2001	1,380	173	8	173		950	29
30		AIR CONDITIONER		2001	2,600	325	8	325		1,788	30
31		PAINTING		2002	590	74	8	74		333	31
32		SUMP PUMP		2002	189	24	8	24		107	32
33		AIR CONDITIONING		2002	2,450	306	8	306		1,377	33
34		CARPETING		2002	350	44	8	44		154	34
35		NEW PUMPS		2002	1,637	205	8	205		717	35
36		WATER HEATER		2002	3,925	491	8	491		1,718	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number BJORKLUND HOUSE

0039149

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	NEW VALVE - FIRE/SPRINKLER SYSTEM	2002	\$ 1,245	\$ 156	8	\$ 156	\$	\$ 546	37
38	CERAMIC TILE FOR BATHROOM	2004	409	27	15	27		41	38
39	SOD	1994	2,150	108	20	108		1,380	39
40	LANDSCAPING	1994	3,441	172	20	172		2,086	40
41	FENCE	1994	719	36	20	36		429	41
42	LANDSCAPING	1994	998	50	20	50		591	42
43	SIDEWALK	1997	1,566	78	20	78		665	43
44	LANDSCAPING	1997	4,545	227	20	227		1,930	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 955,647	\$ 15,727		\$ 15,727	\$	\$ 176,897	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 34,995	\$ 4,153	\$ 4,153	\$	8	\$ 17,045	71
72	Current Year Purchases	40,568	2,533	2,533		8	2,533	72
73	Fully Depreciated Assets	73,786				8	73,783	73
74								74
75	TOTALS	\$ 149,349	\$ 6,686	\$ 6,686	\$		\$ 93,361	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	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 1,164,996	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 22,413	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 22,413	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)		\$ 270,258	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	Land and Building	\$ 379,667	\$ 8,769	\$ 72,049	86
87	Furniture and Fixture	8,871	1,041	6,199	87
88	Vehicle - BJ	58,721	2,100	54,218	88
89	Vehicle - IP	34,707	2,115	34,707	89
90					90
91	TOTALS	\$ 481,966	\$ 14,025	\$ 167,173	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.

Facility Name & ID Number BJORKLUND HOUSE

0039149

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

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

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.	_____ /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 _____.

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	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		1,360		1,360
4	Clinical Wages (b)		680		680
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 2,040	\$	\$ 2,040
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,040		

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	<u>2</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

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

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BJORKLUND HOUSE# 0039149Report Period Beginning: 07/01/2005

Ending:

06/30/2006**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 06/30/2006

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 65,846	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	259,810		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	48,326		5
6	Prepaid Insurance	16,884		6
7	Other Prepaid Expenses	163		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest</u>	500		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 391,529	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	110,000		13
14	Buildings, at Historical Cost	1,285,314		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	251,648		16
17	Accumulated Depreciation (book methods)	(437,392)		17
18	Deferred Charges	395		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,209,965	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,601,494	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 69,540	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	52,407		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,489		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 123,436	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	372,723		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 372,723	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 496,159	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,105,335	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,601,494	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 721,512	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 721,512	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(36,250)	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) Fundraising	415,522	15
16	Other (describe) Separarte DHS Program	4,551	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 383,823	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,105,335	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BJORKLUND HOUSE

0039149

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 844,287	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 844,287	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions	78,282	24
25	Interest and Other Investment Income***	2,702	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 80,984	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Reimbursement	9,603	28
28a	Scrip Income	501	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,104	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 935,375	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	126,318	31
32	Health Care	459,226	32
33	General Administration	297,359	33
B. Capital Expense			
34	Ownership	37,306	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	51,416	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 971,625	40
41	Income before Income Taxes (line 30 minus line 40)**	(36,250)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (36,250)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

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

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

Facility Name & ID Number **BJORKLUND HOUSE**

0039149

Report Period Beginning: **07/01/2005**

Ending:

06/30/2006

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			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses		1,135	32,475	28.61	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook		1,953	22,047	11.29	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers		585	5,553	9.49	17
18	Housekeepers					18
19	Laundry					19
20	Administrator		2,061	54,865	26.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager		2,080	34,320	16.50	23
24	Clerical		1,246	14,005	11.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)		1,059	25,022	23.63	28
29	Resident Services Coordinator		1,008	23,812	23.62	29
30	Habilitation Aides (DD Homes)		26,903	289,204	10.75	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)		38,030	\$ 501,303 *	\$ 13.18	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		4,848	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant		7,030	L10a,C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		1,585	L10a,C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>DENTIST</u>		14,340	L10,C3	46
47	<u>PSYCHOLOGIST/PSYCHIATRIST</u>		4,154	L10,C3	47
48	<u>OPTOMETRIST</u>		2,640	L10,C3	48
49	TOTAL (lines 35 - 48)		\$ 34,597		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 BJORKLUND HOUSE

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 action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 8 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ NONE Line _____
- (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. \$ 51,416
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (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? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 9,603
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: THE CONDON GROUP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name and ID # : Bjorklun House # 0039149
 Period : 7/1/2005 - 6/30/2006

Schedule of Reclassifications - Schedule V - Page 3 and Page 4

<u>Description</u>	<u>Amount</u>				
Medical Director	4,848	Reclass from Medical Director to Ancillary Service Centers	From To	Line 9 Line 39	Medical Director
Nursing and medical Records	2040	Reclass from Nursing and Med Records to CNA Training	From To	Line 10 Line 13	Nursing and medical Records
Program Transportation (Day Training)	10,542	Reclass from Program Transportation to Ancillary Service Centers	From To	Line 14 Line 39	Day-Training Transportation
Employee Benefits and Payroll Taxes	288	Reclass from Employee Benefits to Due, Fees, Subscriptions and Promotions	From To	Line 22 Line 20	Health Care Worker Background Check
Vehicle Insurance (Day Training Transportation)	(19,472)	Reclass from Insurance-Prop. Liab. Ancillary Service Centers	From To	Line 26 Line 39	Vehicle Insurance (Credit) Day-Training Transport
Amortization of Pre-Op & Org	60	Reclass from Amortization to Interest Expense	From To	Line 31 Line 32	Amortization of loan fee reclassified to interest expense

Breakdown of Other Revenue - Schedule XVII, Line E - Other Revenue

Field Trip Contributions	9,702
Family Contributions	43,071
Memorial Contributions	25,509
Interest Income	<u>2,702</u>
Total Other Revenue	<u>80,984</u>

Reconciliation of Taxable Income - Schedule XVII, Line 43

Schedule XVII Line 43 - Net Income or Loss for the Year	(36,250)
Net Income from Separate DHS Program	4,551
Fundraising Income for Building Addition	<u>415,522</u>
Taxable Income Reported of Federal Tax Return	<u>383,823</u>

Facility Name and ID # : Bjorklun House # 0039149

Period : 7/1/2005 - 6/30/2006

Question (12) - Schedule XX General Information

Salary costs are allocated to more than one line when an employee performs more than one function.

Listing of Board of Directors

Mary Almer

Vice Chairman
Box 123
Sawyer, MI 4912

Charlene Sandberg

Secretary
154 17 Oxford Drive
Orland Park, IL 60462

Peter Berghoff

Treasurer
8855 S. Hamilton
Chicago, IL 60620

Harold Spooner

President of C.E.R. of Illinois Board
1817 N. Newcastle
Chicago, IL 60707

Sue Eade

Board Member
15225 S. Hillside Avenue
Oak Forest, IL 60452

David a. Dwight

Staff Advisory
1833 Sunnyside Circle
Northbrook, IL 60062

Rev. Larry G. Griffin

Board Member
5940 W. 159th Street
Oak Forest, IL 60452

Julie Smith

Staff Advisory
15841 Terrace Drive
Oak Forest, IL 60452

Mark S. Olson

Chairman
5353 N. St. Louis Avenue
Chicago, IL 60625

Justin Schrottenboer

Staff Advisory
15841 Terrace Drive
Oak Forest, IL 60452

Tom Olson

Board Member
127 Jeffery Ln
Des Plaines, IL 60018

William Price

Board Member
503 W. Weathersfield Way
Schaumburg, IL 60193