

		FOR BHF USE					

LL1

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: 0032045

Facility Name: Daystar Care Center

Address: 2001 Cedar Street Cairo 62914
 Number City Zip Code

County: Alexander

Telephone Number: 618-734-1700 **Fax #** 618-734-2611

HFS ID Number: 37-1088946

Date of Initial License for Current Owners: 07-17-1987

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: Frederick L. Bernstein, Administrator **Telephone Number:** 618-734-1700

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2006 to 12/31/2006 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) _____	<u>04/30/2007</u>
	(Type or Print Name) <u>Frederick L. Bernstein</u>	(Date)
Paid Preparer	(Title) <u>Administrator</u>	
	(Signed) _____	(Date)
Paid Preparer	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____	Fax # (____) _____
	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 Daystar Care Center

0032045 Report Period Beginning: 01/01/2006 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	83	Skilled (SNF)	83	30,295	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	83	TOTALS	83	30,295	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	3,434	405	1,895	5,734	8
9	SNF/PED					9
10	ICF	14,581	3,000	2,562	20,143	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,015	3,405	4,457	25,877	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.42%

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)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 07/22/1987

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 83 and days of care provided 1,895

Medicare Intermediary Ivans

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 01/01 - 12/31 Fiscal Year: 01/01 - 12/31

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

Facility Name & ID Number Daystar Care Center # 0032045 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	202,211	5,086	2,994	210,291	(24,265)	186,026		186,026			1
2	Food Purchase		145,386		145,386	(15,992)	129,394		129,394			2
3	Housekeeping	138,798	18,710		157,508		157,508		157,508			3
4	Laundry	58,386	2,100		60,486		60,486		60,486			4
5	Heat and Other Utilities			95,190	95,190		95,190		95,190			5
6	Maintenance	55,465	3,200	10,197	68,862		68,862	(1,560)	67,302			6
7	Other (specify):*											7
8	TOTAL General Services	454,860	174,482	108,381	737,723	(40,257)	697,466	(1,560)	695,906			8
	B. Health Care and Programs											
9	Medical Director			5,100	5,100		5,100		5,100			9
10	Nursing and Medical Records	963,420	112,394	25,260	1,101,074		1,101,074		1,101,074			10
10a	Therapy	75,739	1,734	185,533	263,006		263,006		263,006			10a
11	Activities	48,367	1,307	513	50,187		50,187	(198)	49,989			11
12	Social Services	66,063	2,598	2,719	71,380		71,380		71,380			12
13	CNA Training											13
14	Program Transportation			3,718	3,718		3,718		3,718			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,153,589	118,033	222,843	1,494,465		1,494,465	(198)	1,494,267			16
	C. General Administration											
17	Administrative	30,254			30,254		30,254		30,254			17
18	Directors Fees											18
19	Professional Services			48,968	48,968		48,968		48,968			19
20	Dues, Fees, Subscriptions & Promotions			904	904		904		904			20
21	Clerical & General Office Expenses	97,214	17,022	16,551	130,787		130,787		130,787			21
22	Employee Benefits & Payroll Taxes			194,440	194,440	40,257	234,697	(5,200)	229,497			22
23	Inservice Training & Education			150	150		150		150			23
24	Travel and Seminar			30	30		30		30			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			61,047	61,047		61,047		61,047			26
27	Other (specify):*			170,847	170,847		170,847	(167,108)	3,739			27
28	TOTAL General Administration	127,468	17,022	492,937	637,427	40,257	677,684	(172,308)	505,376			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,735,917	309,537	824,161	2,869,615		2,869,615	(174,066)	2,695,549			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 Daystar Care Center #0032045 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			102,763	102,763		102,763		102,763			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			64,784	64,784		64,784	(7,351)	57,433			32
33	Real Estate Taxes			27	27		27	(27)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			167,574	167,574		167,574	(7,378)	160,196			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		4,833		4,833		4,833		4,833			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		4,833		4,833		4,833		4,833			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,735,917	314,370	991,735	3,042,022		3,042,022	(181,444)	2,860,578			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 Daystar Care Center

0032045

Report Period Beginning:

01/01/2006

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	(3,120)	27		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	(7,351)	32		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	(100)	27		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	(163,888)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (174,459)		\$	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))	\$ (174,459)		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

Daystar Care Center

ID# 0032045
 Report Period Beginning: 01/01/2006
 Ending: 12/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Non-Allowable Real Estate Taxes	\$ (27)	33	1
2	Meal Income	(5,200)	22	2
3	Activity Department Revenue	(198)	11	3
4	Transportation Reimbursement	(1,560)	6	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	(6,985)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Daystar Care Center

0032045

Report Period Beginning:

01/01/2006

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	(1,560)	0	0	0	0	0	0	0	0	0	0	(1,560)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,560)	0	0	0	0	0	0	0	0	0	0	(1,560)	8
	B. Health Care and Programs													
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	(198)	0	0	0	0	0	0	0	0	0	0	(198)	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	TOTAL Health Care and Programs	(198)	0	0	0	0	0	0	0	0	0	0	(198)	16
	C. General Administration													
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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(5,200)	0	0	0	0	0	0	0	0	0	0	(5,200)	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):*	(167,108)	0	0	0	0	0	0	0	0	0	0	(167,108)	27
28	TOTAL General Administration	(172,308)	0	0	0	0	0	0	0	0	0	0	(172,308)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(174,066)	0	0	0	0	0	0	0	0	0	0	(174,066)	29

STATE OF ILLINOIS

Facility Name & ID Number Daystar Care Center

0032045

Report Period Beginning:

01/01/2006 Ending:

Summary B

12/31/2006

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	(7,351)	0	0	0	0	0	0	0	0	0	0	(7,351)	32
33	Real Estate Taxes	(27)	0	0	0	0	0	0	0	0	0	0	(27)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(7,378)	0	(7,378)	37									
	Ancillary Expense													
	E. Special Cost Centers													
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	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(181,444)	0	(181,444)	45									

Facility Name & ID Number Daystar Care Center

0032045

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

Daystar Care Center

#

0032045

Report Period Beginning:

01/01/2006

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									\$	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 Daystar Care Center

0032045 Report Period Beginning: 01/01/2006 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 _____
 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	USDA, Rural Development		X	Construct Building	\$15,515.00	09/23/91	\$ 2,217,773	\$ 630,968	10/01/10	7.0000	\$ 49,446	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Capaha Bank		X	Line of Credit		Various	24,942	188,375	03/10/07	8.7500	13,736	6								
7	Interest Income										(7,351)	7								
8												8								
9	TOTAL Facility Related				\$15,515.00		\$ 2,242,715	\$ 819,343			\$ 55,831	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 2,242,715	\$ 819,343			\$ 55,831	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

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.)			\$	27 2
3. Under or (over) accrual (line 2 minus line 1).			\$	27 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.			\$	27 7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2001	20	8		
2002	21	9		
2003	22	10		
2004	25	11		
2005	26	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 Daystar Care Center COUNTY Alexander

FACILITY IDPH LICENSE NUMBER 0032045

CONTACT PERSON REGARDING THIS REPORT Frederick L. Bernstein

TELEPHONE 618-734-1700 FAX #: 618-734-2611

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. <u>2390</u>	<u>Lot 1 Kobler's Addition</u>	\$ <u>27.00</u>	\$ <u>27.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>27.00</u>	\$ <u>27.00</u>

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 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.

Facility Name & ID Number Daystar Care Center

0032045 Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,536 B. General Construction Type: Exterior Wood 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>Building Site</u>	<u>139,264</u>	<u>1,995</u>	<u>\$ 27,200</u>	1
2	<u>Vacant</u>	<u>3,513</u>	<u>1,997</u>	<u>200</u>	2
3	TOTALS	<u>142,777</u>		<u>\$ 27,400</u>	3

Facility Name & ID Number Daystar Care Center

0032045

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	83		1987	1987	\$ 1,148,065	\$ 38,269	30	\$ 38,269	\$	\$ 743,053	4
5			1991	1991	(10,658)	(401)	26.5	(401)		(6,380)	5
6			1994	1994	3,500	152	23	152		1,978	6
7											7
8											8
		Improvement Type**									
9		Heating System		1987	160,880	8,044	20	8,044		156,188	9
10		Piping & Plumbing		1987	176,139	7,045	15	7,045		136,801	10
11		Ventilation Fans		1987	8,120		20			8,120	11
12		Fixtures		1987	45,875	2,294	20	2,294		44,537	12
13		Sprinkler System		1987	41,220	1,649	25	1,649		32,014	13
14		Wiring		1987	170,162	8,508	20	8,508		165,199	14
15		Diesel Generator		1987	25,254	1,262	20	1,262		24,517	15
16		Fire Alarm System		1987	12,529	627	10	627		12,164	16
17		Paging, Alarm and TV		1987	19,705		15			19,705	17
18		Sign		1987	2,554		12			2,554	18
19		Landscaping		1987	7,500		10			7,500	19
20		Walks, Patio, and Curbs		1987	15,709	786	20	786		15,251	20
21		Telephone System		1987	12,889	644	20	644		12,513	21
22		Patio		1988	16,738	836	20	836		15,203	22
23		Storage Shed		1988	2,054	102	20	102		1,926	23
24		Air Condition Window Unit		1990	953		8			953	24
25		Patio		1991	2,611	131	20	131		1,991	25
26		Magic Air Handling Unit		1991	2,241		10			2,241	26
27		Telephone System		1991	1,583		10			1,583	27
28		Gazebo		1992	3,575	179	20	179		2,517	28
29		Gazebo Landscaping		1992	1,180		10			1,180	29
30		Heating and Air Conditioning Unit		1992	1,839	123	15	123		1,758	30
31		Awning for Building		1993	2,500		10			2,500	31
32		Water Heater		1995	4,032	269	15	269		3,069	32
33		Entry Access System		1996	2,883	216	10	216		2,883	33
34		Boiler Shell		1996	2,525	189	10	189		2,525	34
35		Parking Lot Blacktop		1997	8,400	420	20	420		4,130	35
36		A/C Conditioner Condensers (2)		1998	3,386	339	10	339		2,935	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 Daystar Care Center

0032045

Report Period Beginning:

01/01/2006 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Quarry Tile Floor	2000	\$ 14,041	\$ 936	15	\$ 936	\$	\$ 6,396	37
38	Surveillance System	2000	1,846		5			1,846	38
39	Door to Boiler Room	2000	504	72	7	72		480	39
40	Camer System - Alzheimer's Unit	2000	1,200	172	7	172		1,100	40
41	Compressor	2001	2,375	238	10	238		1,346	41
42	Hot Water Heater	2001	6,199	414	15	414		2,170	42
43	Alzheimer's Unit	2002	80,070	2,001	40	2,001		8,507	43
44	Water Heater	2004	8,398	560	15	560		1,586	44
45	Roof	2004	44,350	2,218	20	2,218		4,805	45
46	Sidewalk & Driveway	2006	5,605	93	20	93		93	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)		\$ 2,060,531	\$ 78,387		\$ 78,387	\$	\$ 1,451,437	70

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

Facility Name & ID Number Daystar Care Center # 0032045 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	\$ 269,888	\$ 23,586	\$ 23,586	\$		\$ 195,971	71
72	Current Year Purchases	3,305	275	275			275	72
73	Fully Depreciated Assets	213,826					213,826	73
74								74
75	TOTALS	\$ 487,019	\$ 23,861	\$ 23,861	\$		\$ 410,072	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	2000 Dodge	2001	\$ 30,903	\$ 515	\$ 515	\$	5	\$ 30,903	76
77										77
78										78
79										79
80	TOTALS			\$ 30,903	\$ 515	\$ 515	\$		\$ 30,903	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)	\$ 2,605,853	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 102,763	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 102,763	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)	\$ 1,892,412	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.

Facility Name & ID Number Daystar Care Center

0032045

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

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

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (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.

Facility Name & ID Number Daystar Care Center# 0032045 Report Period Beginning:01/01/2006 Ending: 12/31/2006

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units 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 prescrpts							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 Daystar Care Center# 0032045Report Period Beginning: 01/01/2006

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 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 2,071	\$	1
2	Cash-Patient Deposits	7,500		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>163,888</u>)	714,122		3
4	Supply Inventory (priced at <u>Cost</u>)	4,190		4
5	Short-Term Investments			5
6	Prepaid Insurance	11,365		6
7	Other Prepaid Expenses	500		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 739,748	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	27,400		13
14	Buildings, at Historical Cost	2,057,144		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	521,309		16
17	Accumulated Depreciation (book methods)	(1,892,412)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	210,377		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 923,818	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,663,566	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 534,459	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,500		28
29	Short-Term Notes Payable	188,375		29
30	Accrued Salaries Payable	66,030		30
31	Accrued Taxes Payable (excluding real estate taxes)	183,742		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,516		33
34	Deferred Compensation	55,823		34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Current Portion of LT Debt</u>	146,618		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,187,063	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	484,350		39
40	Mortgage Payable			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)	\$ 484,350	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,671,413	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (7,847)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,663,566	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 242,444	1
2	Restatements (describe):		2
3	Voiding of prior period checks outstanding	432	3
4	Overrecorded accounts payable from prior year	34,091	4
5	Overrecorded prepaid insurance	(33,719)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 243,248	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(251,095)	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)	\$ (251,095)	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)	\$ (7,847)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Daystar Care Center

0032045

Report Period Beginning: 01/01/2006

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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	\$ 3,099,784	1
2	Discounts and Allowances for all Levels	(360,126)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,739,658	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	6,543	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,200	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)	\$ 11,743	23
D. Non-Operating Revenue			
24	Contributions	30,419	24
25	Interest and Other Investment Income***	7,351	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 37,770	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other	1,756	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,756	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,790,927	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	385,763	31
32	Health Care	1,727,456	32
33	General Administration	643,843	33
B. Capital Expense			
34	Ownership	165,992	34
C. Ancillary Expense			
35	Special Cost Centers	118,968	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,042,022	40
41	Income before Income Taxes (line 30 minus line 40)**	(251,095)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (251,095)	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 & ID Number Daystar Care Center

0032045

Report Period Beginning: 01/01/2006

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	1,668	1,750	\$ 42,512	\$ 24.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,858	5,057	115,766	22.89	3
4	Licensed Practical Nurses	13,257	13,987	216,105	15.45	4
5	CNAs & Orderlies	65,021	67,205	555,266	8.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,154	4,443	75,739	17.05	8
9	Activity Director	801	831	14,256	17.16	9
10	Activity Assistants	2,973	3,334	34,111	10.23	10
11	Social Service Workers	4,179	4,395	66,063	15.03	11
12	Dietician					12
13	Food Service Supervisor	1,872	2,070	24,325	11.75	13
14	Head Cook	1,758	1,967	18,546	9.43	14
15	Cook Helpers/Assistants	18,061	19,408	159,340	8.21	15
16	Dishwashers					16
17	Maintenance Workers	4,198	4,420	55,465	12.55	17
18	Housekeepers	14,506	15,474	138,798	8.97	18
19	Laundry	8,308	8,621	58,386	6.77	19
20	Administrator	1,319	1,375	30,254	22.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,043	8,459	97,214	11.49	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	2,907	3,124	33,771	10.81	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,883	165,920	\$ 1,735,917 *	\$ 10.46	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	59	\$ 2,694	1-3	35
36	Medical Director	170	5,100	9-3	36
37	Medical Records Consultant	43	1,952	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	10	500	10-3	39
40	Physical Therapy Consultant	4,638	185,533	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	17	513	11-3	44
45	Social Service Consultant	49	2,719	12-3	45
46	Other(specify) <u>Doctors</u>	120	3,600	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	5,106	\$ 202,611		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 Daystar Care Center

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Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Debra Hartmann</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 30,254</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 62,729</u>	<u>IDPH License Fee</u>	<u>\$</u>	
				<u>Unemployment Compensation Insurance</u>	<u>0</u>	<u>Advertising: Employee Recruitment</u>		
				<u>FICA Taxes</u>	<u>131,268</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>		(Indicate # of checks performed _____)		
				<u>Employee Meals</u>	<u>40,257</u>	<u>Dues & Subscriptions</u>	<u>904</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>				
				<u>Meal Income</u>	<u>(5,200)</u>			
				<u>Other Benefits</u>	<u>443</u>			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 30,254	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>Accumed</u>	<u>Computer Tech Support</u>		<u>\$ 5,510</u>				<u>Out-of-State Travel</u>	<u>\$</u>
<u>Buessink, Hey, Roe, Seabaugh</u>	<u>Audit Fees</u>		<u>29,212</u>					
<u>Computer Solutions</u>	<u>Computer Tech Support</u>		<u>50</u>					
<u>CPU, Inc.</u>	<u>Bookkeeping Service</u>		<u>500</u>				<u>In-State Travel</u>	<u>30</u>
<u>Hardin System</u>			<u>3,018</u>					
<u>Health Tech</u>	<u>Software Support</u>		<u>3,418</u>					
<u>IVANS</u>	<u>Medicare Billing</u>		<u>1,946</u>					
<u>Jantek Electronics</u>	<u>Computer Tech Support</u>		<u>600</u>				<u>Seminar Expense</u>	
<u>Martini, Hughes & Grossman</u>	<u>Attorney Fees</u>		<u>964</u>					
<u>MPPW</u>	<u>Cost Report Preparation</u>		<u>2,750</u>					
<u>Qtrak, Inc.</u>	<u>Timekeeping System Support</u>		<u>1,000</u>				<u>Entertainment Expense</u>	<u>(</u>
TOTAL (agree to Schedule V, line 19, column 3)			\$ 48,968	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							\$ 30	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Daystar Care Center

Report Period Beginning: 01/01/2006 Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	6 Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	Repair Tile - Bathroom	10-94	\$ 5,910	10	\$ 591	\$ 493	\$	\$	\$	\$	\$	\$	\$
2	Repair - Generator	2-96	2,325	10	233	233	233	15					
3													
4													
5													
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15													
16													
17													
18													
19													
20	TOTALS		\$ 8,235		\$ 824	\$ 726	\$ 233	\$ 15	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ NONE Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ _____
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? NONE
- (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. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 5,200
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 1,560
- c. What percent of all travel expense relates to transportation of nurses and patients? 86%
- 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? NONE
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Brown & Thomas CPA's, PC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. Audit has not been delivered.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? None
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.