

Facility Name & ID Number Eden Village Care Center

0023382 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	138	Skilled (SNF)	138	50,370	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	138	TOTALS	138	50,370	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	16,627	24,804	3,205	44,636	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,627	24,804	3,205	44,636	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.62%

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)

Outpatient Therapy

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 05/14/1979

J. Was the facility purchased or leased after January 1, 1978?
YES Date 05/14/1979 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 138 and days of care provided 3,205

Medicare Intermediary Mutual of Omaha, P.O. Box 1602, Omaha, NE, 68101

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	314,770	15,046	472,285	802,101	(12,515)	789,586	(135,654)	653,932		1
2	Food Purchase		42,969		42,969		42,969		42,969		2
3	Housekeeping	242,973	49,489	19,813	312,275		312,275	(212,279)	99,996		3
4	Laundry		4,631		4,631		4,631		4,631		4
5	Heat and Other Utilities			333,884	333,884		333,884	(166,773)	167,111		5
6	Maintenance	270,100	5,422	289,548	565,070		565,070	(331,782)	233,288		6
7	Other (specify):*										7
8	TOTAL General Services	827,843	117,557	1,115,530	2,060,930	(12,515)	2,048,415	(846,488)	1,201,927		8
	B. Health Care and Programs										
9	Medical Director			16,800	16,800		16,800		16,800		9
10	Nursing and Medical Records	2,280,279	294,372	163,405	2,738,056	(143,283)	2,594,773		2,594,773		10
10a	Therapy		2,074	339,248	341,322		341,322		341,322		10a
11	Activities	110,239	3,060	2,946	116,245		116,245	(110,239)	6,006		11
12	Social Services	61,980	3,459	16,871	82,310		82,310	(35,137)	47,173		12
13	CNA Training			20,586	20,586		20,586		20,586		13
14	Program Transportation	37,119	4,391	4,713	46,223		46,223	(39,523)	6,700		14
15	Other (specify):* Seniors N Motion	51,148	176	30	51,354		51,354	(51,354)			15
16	TOTAL Health Care and Programs	2,540,765	307,532	564,599	3,412,896	(143,283)	3,269,613	(236,253)	3,033,360		16
	C. General Administration										
17	Administrative	125,045	191	407,216	532,452		532,452	(320,402)	212,050		17
18	Directors Fees										18
19	Professional Services			54,028	54,028		54,028		54,028		19
20	Dues, Fees, Subscriptions & Promotions			33,676	33,676		33,676	(16,344)	17,332		20
21	Clerical & General Office Expenses	371,645	29,072	102,230	502,947		502,947	(280,363)	222,584		21
22	Employee Benefits & Payroll Taxes			916,495	916,495	12,515	929,010	(123,839)	805,171		22
23	Inservice Training & Education			821	821		821		821		23
24	Travel and Seminar			7,060	7,060		7,060		7,060		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			135,141	135,141		135,141	(12,625)	122,516		26
27	Other (specify):* Marketing	72,262	7,452	8,118	87,832		87,832	(36,131)	51,701		27
28	TOTAL General Administration	568,952	36,715	1,664,785	2,270,452	12,515	2,282,967	(789,704)	1,493,263		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,937,560	461,804	3,344,914	7,744,278	(143,283)	7,600,995	(1,872,445)	5,728,550		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			350,414	350,414		350,414		350,414		30
31	Amortization of Pre-Op. & Org.			8,596	8,596		8,596		8,596		31
32	Interest										32
33	Real Estate Taxes			46,500	46,500		46,500		46,500		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			405,510	405,510		405,510		405,510		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					143,283	143,283		143,283		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			75,555	75,555		75,555		75,555		42
43	Other (specify):* RC Deprec Exp			265,005	265,005		265,005	(265,005)			43
44	TOTAL Special Cost Centers			340,560	340,560	143,283	483,843	(265,005)	218,838		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,937,560	461,804	4,090,984	8,490,348		8,490,348	(2,137,450)	6,352,898		45

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

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	(51,354)	15		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				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	(3,369)	17		24
25	Fund Raising, Advertising and Promotional	(16,344)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,066,383)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,137,450)		\$	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))	\$ (2,137,450)		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	X		143,283	10	43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 143,283		47

BHF USE ONLY					
48		49		50	
				51	
					52

Eden Village Care Center

ID# 0023382

Report Period Beginning: 1/1/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	RC-Dietary	\$ (135,654)	1	1
2	RC-Food	0	2	2
3	RC-Housekeeping	(149,538)	3	3
4	RC-Laundry	(62,741)	3	4
5	RC-Heat & Utilities	(166,773)	5	5
6	RC-Maintainance	(331,782)	6	6
7	RC-Program Transportation	(39,523)	14	7
8	RC-Administrative	(258,885)	17	8
9	RC-Clerical & Office	(280,363)	21	9
10	RC-Employee Benefits/PR Taxes	(123,839)	22	10
11	RC-Insurance	(12,625)	26	11
12	RC-Direct Expenses	(265,005)	43	12
13	RC-Activities Salaries	(110,239)	11	13
14	RC-Social Services Salaries	(35,137)	12	14
15				15
16	RC - Marketing Salaries	(36,131)	27	16
17	RC-Wages	(58,148)	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	(2,066,383)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eden Village Care Center# 0023382

Report Period Beginning:

1/1/06

Ending:

12/31/06

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(135,654)	0	0	0	0	0	0	0	0	0	0	(135,654)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(212,279)	0	0	0	0	0	0	0	0	0	0	(212,279)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(166,773)	0	0	0	0	0	0	0	0	0	0	(166,773)	5
6	Maintenance	(331,782)	0	0	0	0	0	0	0	0	0	0	(331,782)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(846,488)	0	(846,488)	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	(110,239)	0	0	0	0	0	0	0	0	0	0	(110,239)	11
12	Social Services	(35,137)	0	0	0	0	0	0	0	0	0	0	(35,137)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(39,523)	0	0	0	0	0	0	0	0	0	0	(39,523)	14
15	Other (specify):*	(51,354)	0	0	0	0	0	0	0	0	0	0	(51,354)	15
16	TOTAL Health Care and Programs	(236,253)	0	(236,253)	16									
	C. General Administration													
17	Administrative	(320,402)	0	0	0	0	0	0	0	0	0	0	(320,402)	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	(16,344)	0	0	0	0	0	0	0	0	0	0	(16,344)	20
21	Clerical & General Office Expenses	(280,363)	0	0	0	0	0	0	0	0	0	0	(280,363)	21
22	Employee Benefits & Payroll Taxes	(123,839)	0	0	0	0	0	0	0	0	0	0	(123,839)	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	(12,625)	0	0	0	0	0	0	0	0	0	0	(12,625)	26
27	Other (specify):* Marketing Sal.	(36,131)	0	(36,131)	27									
28	TOTAL General Administration	(789,704)	0	(789,704)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,872,445)	0	(1,872,445)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0 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):*	(265,005)	0	0	0	0	0	0	0	0	0	0	(265,005) 43
44	TOTAL Special Cost Centers	(265,005)	0	(265,005) 44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,137,450)	0	(2,137,450) 45									

Facility Name & ID Number

Eden Village Care Center

0023382

Report Period Beginning:

1/1/06

Ending:

12/31/06

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 Eden Village Care Center # 0023382 Report Period Beginning: 1/1/06 Ending: 12/31/06

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 Eden Village Care Center

0023382

Report Period Beginning:

1/1/06

Ending: 12/31/06

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

Facility Name & ID Number

Eden Village Care Center

0023382

Report Period Beginning:

1/1/06

Ending:

12/31/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	Village of Glen Carbon		X	Construction & Equipment		12/31/96	\$ 2,300,000	\$	10/1/2011	5.25-5.8%	\$ 58,164	1						
2	Series 2006 Revenue Bonds		X	Construction & Equipment		12/1/2006	22,390,000	22,390,000	12/1/2036	5.00-5.85%		2						
3												3						
4												4						
5												5						
Working Capital																		
6	The Bank of Edwardsville		X	Line of Credit		10/5/05	1,000,000		4/5/2006	5.2500	11,513	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 25,690,000	\$ 22,390,000			\$ 69,677	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 25,690,000	\$ 22,390,000			\$ 69,677	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

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.		\$	48,000	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.)		\$	44,707	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(3,293)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	49,793	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.		\$	46,500	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	41,968	8
	2002	43,587	9
	2003	44,228	10
	2004	47,704	11
	2005	44,707	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 Eden Village Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0023382

CONTACT PERSON REGARDING THIS REPORT Ron Hassler

TELEPHONE (618) 288-5014 FAX #: (618) 288-0206

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>14-2-15-26-02-202-096</u>	<u>Cottonwood Trace PT Lot 3</u>	\$ <u>80.95</u>	\$ _____
2. <u>14-1-15-26-02-202-098.001</u>	<u>NE/C NE</u>	\$ <u>44.44</u>	\$ _____
3. <u>14-2-15-26-02-202-101</u>	<u>Cottonwood Trace-First Add LT PT 8</u>	\$ <u>1,013.06</u>	\$ _____
4. <u>14-2-15-26-02-202-097</u>	<u>Cottonwood Trace PT Lot 2</u>	\$ <u>8,204.00</u>	\$ _____
5. <u>14-2-15-26-02-202-165</u>	<u>Eden Village Subd 1st Addn Lot 1</u>	\$ <u>35,364.81</u>	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>44,707.26</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? X 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 Eden Village Care Center# 0023382

Report Period Beginning:

1/1/06

Ending:

12/31/06**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	138		1979	1979	\$ 2,008,520	\$ 66,951	30	\$ 66,951	\$	\$ 1,852,205	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot - 13		1979		62,453		10			62,453	9
10	Alarm System-29		1979		1,193		10			1,193	10
11	Additions-106		1985		28,768	959	30	959		20,377	11
12	Roof-239		1989		21,453	1,073	20	1,073		18,772	12
13	Office Addition-269		1990		34,575	1,152	30	1,152		18,824	13
14	Blocks-Parking Lot-279		1991		391		15			391	14
15	Interior Office Walls-280		1991		3,102	124	25	124		1,985	15
16	Gas Pipe-283		1991		5,850	234	25	234		3,725	16
17	Floor-Kitchen-308		1991		3,046	152	20	152		2,322	17
18	Parking Lot-311		1991		8,447	469	15	469		8,447	18
19	Paved entrance Drive-330		1992		1,890	126	15	126		1,848	19
20	Buildings-CC-348		1992		104,840	4,194	25	4,194		59,410	20
21	Walkpads-365		1993		1,085	54	20	54		759	21
22	Gutters-399		1993		293	15	20	15		198	22
23	Fence-400		1993		700	47	15	47		630	23
24	Cedar Patio-Roof-401		1993		3,285	164	20	164		2,218	24
25	Roof-424		1993		10,956	548	20	548		7,258	25
26	Remodeling-Hall I-425		1993		23,174	927	25	927		12,283	26
27	Driveway Seal-433		1993		950	48	20	48		626	27
28	Signs-441		1993		6,956		12			6,956	28
29	Remodeling-Hall III-442		1993		20,060	802	25	802		10,499	29
30	Remodeling Hall 3-454		1994		10,620	425	25	425		5,452	30
31	Remodeling - Hall 5-455		1994		8,141	326	25	326		4,180	31
32	Improvements - 462		1994		2,896	193	15	193		2,462	32
33	Parking Lot-482		1994		3,188	159	20	159		1,994	33
34	Improvements-506		1994		650	43	15	43		531	34
35	Improvements-519		1994		138	9	15	9		111	35
36	Crash Rails-525		1994		3,070	205	15	205		2,472	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Eden Village Care Center

0023382

Report Period Beginning:

1/1/06

Ending:

12/31/06

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	Improvements-541	1995	\$ 2,360	\$ 118	20	\$ 118	\$	\$ 1,396	37
38	Design & engineering Costs-546	1995	4,410	221	20	221		2,592	38
39	Improvements Rm. 501 - 554	1995	1,800	90	20	90		1,058	39
40	Improvements Rms. 403, 405, 407 - 555	1995	5,400	270	20	270		3,173	40
41	Improvements Rms. 400 & 401	1995	4,035	202	20	202		2,370	41
42	Improvements Rms. 409,411,413 - 567	1995	5,400	270	20	270		3,128	42
43	Improvements Rms. 408,410,412 - 572	1995	5,754	288	20	288		3,309	43
44	Rubber Roof & Insulation-583	1995	23,522	1,176	20	1,176		13,427	44
45	Improvements Rms. 402,404,406 - 584	1995	5,594	280	20	280		3,193	45
46	Improvements - 608	1995	2,841	142	20	142		1,587	46
47	Rubber Roof & Insulation-609	1995	23,522	1,176	20	1,176		13,133	47
48	Shower Room Improvements-619	1995	6,285	314	20	314		3,483	48
49	Improvements-622	1996	1,867	93	20	93		1,027	49
50	Crash Rails-627	1996	2,829	189	15	189		2,059	50
51	Remodel Rooms 509, 511, 513 - 635	1996	7,080	354	20	354		3,805	51
52	Remodel Rooms 503, 505, 507 - 641	1996	7,080	354	20	354		3,805	52
53	Install Phone Jacks-645	1996	210	7	10	7		210	53
54	Remodel Rooms 502,504,506 - 650	1996	7,080	354	20	354		3,776	54
55	Install Phone Jacks-656	1996	210	9	10	9		210	55
56	Remodel Rooms 508,510,512 - 668	1996	7,080	354	20	354		3,717	56
57	Remodel Rooms 209,211,213 - 684	1996	7,080	354	20	354		3,658	57
58	Remodel Rooms 203, 205,207 - 699	1996	7,080	354	20	354		3,628	58
59	Remodel Rooms 200,202,204 - 708	1996	7,080	354	20	354		3,599	59
60	Remodel Rooms 206,208,210 - 715	1996	7,080	354	20	354		3,570	60
61	Remodel Room 212	1996	2,360	118	20	118		1,189	61
62	Roof Repair-769	1997	3,550	178	20	178		1,656	62
63	CC Expan - Carpet & Wallcovering-806	1998	14,587		5			14,587	63
64	CC Const.-Administration/CC-807	1998	895,205	22,380	40	22,380		201,421	64
65	CC Const.-Therapy Center - 850	1998	522,203	13,055	40	13,055		116,407	65
66	CC Const.-Eng & Architect Fees-851	1998	126,455	4,215	30	4,215		37,584	66
67	Admin & chapel Carpet-853	1998	19,121		5			19,121	67
68	Walk-Off Pad-873	1998	1,514	101	15	101		900	68
69	Wall Covering - Lobby-877	1998	876	88	10	88		781	69
70	TOTAL (lines 4 thru 69)		\$ 4,119,240	\$ 127,211		\$ 127,211	\$	\$ 2,589,140	70

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

Facility Name & ID Number Eden Village Care Center# 0023382

Report Period Beginning:

1/1/06

Ending:

12/31/06**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,119,240	\$ 127,211		\$ 127,211	\$	\$ 2,589,140	1
2	Wall Covering-Therapy-881	1998	1,603	160	10	160		1,416	2
3	CC Roof Repair-886	1998	7,452	745	10	745		6,521	3
4	Wall Coverings-7 rooms-898	1998	17,500	1,750	10	1,750		14,875	4
5	Wallcoverings, Main Hall & Access-971	1999	1,566	157	10	157		1,253	5
6	Wallcoverings, Hall 3 & 4-972	1999	8,763	876	10	876		7,011	6
7	Crash Rails-973	1999	25,475	1,698	15	1,698		13,587	7
8	Install 17 fire/Smoke Dampers-985	1999	22,104	1,474	15	1,474		11,789	8
9	Monumental Bronze Plaque-987	1999	148	15	10	15		118	9
10	VH Design Charges-993	1999	734	24	30	24		194	10
11	Wallcoverings, Hall 1 & 2-997	1999	1,584	158	10	158		1,241	11
12	Wallcoverings-Nurse Station-1004	1999	669	67	10	67		519	12
13	Wallcoverings, Fire Doors & Nrs Stn-1008	1999	1,145	114	10	114		887	13
14	Wallcovering, Main dining Room-1009	1999	5,432	543	10	543		4,210	14
15	Alzheimers Corner Protectors	1999	1,701	113	15	113		869	15
16	Alz, Wallcovering-Liv/Din Area-1019	1999	4,493	449	10	449		3,444	16
17	Sprinkler System Improv.-1021	1999	3,135	209	15	209		1,585	17
18	Install Activity Room cove Base-1024	1999	60	6	10	6		46	18
19	Alarm System Repair-1025	1999	1,840	123	15	123		930	19
20	Alzheimers construction-1026	1999	504,922	12,623	40	12,623		95,724	20
21	Electrical Circuit Installation-1037	1999	447	30	15	30		224	21
22	Engineering Consulting-1057	1999	899	60	15	60		434	22
23	Wallcovering, Hall 1 Restroom-1060	1999	954	95	10	95		692	23
24	Custom Door, Frame, Hinges-1103	2000	555	56	10	56		384	24
25	Final CC Renovation Payment-1113	2000	11,000	275	40	275		1,857	25
26	Chair Rails-1167	2000	5,843	584	10	584		3,554	26
27	Carpet-Service Hall-1165	2000	2,444		5			2,444	27
28	Alzheimer Construction-Final-1500	2001	31,865	2,124	15	2,124		12,392	28
29	Skilled nursing Facility-1312	2005	14,928	1,493	10	1,493		2,612	29
30	Remodel Skilled Facility-3219	2005	18,720	1,872	10	1,872		3,276	30
31	Comp Activity Study-3224	2005	7,500	750	10	750		1,313	31
32	Skilled Nursing Facility-28% Work completed-3233	2005	15,720	1,572	10	1,572		2,620	32
33	50% Skilled Completed - 3249	2005	28,348	2,835	10	2,835	(0)	4,488	33
34	TOTAL (lines 1 thru 33)		\$ 4,868,789	\$ 160,261		\$ 160,261	\$ (0)	\$ 2,791,649	34

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

Facility Name & ID Number Eden Village Care Center# 0023382

Report Period Beginning:

1/1/06

Ending:

12/31/06**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,868,789	\$ 160,261		\$ 160,261	\$ (0)	\$ 2,791,649	1
2	Skilled Nursing Facility 70%-3265	2005	24,695	2,469	10	2,469		3,704	2
3	Care Center Review Blueprints-3268	2005	9,600	960	10	960		1,360	3
4	Consult Remodeling Campus-3272	2005	1,743	174	10	174		247	4
5	Remodel Skill Nursing Facility - 80@ Complete-3274	2005	12,941	1,294	10	1,294		1,833	5
6	Update Market Feasability Study-glen Carbon-3284	2005	2,642	264	10	264		330	6
7	Update Market Feasability Study-glen Carbon-3285	2005	3,900	390	10	390		488	7
8	Hall 2 Exit Drawings-3333	2006	1,826	167	10	167		167	8
9	Pull New Cable SNF Const. Package-3337	2006	1,512	139	10	139		139	9
10	Exit Upgrades to Code-3351	2006	82,926	2,764	20	2,764		2,764	10
11	Hall 3 remodel-3376	2006	949	47	10	47		47	11
12	Landscaping -CC-398	1993	809		10			809	12
13	Flower Bed Irrigation system-786	1997	2,450	163	15	163		1,497	13
14	Vinyl Fence-852	1997	3,731	249	15	249		2,218	14
15	Parking Lot Asphalt-922	1998	18,949	1,895	10	1,895		15,791	15
16	Upgrade Parking Lighting-CC-955	1998	3,750	250	15	250		2,021	16
17	Signage Program, 1/2 CC-1000	1999	20,523	1,368	15	1,368		10,718	17
18	Courtyard Landscaping-CC-1044	1999	8,900	890	10	890		6,601	18
19	Pond sidewalk Repair-CC-1046	1999	3,485	232	15	232		1,723	19
20	100 Ft. Vinyl Fence-CC-1069	1999	1,383	92	15	92		660	20
21	Wallpaper & Floor Covering, Activity-1150	2000	1,537		5			1,537	21
22	Linoleum-Activity Room-1161	2000	5,523		5			5,523	22
23	Sidewalk-1162	2000	4,235	212	20	212		1,306	23
24	Landscaping-Main Ent & Therapy-1543	2001	4,865	486	10	486		2,716	24
25	Painting-Main Hall & Bathrooms-1544	2001	1,774	177	10	177		990	25
26	RipRap (Rock)-Lake-1545	2001	1,109	111	10	111		609	26
27	Parking Lot Sealing/Striping - CC/Therapy-1546	2001	7,183	718	10	718		3,771	27
28	Install Delayed Egress on Doors-1547	2001	3,400	340	10	340		1,728	28
29	Tree Removal-1548	2001	585	59	10	59		312	29
30	Clean Nurse Stn A/C Unit-1549	2001	916	92	10	92		511	30
31	Heat Tape in Downspouts-1550	2001	4,905	491	10	491		2,739	31
32	Roof Repairs-1551	2002	3,148	315	10	315		1,757	32
33	Employee Lounge-2081	2002	3,150	126	25	126		525	33
34	TOTAL (lines 1 thru 33)		\$ 5,117,833	\$ 177,195		\$ 177,195	\$ (0)	\$ 2,868,790	34

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

Facility Name & ID Number Eden Village Care Center# 0023382

Report Period Beginning:

1/1/06

Ending:

12/31/06**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,117,833	\$ 177,195		\$ 177,195	\$ (0)	\$ 2,868,790	1
2	Front Receptionist Desk Area-2084	2002	2,400	96	25	96		392	2
3	New Nurses Station Hall 6-2085	2002	800	32	25	32		131	3
4	Nurses Station Hall 6-2086	2002	2,850	114	25	114		466	4
5	Removal of Nurses Station-3003	2003	875	35	25	35		140	5
6	Carpet by Aviary-CC-3021	2003	2,885	115	25	115		452	6
7	Restripe Parking Lot-3028	2003	735	74	10	74		276	7
8	Landscape Lake Area-3068	2003	671	67	10	67		212	8
9	Landscape Main entrance-3070	2003	2,625	263	10	263		831	9
10	Walls for Art/Music Therapy Room-3076	2003	2,170	108	20	108		334	10
11	Kitchen/Store Room/Office-3089	2004	7,201	360	20	360		1,050	11
12	Concrete Work-CC-3117	2004	1,095	110	10	110		274	12
13	Employee Smoking Area/1st Half-3145	2004	2,500	100	25	100		208	13
14	Glass Window PT Recept Desk-3147	2004	3,058	122	25	122		255	14
15	Floor for Tub Room 2,4,5-3149	2004	4,820	193	25	193		402	15
16	Floor for Two Entry Baths-3150	2004	872	35	25	35		73	16
17	Floor in Tub Room #1-3151	2004	1,221	49	25	49		102	17
18	Employee Patio-3158	2004	2,500	100	25	100		208	18
19	Lavatories 306/308-3205	2005	210	21	10	21		39	19
20	Sewer in Hallways-3206	2005	1,180	118	10	118		216	20
21	6 Insulated windows-3244	2005	2,140	214	10	214		339	21
22	Metal Doors-3245	2005	3,696	148	25	148		234	22
23	Dock foundation-3251	2005	550	37	15	37		55	23
24	Care Center Roof-3273	2005	24,639	986	25	986		1,399	24
25	Sealing & Strip Parking Lot-3278	2005	5,550	1,110	5	1,110		1,388	25
26	New Conf Room Door-3334	2006	725	72	10	72		72	26
27	Two Mute Swans-3353	2006	1,425	190	5	190		190	27
28	Sidewalk-3356	2006	1,020	68	10	68		68	28
29	Reimbursement Swan Purchase-3364	2006	625	73	5	73		73	29
30	Cooler electric to Generator-3419	2006	11,640	388	10	388		388	30
31	Hall 3 renovations-3431	2006	2,710	68	10	68		68	31
32	Waterblast & Prep/Paint-500C	1994	13,333		10			13,333	32
33	Asset Retirement Cost (FIN 47)	2006	20,377		30				33
34	TOTAL (lines 1 thru 33)		\$ 5,246,931	\$ 182,661		\$ 182,661	\$ (0)	\$ 2,892,458	34

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

Facility Name & ID Number Eden Village Care Center

0023382

Report Period Beginning:

1/1/06

Ending:

12/31/06

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	\$ 1,237,011	\$ 142,235	\$ 142,235	\$	Various	\$ 675,351	71
72	Current Year Purchases	175,856	9,879	9,879		Various	9,879	72
73	Fully Depreciated Assets	809,495	12,004	12,004		Various	809,495	73
74								74
75	TOTALS	\$ 2,222,362	\$ 164,118	\$ 164,118	\$		\$ 1,494,725	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	Facility business	1990 Van - 275	1990	\$ 40,188	\$	\$	\$	4	\$ 40,188	76
77	Facility Business	2005 Ford 20 Passenger Bus	2004	54,530	3,635	3,635		15	7,990	77
78										78
79										79
80	TOTALS			\$ 94,718	\$ 3,635	\$ 3,635	\$		\$ 48,178	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)	\$ 7,730,306	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 350,414	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 350,414	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,435,361	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	Other Autos	\$ 61,474	\$ 7,250	\$ 58,557	86
87	RC/Apt Duplexes Land	126,596			87
88	Retirement Center Apts/Duplexes	6,753,591	257,755	4,364,046	88
89					89
90					90
91	TOTALS	\$ 6,941,661	\$ 265,005	\$ 4,422,603	91

G. Construction-in-Progress

	Description	Cost	
92	CIP-CC	\$ 14,174	92
93	CIP	2,148,834	93
94	CIP-Cap Int.	72,022	94
95		\$ 2,235,030	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

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

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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. <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 checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>111</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>44</u></p>
--	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$ 4,844	\$ 15,742	\$	\$ 20,586
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	\$ 4,844	\$ 15,742	\$	\$ 20,586
10	SUM OF line 9, col. 1 and 2 (e)	\$ 20,586			

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	26
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	8
2. From other facilities (f)	
TOTAL TRAINED	34

- (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	\$		\$ 121,875	\$		\$ 121,875	1
2	Licensed Speech and Language Development Therapist		hrs			57,453			57,453	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			152,443			152,443	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				143,283		143,283	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			\$		\$ 331,771	\$ 143,283		\$ 475,054	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.

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,615,961	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,615,961	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(435,121)	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)	\$ (435,121)	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)	\$ 4,180,840	24 *

* This must agree with page 17, line 47.

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	\$ 7,296,515	1
2	Discounts and Allowances for all Levels	(1,207,584)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,088,931	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	18,731	5
6	Therapy	117,319	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 136,050	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	33,552	13
14	Non-Patient Meals	11,725	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	4,372	19
20	Radiology and X-Ray	107	20
21	Other Medical Services	213,231	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 262,987	23
	D. Non-Operating Revenue		
24	Contributions	43,893	24
25	Interest and Other Investment Income***	16,654	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 60,547	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Apt/Garden Home Revenue</u>	1,501,323	28
28a	<u>Other Revenue</u>	5,389	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,506,712	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,055,227	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,769,949	31
32	Health Care	3,289,596	32
33	General Administration	2,175,148	33
	B. Capital Expense		
34	Ownership	412,110	34
	C. Ancillary Expense		
35	Special Cost Centers	767,990	35
36	Provider Participation Fee	75,555	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,490,348	40
41	Income before Income Taxes (line 30 minus line 40)**	(435,121)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (435,121)	43

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

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

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

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

Facility Name & ID Number Eden Village Care Center

0023382

Report Period Beginning:

1/1/06

Ending:

12/31/06

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	4,687	3,852	\$ 106,596	\$ 27.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,138	6,788	172,345	25.39	3
4	Licensed Practical Nurses	41,385	35,714	723,731	20.26	4
5	CNAs & Orderlies	110,845	102,047	1,122,925	11.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,096	8,139	110,239	13.54	10
11	Social Service Workers	6,398	4,515	77,199	17.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	39,328	35,547	314,770	8.86	15
16	Dishwashers					16
17	Maintenance Workers	17,564	11,336	136,976	12.08	17
18	Housekeepers	20,432	14,093	126,882	9.00	18
19	Laundry	9,180	6,332	57,005	9.00	19
20	Administrator	2,330	964	43,530	45.16	20
21	Assistant Administrator	2,240	1,916	53,316	27.83	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,058	14,128	304,001	21.52	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	7,452	6,882	72,712	10.57	31
32	Other Health Care(specify)	4,318	3,983	51,148	12.84	32
33	Other(specify) <u>Marketing & RC</u>	13,886	30,273	464,185	15.33	33
34	TOTAL (lines 1 - 33)	318,337	286,509	\$ 3,937,560 *	\$ 13.74	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	192	\$ 6,720	1-3	35
36	Medical Director	72	16,800	9-3	36
37	Medical Records Consultant	25	1,136	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,750	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	289	\$ 26,406		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	61	\$ 2,550	10-3	50
51	Licensed Practical Nurses	322	10,261	10-3	51
52	Certified Nurse Assistants/Aides	3,517	66,150	10-3	52
53	TOTAL (lines 50 - 52)	3,900	\$ 78,961		53

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		
Jane Rubin	Administrator		\$ 37,330	Workers' Compensation Insurance	\$ 203,778	IDPH License Fee	\$		
(1/2 of salary is allocated to RCF)			37,330	Unemployment Compensation Insurance	27,476	Advertising: Employee Recruitment			
Tina Kassing	RC Administrator		50,385	FICA Taxes	296,883	Health Care Worker Background Check			
				Employee Health Insurance	334,578	(Indicate # of checks performed)			
				Employee Meals	12,515				
				Illinois Municipal Retirement Fund (IMRF)*		Marketing, Advertising, & PR	16,344		
				401K	30,935	Dues, Subscriptions, & Licenses	17,332		
				General Incentives	22,845				
				RC Allocation	(123,839)				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 125,045	TOTAL (agree to Schedule V, line 22, col.8)		\$ 805,171	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,332	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Interest Expense			\$ 69,677			\$	Out-of-State Travel	\$ 1,693	
Conversion to PTO			60,000						
Cumulative Change in Accounting Principle			233,141				In-State Travel	1,757	
Miscellaneous			44,398				Seminar Expense	3,610	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 407,216	TOTAL		\$	Entertainment Expense	()	
C. Professional Services									
Vendor/Payee	Type		Amount						
Coffey Law Firm	Legal		\$ 11,636						
Thomas E. Kennedy	Legal		16,065						
LarsonAllen	Accounting		26,327						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 54,028					TOTAL (agree to Sch. V, line 24, col. 8)	\$ 7,060

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Eden Village Care Center# 0023382

Report Period Beginning:

1/1/06

Ending:

12/31/06**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN - \$8,861
- (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. \$ 51,351 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 75,555
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 12,515 Has any meal income been offset against related costs? N/A Indicate the amount. \$ No
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
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? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Larson, Allen, Weishair & Co., LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. will send once audit is finalized
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees