

		FOR BHF USE					

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

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

**I. IDPH Facility ID Number:** 0008409

**Facility Name:** Eunice Smith Home

**Address:** 1251 College Avenue Alton 62002  
 Number City Zip Code

**County:** Madison

**Telephone Number:** 618-463-7330 Fax # ( )

**HFS ID Number:** 37-0661172

**Date of Initial License for Current Owners:** 12-30-66

**Type of Ownership:**

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

**In the event there are further questions about this report, please contact:**  
**Name:** Paul Bradshaw **Telephone Number:** 314-653-5366

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2006 to 12/31/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Gladys A. Sullivan</u>	
	(Title) <u>Administrator</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____ Fax # ( ) _____	

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

Facility Name & ID Number Eunice Smith Home

# 0008409 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>62</u>	Skilled (SNF)	<u>62</u>	<u>22,630</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>62</u>	TOTALS	<u>62</u>	<u>22,630</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>2,238</u>	<u>18,813</u>	<u>555</u>	<u>21,606</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>2,238</u>	<u>18,813</u>	<u>555</u>	<u>21,606</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.48%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

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

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

YES  NO

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

YES  NO

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

Date started 12/30/1966

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 7 and days of care provided 555

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Eunice Smith Home # 0008409 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary		179,534	59,554	239,088		239,088	298,414	537,502			1
2	Food Purchase											2
3	Housekeeping	116,868	12,541	4,439	133,848		133,848		133,848			3
4	Laundry		10,592	38,360	48,952		48,952		48,952			4
5	Heat and Other Utilities			70,558	70,558		70,558		70,558			5
6	Maintenance	38,788	1,012	47,418	87,218		87,218		87,218			6
7	Other (specify):* Cafeteria							22,998	22,998			7
8	<b>TOTAL General Services</b>	<b>155,656</b>	<b>203,679</b>	<b>220,329</b>	<b>579,664</b>		<b>579,664</b>	<b>321,412</b>	<b>901,076</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,490,043	145,729	9,811	1,645,583		1,645,583	13,121	1,658,704			10
10a	Therapy	17,427	116	205	17,748		17,748		17,748			10a
11	Activities											11
12	Social Services	69,433	2,534	7,755	79,722		79,722		79,722			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>1,576,903</b>	<b>148,379</b>	<b>22,571</b>	<b>1,747,853</b>		<b>1,747,853</b>	<b>13,121</b>	<b>1,760,974</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	148,963	12,163	166,706	327,832		327,832	33,134	360,966			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			5,279	5,279		5,279	(2,090)	3,189			20
21	Clerical & General Office Expenses							18,212	18,212			21
22	Employee Benefits & Payroll Taxes			558,041	558,041		558,041		558,041			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,225	13,225		13,225		13,225			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			23,921	23,921		23,921		23,921			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	<b>148,963</b>	<b>12,163</b>	<b>767,172</b>	<b>928,298</b>		<b>928,298</b>	<b>49,256</b>	<b>977,554</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,881,522</b>	<b>364,221</b>	<b>1,010,072</b>	<b>3,255,815</b>		<b>3,255,815</b>	<b>383,789</b>	<b>3,639,604</b>			<b>29</b>

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

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

Facility Name & ID Number Eunice Smith Home #0008409 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			110,709	110,709		110,709		110,709		30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes			16,122	16,122		16,122		16,122		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			126,831	126,831		126,831		126,831		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	5,419	38,022		43,441		43,441		43,441		39
40	Barber and Beauty Shops			11,304	11,304		11,304		11,304		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee							33,945	33,945		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>	5,419	38,022	11,304	54,745		54,745	33,945	88,690		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,886,941	402,243	1,148,207	3,437,391		3,437,391	417,734	3,855,125		45

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

Facility Name & ID Number Eunice Smith Home

# 0008409

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(11,329)	17		24
25	Fund Raising, Advertising and Promotional	(2,090)	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 <u>Provider Participation Fee</u>	33,945	42		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 20,526		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 20,526		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Eunice Smith Home

ID# 0008409

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eunice Smith Home# 0008409

Report Period Beginning:

01/01/2006

Ending:

12/31/2006**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	298,414	0	0	0	0	0	0	0	0	0	298,414	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	22,998	0	0	0	0	0	0	0	0	0	22,998	7
8	<b>TOTAL General Services</b>	0	321,412	0	0	0	0	0	0	0	0	0	321,412	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	13,121	0	0	0	0	0	0	0	0	0	13,121	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	13,121	0	0	0	0	0	0	0	0	0	13,121	16
	<b>C. General Administration</b>													
17	Administrative	(11,329)	44,463	0	0	0	0	0	0	0	0	0	33,134	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	(2,090)	0	0	0	0	0	0	0	0	0	0	(2,090)	20
21	Clerical & General Office Expenses	0	18,212	0	0	0	0	0	0	0	0	0	18,212	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(13,419)	62,675	0	0	0	0	0	0	0	0	0	49,256	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(13,419)	397,208	0	0	0	0	0	0	0	0	0	383,789	29

STATE OF ILLINOIS

Facility Name & ID Number Eunice Smith Home

# 0008409

Report Period Beginning:

01/01/2006 Ending:

Summary B

12/31/2006

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

	Capital Expense	PAGES	PAGE	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	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	<b>TOTAL Ownership</b>	0	0	0	0	0	0	0	0	0	0	0	0	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	0	0	0	0	0	0	0	0	0	0	0	0	44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	(13,419)	397,208	0	0	0	0	0	0	0	0	0	383,789	45

Facility Name & ID Number Eunice Smith Home

# 0008409

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

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alton Memorial Hospital	100					
BJC Health System	100					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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 Dietary	\$ 239,089	Alton Memorial Hospital	100.00%	\$ 537,503	\$ 298,414 1
2	V	7 Cafeteria		Alton Memorial Hospital	100.00%	22,998	22,998 2
3	V	10 Medical Records		Alton Memorial Hospital	100.00%	13,121	13,121 3
4	V	21 Administrative & General		Alton Memorial Hospital	100.00%	18,212	18,212 4
5	V	17 Home Office Costs	116,203	BJC Home Office	100.00%	160,666	44,463 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		\$ 355,292			\$ 752,500	\$ * 397,208 14

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

Facility Name &amp; ID Number

Eunice Smith Home

#

0008409

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1									\$	1
2										2
3			There were no payments.							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 Eunice Smith Home

# 0008409 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Meals	218,980	5	\$ 1,837,807	\$ 64,045	\$ 537,503	1
2	7	Cafeteria	FTE's	62,512	33	259,789	5,534	22,998	2
3	10	Medical Records	Gross Revenue	313,065,254	24	1,200,606	3,421,465	13,121	3
4	21	Finance	Gross Revenue	313,356,835	25	1,393,654	3,421,465	15,217	4
5		A&G	Accumulated Cost	71,224,250	43	14,028,111	15,215	2,997	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					\$ 18,719,967	\$	\$ 591,836	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1							\$	\$			\$	1
2			NA									2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$	\$			\$	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	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.	\$	15,114	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.)	\$	15,653	2
3. Under or (over) accrual (line 2 minus line 1).	\$	539	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	15,583	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	16,122	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	8
	2002	13,596
	2003	14,224
	2004	15,150
	2005	15,653

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

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

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

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

FACILITY NAME Eunice Smith Home COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0008409

CONTACT PERSON REGARDING THIS REPORT Paul Bradshaw

TELEPHONE 314-653-5366 FAX #: 314-653-4162

**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>23-1-07-12-12-201-009</u>	<u>PT SE NE PART SW NE</u>	\$ <u>15,653.00</u>	\$ <u>15,653.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>15,653.00</u>	\$ <u>15,653.00</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

Facility Name & ID Number Eunice Smith Home

# 0008409 Report Period Beginning:

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 32,604 B. General Construction Type: Exterior Brick Frame Steel Number of Stories \_\_\_\_\_

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).

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1937	\$ 21,169	1
2					2
3	TOTALS			\$ 21,169	3

Facility Name &amp; ID Number Eunice Smith Home

# 0008409

Report Period Beginning:

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

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1966	1966	\$ 433,793	\$ 6,139	40	\$ 6,139		\$ 433,793	4
5			1968	1968	1,770		Various			1,770	5
6			1968	1968	762		Various			762	6
7			1973	1973	1,000	21	33	21		1,000	7
8			1980	1980	1,178		Various			1,178	8
<b>Improvement Type**</b>											
9	A/C Units			1995	222		5			222	9
10	7 1/2 Ton			1981	6,888		20			6,888	10
11	Water Heater			1981	16,430		15			16,430	11
12	Sprinkler			1981	1,980		25			1,980	12
13	Painting			1985	13,850		Various			13,850	13
14	Misc Renovation			1988	75,082		15			75,082	14
15	Misc Renovation			1992	4,155	208	20	208		3,536	15
16	A/C Units			1989	16,438		15			16,438	16
17	Misc Renovation			1990	53,990		Various			53,990	17
18	Plumbing			1966	521,325		Various			521,325	18
19	Incinerator Upgrade			1973	695		5			695	19
20	Misc			1968	790		Various			790	20
21	Misc			1970	190		10			190	21
22	Incinerator Upgrade			1967	3,825		20			3,825	22
23	Parking/Wheelchair			1983	40,133		12			40,133	23
24	Driveway			1989	4,900		10			4,900	24
25	Driveway			1995	8,972	598	15	598		7,176	25
26	Fence Extension			1990	698		15			698	26
27	Parkin/Walk/Curbs			1966	47,660		Various			47,660	27
28	Misc Landscaping			1968	330		Various			330	28
29	Misc Landscaping			1970	600		Various			600	29
30	Oil & Chip Roadway			1981	3,805		5			3,805	30
31	Wall Construction			1991	5,509	275	20	275		4,263	31
32	Door Frame			1991	1,770		10			1,770	32
33	Concrete			1992	726	48	15	48		576	33
34	Patch & Seal Parking			1994	7,435	305	12	305		7,435	34
35	Door Frame			1995	1,449		10			1,449	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Eunice Smith Home

# 0008409

Report Period Beginning:

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Install Water Softener	1995	\$ 14,149	\$	10	\$	\$	\$ 14,149	37
38	Window Treatment Lobby	1995	2,138		10			2,138	38
39	East Dining Room Carpet	1995	2,844		5			2,844	39
40	East Dining Room Alum Door	1995	1,449	72	20	72		828	40
41	East Dining Room Wall Covering	1995	2,845		5			2,845	41
42	Landscape	1995	42,800	2,853	15	2,853		32,810	42
43	Conference Room Renovation	1996	7,916	792	10	792		7,724	43
44	Replace Secondary Signage	1997	9,471	947	10	947		9,471	44
45	Install Vinyl Flooring Rest Rooms	1997	32,700	3,270	10	3,270		32,700	45
46	Elevator Door Protection	1997	1,656	162	10	162		1,656	46
47	Flat Roof Replacement	1997	82,637	8,264	10	8,264		75,065	47
48	Cabinetry	1997	5,816	291	20	291		2,657	48
49	Corridor Painting	1997	5,771		5			5,771	49
50	Door Frame Protectors	1997	2,426	244	10	244		2,226	50
51	Interior & Exterior Lighting	1997	20,084	2,014	10	2,014		18,401	51
52	Install Vinyl Flooring Rest Rooms	1997	29,773	2,986	10	2,986		24,301	52
53	Replace Carpet East Dining Room	1998	7,927		5			7,927	53
54	Install New Transformer	1998	28,092	1,405	20	1,405		11,942	54
55	Storm Drain Back Parking Lot	1999	8,413	467	18	467		3,503	55
56	Install 4 Smoke Dampers in Basement	1999	6,248	417	15	417		3,127	56
57	Install Wandeguard Locking System	1999	2,162	51	7	51		2,162	57
58	Wall Covering & Paint	2001	8,106	811	5	811		8,106	58
59	Fire Sprinkler System	2001	193,922	7,757	25	7,757		43,956	59
60	Roof Replacement	2003	31,668	3,167	10	3,167		12,670	60
61	Air Conditioning System	2003	75,514	15,103	5	15,103		60,412	61
62	Security Camera Upgrade	2003	4,737	947	5	947		3,788	62
63	Wandeguard Door Alarm	2003	28,750	2,875	10	2,875		9,344	63
64	Air Conditioning System	2003	54,665	10,933	5	10,933		34,621	64
65	Wood Fencing Courtyard	2004	21,760	2,720	8	2,720		6,347	65
66	Landscaping	2004	21,759	2,176	10	2,176		5,077	66
67	Carpentry Work Alzheimer's Unit	2004	44,130	2,942	15	2,942		8,581	67
68	Carpentry Work Tub Room Conversion	2004	11,500	767	15	767		1,853	68
69	Carpentry Work Screen Patio West Wing	2004	19,200	1,280	15	1,280		2,773	69
70	TOTAL (lines 4 thru 69)		\$ 2,111,378	\$ 83,307		\$ 83,307	\$	\$ 1,736,314	70

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

Facility Name & ID Number Eunice Smith Home

# 0008409

Report Period Beginning:

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,111,378	\$ 83,307		\$ 83,307	\$	\$ 1,736,314	1
2	Metal or Wood Cabinets	2004	26,500	1,767	15	1,767		4,270	2
3	Commercial Water Heater	2004	44,917	4,492	10	4,492		11,200	3
4	Extend Floor Structure, Install Fire Dampers	2005	31,438	2,096	15	2,096		3,493	4
5	Floor Finishes- Carpet	2005	3,621	724	5	724		1,448	5
6	Fire Protection Sprinkler System	2005	3,650	146	25	146		243	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,221,504	\$ 92,532		\$ 92,532	\$	\$ 1,756,968	34

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

Facility Name & ID Number Eunice Smith Home # 0008409 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 494,746	\$ 18,177	\$ 18,177	\$		\$ 476,172	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 494,746	\$ 18,177	\$ 18,177	\$		\$ 476,172	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	Nursing Home Business	1992 Ford Savannah	1991	\$ 33,255	\$	\$	\$		\$ 33,255	76
77										77
78										78
79										79
80	TOTALS			\$ 33,255	\$	\$	\$		\$ 33,255	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	2,770,674	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	110,709	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	110,709	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)	\$	2,266,395	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Not Applicable

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

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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	<b>TOTAL</b>		\$	\$	21

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

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

**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)	
<b>TOTAL TRAINED</b>	

- (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	2 Staff		3		4 Outside Practitioner (other than consultant)		5	6	7	8	
			Units of Service	Cost	Units	Cost	Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)				
1	Licensed Occupational Therapist		418 hrs	\$ 10,497		\$	\$ 30	418	\$ 10,527	1			
2	Licensed Speech and Language Development Therapist		4 hrs	171			24	4	195	2			
3	Licensed Recreational Therapist		hrs							3			
4	Licensed Physical Therapist		321 hrs	6,758			61	321	6,819	4			
5	Physician Care		visits							5			
6	Dental Care		visits							6			
7	Work Related Program		hrs							7			
8	Habilitation		hrs							8			
9	Pharmacy		# of prescrpts							9			
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10			
11	Academic Education		hrs							11			
12	Exceptional Care Program									12			
13	Other (specify):									13			
14	<b>TOTAL</b>			\$ 17,426		\$	\$ 115	743	\$ 17,541	14			

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

Facility Name & ID Number Eunice Smith Home# 0008409Report Period Beginning: 01/01/2006

Ending:

12/31/2006

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$ 31,640,710	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )		11,972,423	3
4	Supply Inventory (priced at )		611,462	4
5	Short-Term Investments			5
6	Prepaid Insurance		381,049	6
7	Other Prepaid Expenses		192,166	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		7,991,046	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$	\$ 52,788,856	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		525,000	12
13	Land		183,572	13
14	Buildings, at Historical Cost		70,954,170	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		42,849,470	16
17	Accumulated Depreciation (book methods)		(76,556,673)	17
18	Deferred Charges		2,683,979	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):		94,547,524	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 135,187,042	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$	\$ 187,975,898	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	\$ 1,137,548	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		5,502,720	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		107,500	33
34	Deferred Compensation		367,387	34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Other Current Liabilities</u>		13,007,294	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$	\$ 20,122,449	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		17,953,642	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Self Ins Liability</u>		4,179,960	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 22,133,602	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$	\$ 42,256,051	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 145,719,847	\$ 145,719,847	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 145,719,847	\$ 187,975,898	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 126,699,762	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 126,699,762	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(182,595)	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) <u>AMH Net Income</u>	19,101,652	15
16	Other (describe) <u>Change In Restricted Fund Assets</u>	101,028	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 19,020,085	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 145,719,847	24 *

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

Facility Name & ID Number Eunice Smith Home# 0008409Report Period Beginning: 01/01/2006Ending: 12/31/2006**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,427,896	1
2	Discounts and Allowances for all Levels	(201,714)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,226,182	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	16,508	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 16,508	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Misc Non Operating Revenue	11,835	28
28a	Misc Other Operating Revenue	271	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 12,106	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,254,796	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	579,664	31
32	Health Care	1,747,853	32
33	General Administration	928,298	33
<b>B. Capital Expense</b>			
34	Ownership	126,831	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	54,745	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,437,391	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(182,595)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (182,595)	43

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

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

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

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

Facility Name & ID Number Eunice Smith Home

# 0008409

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,742	2,080	\$ 59,228	\$ 28.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,586	18,104	485,348	26.81	3
4	Licensed Practical Nurses	10,747	12,522	249,171	19.90	4
5	CNAs & Orderlies	50,178	57,220	696,296	12.17	5
6	CNA Trainees					6
7	Licensed Therapist	615	744	17,427	23.42	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	4,879	5,643	69,433	12.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,953	2,226	38,788	17.42	17
18	Housekeepers	10,135	11,596	116,868	10.08	18
19	Laundry					19
20	Administrator	1,542	2,080	79,547	38.24	20
21	Assistant Administrator					21
22	Other Administrative	2,869	3,094	69,416	22.44	22
23	Office Manager					23
24	Clerical					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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Pharmacy</u>	104	117	5,419	46.32	33
34	TOTAL (lines 1 - 33)	100,350	115,426	\$ 1,886,941 *	\$ 16.35	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

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

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Eunice Smith Home

# 0008409

Report Period Beginning: 01/01/2006

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**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	
Administrator			\$ 79,547	Workers' Compensation Insurance	\$ 29,920	IDPH License Fee	\$	
Clerical			69,416	Unemployment Compensation Insurance	4,575	Advertising: Employee Recruitment		
				FICA Taxes	136,991	Health Care Worker Background Check		
				Employee Health Insurance	250,822	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Nursing Home Assoc Dues	3,050	
				Life Insurance	2,298	Other Dues	129	
				Long Term Disability	2,711	Advertising	2,090	
				Pension	129,008			
				Employee Activities	471			
				Employee Assistance	1,245	Less: Public Relations Expense	( )	
						Non-allowable advertising	(2,090)	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 148,963	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 558,041		\$ 3,179		
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
Corporate Fees			\$ 135,946				Out-of-State Travel	\$
Bad Debt			11,329					
Purchased Services			7,345				In-State Travel	1,444
Other (See Attached)			12,086				See Attached	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 166,706				Seminar Expense	11,781
							See Attached	
C. Professional Services								
Vendor/Payee	Type					Amount		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 13,225	

\* Attach copy of IMRF notifications

\*\*See instructions.



**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. Life Services Network \$3,050
- (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? None Added
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,476 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. \$ 33,945  
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. \$ NA Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? NA  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NA  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NA  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ernst & Young 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 Cover Letter
- (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? NA  
Attach invoices and a summary of services for all architect and appraisal fees.