

Facility Name & ID Number The Elms

0021568 Report Period Beginning: 12/1/05 Ending: 11/30/06

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 98

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

186 (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 10/11/77

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 49 and days of care provided 1,202

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: N/A Fiscal Year: 11/30/06

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>98</u>	Skilled (SNF)	<u>98</u>	<u>35,770</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>98</u>	TOTALS	<u>98</u>	<u>35,770</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		<u>1,538</u>	<u>1,202</u>	<u>2,740</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>23,184</u>	<u>9,062</u>		<u>32,246</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,184</u>	<u>10,600</u>	<u>1,202</u>	<u>34,986</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.81%

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/05 Ending: 11/30/06

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	283,707	21,231	6,758	311,696		311,696	(394)	311,302			1
2	Food Purchase		176,481		176,481		176,481	(1,668)	174,813			2
3	Housekeeping	144,943	19,906	697	165,546		165,546	(24)	165,522			3
4	Laundry	60,984	54,465	1,944	117,393		117,393		117,393			4
5	Heat and Other Utilities			94,662	94,662		94,662		94,662			5
6	Maintenance	72,571	22,012	14,872	109,455		109,455		109,455			6
7	Other (specify):* Waste Removal			1,431	1,431		1,431		1,431			7
8	TOTAL General Services	562,205	294,095	120,364	976,664		976,664	(2,086)	974,578			8
	B. Health Care and Programs											
9	Medical Director			360	360		360		360			9
10	Nursing and Medical Records	1,640,669	151,148	12,366	1,804,183		1,804,183	(25,987)	1,778,196			10
10a	Therapy	100,048		62,255	162,303		162,303		162,303			10a
11	Activities	100,388		12,399	112,787		112,787		112,787			11
12	Social Services	66,593		1,000	67,593		67,593		67,593			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,907,698	151,148	88,380	2,147,226		2,147,226	(25,987)	2,121,239			16
	C. General Administration											
17	Administrative	70,508			70,508		70,508		70,508			17
18	Directors Fees											18
19	Professional Services			15,505	15,505		15,505		15,505			19
20	Dues, Fees, Subscriptions & Promotions			17,079	17,079		17,079	(2,754)	14,325			20
21	Clerical & General Office Expenses	125,283	9,907	46,335	181,525		181,525	(21,883)	159,642			21
22	Employee Benefits & Payroll Taxes			840,179	840,179		840,179	226,380	1,066,559			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,162	2,162		2,162		2,162			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice							27,196	27,196			26
27	Other (specify):* County Assessment			120,168	120,168		120,168		120,168			27
28	TOTAL General Administration	195,791	9,907	1,041,428	1,247,126		1,247,126	228,939	1,476,065			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,665,694	455,150	1,250,172	4,371,016		4,371,016	200,866	4,571,882			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Elms

#0021568

Report Period Beginning:

12/1/05

Ending:

11/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			151,745	151,745	151,745	151,745					30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Loss on disposal			2,855	2,855	2,855	2,855	2,855				36
37	TOTAL Ownership			154,600	154,600	154,600	154,600	154,600				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655	53,655	53,655	53,655				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			53,655	53,655	53,655	53,655	53,655				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,665,694	455,150	1,458,427	4,579,271	4,579,271	200,866	4,780,137				45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms

0021568

Report Period Beginning: 12/1/05

Ending: 11/30/06

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	(1,668)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,111)	21		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	(8,581)	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				18
19	Entertainment	(3,819)	22		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,754)	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	(43,379)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (65,312)		\$	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)	266,178	6,22,26,32	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 266,178		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 200,866		37

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

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

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

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

The Elms

ID# 0021568

Report Period Beginning: 12/1/05

Ending: 11/30/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Food Service Reimbursement	\$ (394)	1	1
2	Pop and Vending	(16,466)	21	2
3	Nursing Reimbursement	(25,987)	10	3
4	Clerical and General Office	(306)	21	4
5	Employee Benefit Reimbursement	(202)	22	5
6	Housekeeping Reimbursement	(24)	3	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	(43,379)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Elms

0021568

Report Period Beginning:

12/1/05

Ending:

11/30/06

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	(394)	0	0	0	0	0	0	0	0	0	0	(394)	1
2	Food Purchase	(1,668)	0	0	0	0	0	0	0	0	0	0	(1,668)	2
3	Housekeeping	(24)	0	0	0	0	0	0	0	0	0	0	(24)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,086)	0	0	0	0	0	0	0	0	0	0	(2,086)	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	(25,987)	0	0	0	0	0	0	0	0	0	0	(25,987)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(25,987)	0	0	0	0	0	0	0	0	0	0	(25,987)	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	(2,754)	0	0	0	0	0	0	0	0	0	0	(2,754)	20
21	Clerical & General Office Expenses	(21,883)	0	0	0	0	0	0	0	0	0	0	(21,883)	21
22	Employee Benefits & Payroll Taxes	(4,021)	230,401	0	0	0	0	0	0	0	0	0	226,380	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	27,196	0	0	0	0	0	0	0	0	0	27,196	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(28,658)	257,597	0	228,939	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(56,731)	257,597	0	200,866	29								

STATE OF ILLINOIS

Facility Name & ID Number The Elms

0021568 Report Period Beginning:

12/1/05 Ending:

Summary B

11/30/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	(8,581)	8,581	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	(8,581)	8,581	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):*	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)	(65,312)	266,178	0	200,866	45								

Facility Name & ID Number The Elms

0021568

Report Period Beginning:

12/1/05

Ending:

11/30/06

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
				McDonough County	Macomb, IL	Local Gov't Unit
				Macomb Public Bldg. Commission	Macomb, IL	Local Gov't Unit

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	6 Maintenance	\$	Macomb Public Building Commission	N/A	\$	\$	1
2	V	22 Employer's Share of IMRF and FICA		McDonough County	N/A	230,401	230,401	2
3	V	26 Property and Liability Insurance		McDonough County	N/A	27,196	27,196	3
4	V	32 Interest		Macomb Public Building Commission	N/A	7,995	7,995	4
5	V	32 Interest - Amortization of Bond Costs		Macomb Public Building Commission	N/A	586	586	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		\$			\$ 266,178	\$ * 266,178	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Not Applicable								\$		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms

0021568 Report Period Beginning: 12/1/05 Ending: 11/30/06

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	Not Applicable				\$	\$		\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Macomb Public Building	X		Expansion of Facility		12/1/93	\$ 450,000	\$ 125,316	2/1/09	.0400 to 0.0575	\$ 7,995	1								
2	Commission Bonds											2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 450,000	\$ 125,316			\$ 7,995	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 450,000	\$ 125,316			\$ 7,995	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 The Elms COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0021568

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

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

C. Tax Bills

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

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

Facility Name & ID Number The Elms

0021568 Report Period Beginning:

12/1/05 Ending:

11/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,100 B. General Construction Type: Exterior Brick Frame _____ 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A
(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>Facility Site (acres)</u>	<u>7</u>	<u>1975</u>	<u>\$ 49,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>7</u>		<u>\$ 49,000</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms

0021568

Report Period Beginning:

12/1/05

Ending:

11/30/06

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	98		1977	1976	\$ 1,995,722	\$ 39,914	50	\$ 39,914		\$ 1,164,171	4
5	Building		1978	1978	30,054	601	50	601		17,431	5
6	Building		1980	1980	186,829	3,737	50	3,737		97,746	6
7	Building		1981	1981	32,336	647	50	647		16,762	7
8	Storm Sewers		1977	1977	77,642	2,588	30	2,588		75,571	8
	Improvement Type**										
9	Storage Building E			1978	15,445		20			15,445	9
10	Road & Parking Lot E			1978	27,033		25			27,033	10
11	Rock for Driveway E			1979	2,381		10			2,381	11
12	Doors/Storage Building E			1980	320		10			320	12
13	Furnace/Storage Building E			1980	652		15			652	13
14	Bathroom Heaters			1981	4,342		10			4,342	14
15	Annunciator Panel			1981	1,867		10			1,867	15
16	Fire Sprinklers			1981	1,455	2	25	2		1,455	16
17	Energy Management System			1982	18,400		20			18,400	17
18	Tile			1982	2,956		10			2,956	18
19	Dietary Remodeling			1982	26,152	872	30	872		20,051	19
20	Lighting Fixtures			1982	303		10			303	20
21	Dietary Remodeling			1983	270,793	9,026	30	9,026		207,607	21
22											22
23	Tile			1983	2,092		10			2,092	23
24	Parking Lot Lights			1983	5,100		20			5,100	24
25	Road E			1983	24,963	999	25	999		23,966	25
26	Air Handling Unit			1985	6,100		20			6,100	26
27	Exhaust Fan			1985	2,473		10			2,473	27
28	Transformer			1985	1,675		10			1,675	28
29	Ceiling Tiles			1986	457		10			457	29
30	Compressor			1986	1,391		15			1,391	30
31	Generator			1987	1,557	78	20	78		1,500	31
32	Ceiling Tiles			1987	1,540		10			1,540	32
33	Exchange System			1988	7,622	381	20	381		6,954	33
34	Driveway Paving			1988	12,172	609	20	609		11,111	34
35											35
36	TOTAL (lines 4 through 35)				2,761,824	59,454		59,454		1,738,852	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms

0021568

Report Period Beginning:

12/1/05

Ending:

11/30/06

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	
	Bed* FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Storm Sewer	1978	1978	\$ 5,078	\$ 169	30	\$ 169		\$ 4,908	4
5	Landscape	1977	1977	24,326		20			24,326	5
6	Landscape	1978	1978	15,382		20			15,382	6
7	Landscape	1980	1980	500		20			500	7
8	Landscape	1981	1981	19,864		20			19,864	8
	Improvement Type**									
9	Asphalt Parking Lot		1988	33,039		15			33,039	9
10	Holby Tempering Valves		1989	2,530		10			2,530	10
11	Energy Management System		1989	16,500	825	20	825		14,094	11
12	Control Panel		1989	3,400	170	20	170		2,905	12
13	Driveway Improvements		1989	1,152	58	20	58		1,026	13
14	Ceiling Fans (4)		1990	3,600		15			3,600	14
15	Nurses Station		1990	4,659	233	20	233		3,920	15
16	Energy Management System		1990	16,363	818	20	818		13,581	16
17	Paint/Wall Covering/Bath		1991	7,387	369	20	369		5,875	17
18	Wall Covering N & S Corridor		1991	9,407	470	20	470		7,444	18
19	Painting/Labor		1991	2,600		10			2,600	19
20	Drywall/ N & S Corridor		1991	10,800	540	20	540		8,548	20
21	Tempered Glass		1991	4,787	239	20	239		3,708	21
22	Additional Wall Covering N & S Corridor		1991	7,018	351	20	351		5,408	22
23	Roof Repair		1991	43,249	2,162	20	2,162		32,979	23
24	Repair Sidewalk		1991	1,030	52	20	52		787	24
25	Roof Repair		1991	27,243	1,362	20	1,362		20,431	25
26	Water Heater		1992	3,300		10			3,300	26
27	Water Heater		1992	3,150		10			3,150	27
28	Fire Alarm/Smoke Detector		1992	504		10			504	28
29	Fire Alarm/Smoke Detector		1993	2,921		10			2,921	29
30	Cubicle Curtains		1993	22,395	1,493	15	1,493		20,778	30
31	Driveway		1993	2,010	101	20	101		1,325	31
32	Carpet		1993	1,710		6			1,710	32
33	Compressor		1994	350		10			350	33
34	Nurses Stations		1994	1,042	52	20	52		668	34
35	Water Heater		1994	5,645		10			5,645	35
36	TOTAL (lines 4 through 35)			302,941	9,464		9,464		267,806	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms

0021568

Report Period Beginning:

12/1/05

Ending:

11/30/06

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	Landscape		1982	1985	\$ 318	\$		\$	\$	\$ 318	4
5	Building		1982	1985	8,500	170	50	170		4,250	5
6	Landscape		1984	1984	449					449	6
7	Landscape		1984	1984	1,486					1,486	7
8	Storage		1989	1989	29,469	1,473	20	1,473		25,047	8
	Improvement Type**										
9	Energy Management System			1995	8,325	416	20	416		4,786	9
10	Handrails			1996	750	39	20	39		406	10
11	Tile Flooring			1996	374	17	10	17		374	11
12	Carpeting			1997	2,240		6			2,240	12
13	Dormer Repair			1997	8,046	403	20	403		3,788	13
14	Emergency Arcing			1997	2,659	266	10	266		2,504	14
15	Exterior Masonry Waterproofing			1997	3,991	200	20	200		1,848	15
16	Engineering Costs - Underground Storage Tank Removal			1997	3,000	200	15	200		1,833	16
17	Tile Flooring			1998	9,002	900	10	900		8,026	17
18	Soffit & Fascia			1998	9,400	470	20	470		4,152	18
19	Heat Pump Compressors			1998	2,637	264	10	264		2,221	19
20	Overhead Heat Pump			1998	672	67	10	67		548	20
21	2 L-Shaped Counter Tops			1999	1,300	65	20	65		509	21
22	Fascia & Ceiling Panels			1999	595	60	10	60		460	22
23	Counter Top			1999	480	24	20	24		184	23
24	2 Counter Tops			1999	640	32	20	32		243	24
25	Vinyl Blinds			1999	757	50	15	50		367	25
26	Painting - Resident Rooms			1999	25,856	2,586	10	2,586		19,394	26
27	Painting - N & S Lounges			1999	7,194	719	10	719		5,034	27
28	Carpeting - Nurses Station			2000	579	55	6	55		579	28
29	Roof - Generator Room			2000	500	34	15	34		205	29
30	Grease Pit			2001	3,348	335	10	335		1,675	30
31	Disposer			2002	1,961	196	10	196		947	31
32	Boiler for Steamer			2002	3,519	176	20	176		836	32
33	Resident Walls			2003	1,040	104	10	104		381	33
34	Shelter House			2003	3,628	181	20	181		590	34
35											35
36	TOTAL (lines 4 through 35)				142,715	9,502		9,502		95,680	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms

0021568

Report Period Beginning:

12/1/05

Ending:

11/30/06

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	Building		1993	1993	\$ 16,906	\$ 338	50	\$ 338		\$ 4,057	4
5	Building		1994	1994	489,387	9,788	50	9,788		117,454	5
6	Landscape		1994	1994	1,600	80	20	80		1,000	6
7	Landscape		1994	1994	350		10			350	7
8	Building		1995	1995	101,007	2,020	50	2,020		23,063	8
	Improvement Type**										
9	Resident Door Latches			2004	3,000	300	10	300		698	9
10	Bathroom Guardrails			2005	1,220	122	10	122		233	10
11	Water Heater			2005	3,411	341	10	341		482	11
12	Temp Control System			2005	38,330	1,917	20	1,917		2,715	12
13	Nurses Call System			2006	22,851	762	20	762		762	13
14	Cooling Tower/Lines			2006	83,319	1,041	20	1,041		1,041	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	TOTAL (lines 4 through 35)				761,381	16,709		16,709		151,855	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms

0021568

Report Period Beginning:

12/1/05

Ending:

11/30/06

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	Landscape		1995	1995	\$ 2,719	\$	10	\$	\$	\$ 2,719	4
5	Building		1996	1996	479	10	50	10		101	5
6	Landscape		1996	1996	1,505	75	20	75		789	6
7	Building		1997	1997	1,251	25	50	25		233	7
8	Landscape		1998	1998	2,966	148	20	148		1,235	8
	Improvement Type**										
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	TOTAL (lines 4 through 35)				8,920	258		258		5,077	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms

0021568

Report Period Beginning:

12/1/05

Ending:

11/30/06

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	Storm Sewer		2001	2001	\$ 18,898	\$ 630	30	\$ 630	\$	\$ 3,360	4
5											5
6											6
7											7
8											8
Improvement Type**											
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	TOTAL (lines 4 through 35)				18,898	630		630		3,360	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms

0021568

Report Period Beginning:

12/1/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 3,996,679	\$ 96,017		\$ 96,017	\$	\$ 2,262,630	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/05 Ending: 11/30/06

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	\$ 226,323	\$ 45,473	\$ 45,473	\$		\$ 44,081	71
72	Current Year Purchases	51,020	5,281	5,281			5,281	72
73	Fully Depreciated Assets	608,736					608,736	73
74								74
75	TOTALS	\$ 886,079	\$ 50,754	\$ 50,754	\$		\$ 658,098	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	Maintenance	2004 Chevy Truck	2004	\$ 24,869	\$ 4,974	\$ 4,974	\$	5	\$ 14,922	76
77	Staff Transportation	1997 Dodge Van	1997	16,993				5	16,993	77
78										78
79										79
80	TOTALS			\$ 41,862	\$ 4,974	\$ 4,974	\$		\$ 31,915	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)		\$ 4,973,620	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 151,745	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 151,745	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)		\$ 2,952,643	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	Farmland (5 Acres) 1993	\$ 12,427	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 12,427	\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable - McDonough County/Macomb Public Building Commission - See page 11 note.

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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/05 Ending: 11/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/06 (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	\$ 837,933	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 0)	596,268		3
4	Supply Inventory (priced at <u>Cost</u>)	47,097		4
5	Short-Term Investments	1,150,000		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,188		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>IntRec14,553PropTax290,000</u>	304,553		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,938,039	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	61,427		13
14	Buildings, at Historical Cost	3,139,446		14
15	Leasehold Improvements, at Historical Cost	857,233		15
16	Equipment, at Historical Cost	927,941		16
17	Accumulated Depreciation (book methods)	(2,952,643)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,033,404	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,971,443	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 246,535	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	100,498		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accr'dVac111,227/DefPropTax290,000</u>	401,227		36
37	<u>APTDueCty10730/DefCaidRev28410</u>	39,140		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 787,400	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 787,400	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,184,043	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,971,443	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,931,301	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,931,301	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	252,742	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)	\$ 252,742	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)	\$ 4,184,043	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms

0021568

Report Period Beginning: 12/1/05

Ending: 11/30/06

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	\$ 4,270,817	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,270,817	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,668	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)	\$ 1,668	23
D. Non-Operating Revenue			
24	Contributions	6,076	24
25	Interest and Other Investment Income***	75,367	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 81,443	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other - see attached schedule	330,298	28
28a	On-behalf receipts - Farm & Macomb PublicBldgComm	147,787	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 478,085	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,832,013	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	976,664	31
32	Health Care	2,147,226	32
33	General Administration	1,247,126	33
B. Capital Expense			
34	Ownership	151,745	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	53,655	36
D. Other Expenses (specify):			
37	Loss on disposal of equipment	2,855	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,579,271	40
41	Income before Income Taxes (line 30 minus line 40)**	252,742	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 252,742	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Elms

0021568

Report Period Beginning:

12/1/05

Ending:

11/30/06

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	1,847	2,127	\$ 63,052	\$ 29.64	1
2	Assistant Director of Nursing	1,507	2,086	47,002	22.53	2
3	Registered Nurses	19,730	22,247	487,320	21.90	3
4	Licensed Practical Nurses	16,613	19,006	303,472	15.97	4
5	CNAs & Orderlies	72,967	83,106	817,306	9.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,815	2,142	33,343	15.57	9
10	Activity Assistants	5,961	6,766	67,045	9.91	10
11	Social Service Workers	3,563	4,281	66,593	15.56	11
12	Dietician					12
13	Food Service Supervisor	3,665	4,224	60,954	14.43	13
14	Head Cook	5,531	6,486	62,014	9.56	14
15	Cook Helpers/Assistants	9,302	10,517	99,606	9.47	15
16	Dishwashers	7,293	8,050	61,133	7.59	16
17	Maintenance Workers	3,587	4,222	72,571	17.19	17
18	Housekeepers	14,269	16,247	144,943	8.92	18
19	Laundry	4,797	5,556	60,984	10.98	19
20	Administrator	1,861	2,086	70,508	33.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,959	2,212	53,410	24.15	23
24	Clerical	5,728	6,350	71,873	11.32	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	1,795	2,107	22,565	10.71	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	183,790	209,818	\$ 2,665,694 *	\$ 12.70	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	144	\$ 5,051	1,3	35
36	Medical Director	12	360	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,200	10,3	39
40	Physical Therapy Consultant	21	1,368	10a,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	15	742	11,3	44
45	Social Service Consultant	15	742	12,3	45
46	Other(specify)				46
47	Computer Consultants	96	4,805	19,3	47
48					48
49	TOTAL (lines 35 - 48)	315	\$ 14,268		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms

Report Period Beginning: 12/1/05

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	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	Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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. See Schedule F, Page 21
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 38,517 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 53,655
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,668
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Clifton Gunderson 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. See Attachments, Page 25
- (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 \$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.

SEE ACCOUNTANTS' COMPILATION REPORT