

		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: 0035246

Facility Name: Henderson County Retirement Center

Address: 604 Oakwood Drive Stronghurst 61480
 Number City Zip Code

County: Henderson

Telephone Number: 309-924-1123 **Fax #** 309-924-1926

HFS ID Number: 363378161101

Date of Initial License for Current Owners: 06/28/89

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: James G. Hull, C.P.A. **Telephone Number:** 217-228-1950

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	(Title) _____
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>James G. Hull, C.P.A.</u> <u>Vice President</u>	
	(Firm Name & Address) <u>WDM Computer Services, Inc.</u> <u>1900 Harrison, Quincy, IL 62301</u>	
	(Telephone) <u>217-228-1950</u> Fax # <u>217-222-6053</u>	

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

Facility Name & ID Number Henderson County Retirement Center

0035246 Report Period Beginning: _____ Ending: _____

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	54	Skilled (SNF)	54	19,710	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	54	TOTALS	54	19,710	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			235	235	8
9	SNF/PED					9
10	ICF	8,606	6,223	11	14,840	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,606	6,223	246	15,075	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.48%

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)

N/A

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 06/28/89

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

YES Date 05/16/89 NO

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

YES NO If YES, enter number of beds certified 54 and days of care provided 235

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Henderson County Retirement Center # 0035246 Report Period Beginning: Ending:

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	105,094	9,213	4,058	118,365		118,365		118,365		1
2	Food Purchase		88,409		88,409		88,409	(158)	88,251		2
3	Housekeeping	47,628	10,239		57,867		57,867		57,867		3
4	Laundry	24,863	3,894	13,727	42,484		42,484		42,484		4
5	Heat and Other Utilities			50,850	50,850		50,850		50,850		5
6	Maintenance	94	8,999	58,700	67,793	443	68,236		68,236		6
7	Other (specify):*										7
8	TOTAL General Services	177,679	120,754	127,335	425,768	443	426,211	(158)	426,053		8
	B. Health Care and Programs										
9	Medical Director			13,415	13,415		13,415		13,415		9
10	Nursing and Medical Records	561,384	61,057	2,227	624,668		624,668		624,668		10
10a	Therapy	13,738	3	10,399	24,140		24,140		24,140		10a
11	Activities	36,200	4,098	738	41,036		41,036		41,036		11
12	Social Services	32,571	161	738	33,470		33,470		33,470		12
13	CNA Training										13
14	Program Transportation		2,550		2,550		2,550		2,550		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	643,893	67,869	27,517	739,279		739,279		739,279		16
	C. General Administration										
17	Administrative	44,305			44,305		44,305		44,305		17
18	Directors Fees										18
19	Professional Services			22,870	22,870		22,870		22,870		19
20	Dues, Fees, Subscriptions & Promotions			18,539	18,539	(30)	18,509	(11,685)	6,824		20
21	Clerical & General Office Expenses	42,003	9,270	14,997	66,270		66,270		66,270		21
22	Employee Benefits & Payroll Taxes			139,841	139,841		139,841		139,841		22
23	Inservice Training & Education			1,520	1,520	99	1,619		1,619		23
24	Travel and Seminar			3,521	3,521	(560)	2,961		2,961		24
25	Other Admin. Staff Transportation		283		283	18	301		301		25
26	Insurance-Prop.Liab.Malpractice			59,860	59,860	30	59,890		59,890		26
27	Other (specify):*			324	324		324	1,547	1,871		27
28	TOTAL General Administration	86,308	9,553	261,472	357,333	(443)	356,890	(10,138)	346,752		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	907,880	198,176	416,324	1,522,380		1,522,380	(10,296)	1,512,084		29

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

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

Facility Name & ID Number Henderson County Retirement Center

#0035246

Report Period Beginning:

Ending:

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			104,664	104,664		104,664	(12,084)	92,580			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			64,927	64,927		64,927	(13,106)	51,821			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,161	4,161		4,161		4,161			35
36	Other (specify):*											36
37	TOTAL Ownership			173,752	173,752		173,752	(25,190)	148,562			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			9,002	9,002		9,002		9,002			40
41	Coffee and Gift Shops		3,551		3,551		3,551		3,551			41
42	Provider Participation Fee			29,565	29,565		29,565		29,565			42
43	Other (specify):*			173	173		173	(174)	(1)			43
44	TOTAL Special Cost Centers		3,551	38,740	42,291		42,291	(174)	42,117			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	907,880	201,727	628,816	1,738,423		1,738,423	(35,660)	1,702,763			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 Henderson County Retirement Center

0035246

Report Period Beginning:

Ending:

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	(149)	2		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	(88)	30		9
10	Interest and Other Investment Income	(13,106)	32		10
11	Discounts, Allowances, Rebates & Refunds	(9)	2		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	(124)	43		18
19	Entertainment				19
20	Contributions	(50)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	1,547	27		24
25	Fund Raising, Advertising and Promotional	(11,685)	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 See List Attached	(11,996)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (35,660)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (35,660)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Henderson County Retirement Center

ID# 0035246

Report Period Beginning: _____

Ending: _____

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	LEASE BUYOUT	\$ (11,996)	30
2			
3			
4			
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49	Total	(11,996)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Henderson County Retirement Center

0035246

Report Period Beginning:

Ending:

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(158)	0	0	0	0	0	0	0	0	0	0	(158)	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	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(158)	0	0	0	0	0	0	0	0	0	0	(158)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(11,685)	0	0	0	0	0	0	0	0	0	0	(11,685)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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):*	1,547	0	0	0	0	0	0	0	0	0	0	1,547	27
28	TOTAL General Administration	(10,138)	0	0	0	0	0	0	0	0	0	0	(10,138)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(10,296)	0	0	0	0	0	0	0	0	0	0	(10,296)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Henderson County Retirement Center

0035246 Report Period Beginning:

Ending:

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(12,084)	0	0	0	0	0	0	0	0	0	0	(12,084)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,106)	0	0	0	0	0	0	0	0	0	0	(13,106)	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	(25,190)	0	(25,190)	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):*	(174)	0	0	0	0	0	0	0	0	0	0	(174)	43
44	TOTAL Special Cost Centers	(174)	0	(174)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(35,660)	0	(35,660)	45									

Facility Name & ID Number Henderson County Retirement Center

0035246

Report Period Beginning:

Ending:

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Henderson County Retirement Center # 0035246 Report Period Beginning: _____ Ending: _____

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Henderson County Retirement Center

0035246 Report Period Beginning:

Ending:

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Henderson County Retirement Center # 0035246 Report Period Beginning: _____ Ending: _____

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Security Savings		X	Mortgage	\$5,815.86	04/01/93	\$ 2,000,000	\$ 875,648	07/01/08	6.2500	\$ 57,325	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	See List Attached		X	Cash Flow	Interest	Various	1,635,000	100,000	Various	Various	7,602	6						
7												7						
8												8						
9	TOTAL Facility Related				\$5,815.86		\$ 3,635,000	\$ 975,648			\$ 64,927	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 3,635,000	\$ 975,648			\$ 64,927	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.)

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 Henderson County Retirement Center COUNTY Henderson

FACILITY IDPH LICENSE NUMBER 0035246

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 Henderson County Retirement Center

0035246 Report Period Beginning:

Ending:

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,636 B. General Construction Type: Exterior Brick Frame Wood-Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Care Related	217,600	1988	\$ 15,000	1
2					2
3	TOTALS	217,600		\$ 15,000	3

Facility Name & ID Number Henderson County Retirement Center

0035246

Report Period Beginning:

Ending:

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	60		1989	1988	\$ 1,260,000	\$ 42,031	30	\$ 42,000	\$ (31)	\$ 738,110	4
5	6		2000	2000	530,989	13,301	40	13,275	(26)	84,516	5
6											6
7											7
8											8
	Improvement Type**										
9		PARKING LOT/LANDSCAPING	1989		25,102	1,258	20	1,255	(3)	21,822	9
10		LANDSCAPING	1990		937	47	20	47		761	10
11		LAND IMPROVEMENT	1995		1,839	92	20	92		1,089	11
12		BRICK SIGN	1996		12,915	620	12	646	26	6,918	12
13		LAND IMPROVEMENT	1992		2,003	101	20	100	(1)	1,416	13
14		LIGHTNING RODS	1998		3,600	240	15	240		2,060	14
15		NEW SOFFITS	1998		26,138	1,752	15	1,743	(9)	14,894	15
16		PHONE SYSTEM	1998		6,738	449	15	449		3,780	16
17		SIDE WALKS	1998		4,500	226	20	225	(1)	1,845	17
18		ALARM SYSTEM	1998		8,266	834	10	827	(7)	6,808	18
19		LAUNDRY/GARAGE BLDG	1999		50,330	3,374	15	3,355	(19)	24,743	19
20		STORAGE BLDG	1999		8,911	597	15	594	(3)	4,381	20
21		NEW ROOF	1999		16,311	1,093	15	1,087	(6)	7,745	21
22		LANDSCAPING	2000		1,706	85	20	85		526	22
23		FURNICE	2001		2,848	285	10	285		1,685	23
24		NEW EXIT	2001		1,645	110	15	110		634	24
25		LANDSCAPING	2002		954	95	10	95		445	25
26		GARAGE/STORAGE BUILDING	2002		12,800	858	15	853	(5)	3,789	26
27		ROOFING/SHINGLES	2003		17,838	1,192	15	1,189	(3)	4,133	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											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 & ID Number Henderson County Retirement Center

0035246

Report Period Beginning:

Ending:

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)	\$ 1,996,370	\$ 68,640		\$ 68,552	\$ (88)	\$ 932,100	70

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

Facility Name & ID Number Henderson County Retirement Center # 0035246 Report Period Beginning: _____ Ending: _____

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	\$ 191,564	\$ 18,458	\$ 18,458	\$	8	\$ 118,132	71
72	Current Year Purchases	10,410	570	570		8	570	72
73	Fully Depreciated Assets	427,429					427,429	73
74								74
75	TOTALS	\$ 629,402	\$ 19,028	\$ 19,028	\$		\$ 546,131	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	Care Related	Dodge Van	1998	\$ 8,000	\$	\$	\$	5	\$ 8,000	76
77	Care Related	1997 Ford Eldorado	2002	25,000	5,000	5,000		5	20,417	77
78										78
79										79
80	TOTALS			\$ 33,000	\$ 5,000	\$ 5,000	\$		\$ 28,417	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)	\$	2,673,772	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	92,668	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	92,580	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	(88)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	1,506,648	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Henderson County Retirement Center

0035246

Report Period Beginning: _____

Ending: _____

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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

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

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

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

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

YES NO

16. Rental Amount for movable equipment: \$ 4,161 Description: Oxygen Conc. (\$1,904.80), Copier rent (\$2256.00)

(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.

Facility Name & ID Number Henderson County Retirement Center # 0035246 Report Period Beginning: _____ Ending: _____

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.

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

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

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

Facility Name & ID Number Henderson County Retirement Center

0035246

Report Period Beginning:

Ending:

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of

(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	\$ 84,295	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	300,886		3
4	Supply Inventory (priced at <u>FIFO</u>)	10,821		4
5	Short-Term Investments	280,685		5
6	Prepaid Insurance	6,442		6
7	Other Prepaid Expenses	8,712		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>INT. Receivable</u>	1,257		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 693,098	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,500		13
14	Buildings, at Historical Cost	2,369,112		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	666,388		16
17	Accumulated Depreciation (book methods)	(1,671,439)		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 (spe <u>CIP</u>)	1,105		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,387,666	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,080,764	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 45,653	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	100,000		29
30	Accrued Salaries Payable	92,325		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	5,090		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 243,068	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	875,648		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)	\$ 875,648	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,118,715	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 962,049	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,080,764	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,007,100	1
2	Restatements (describe):		2
3	05 Audit Adjustment	(14,950)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 992,150	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(30,101)	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) Rounding		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (30,101)	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)	\$ 962,049	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Henderson County Retirement Center# 0035246

Report Period Beginning:

Ending:

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	\$ 1,620,631	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,620,631	3
B. Ancillary Revenue			
4	Day Care	1,309	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	275	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,584	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	3,335	12
13	Barber and Beauty Care	8,370	13
14	Non-Patient Meals	149	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 11,854	23
D. Non-Operating Revenue			
24	Contributions	44,279	24
25	Interest and Other Investment Income***	13,106	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 57,385	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	682	28
28a	See List Attached	16,186	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 16,868	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,708,322	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	425,768	31
32	Health Care	739,279	32
33	General Administration	357,333	33
B. Capital Expense			
34	Ownership	173,752	34
C. Ancillary Expense			
35	Special Cost Centers	12,726	35
36	Provider Participation Fee	29,565	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,738,423	40
41	Income before Income Taxes (line 30 minus line 40)**	(30,101)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (30,101)	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 Henderson County Retirement Center

0035246

Report Period Beginning:

Ending:

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	1,884	2,088	\$ 41,829	\$ 20.03	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,301	3,608	61,255	16.98	3
4	Licensed Practical Nurses	10,847	11,718	181,303	15.47	4
5	CNAs & Orderlies	26,848	28,466	236,084	8.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	858	1,244	13,738	11.04	8
9	Activity Director	1,644	2,088	20,966	10.04	9
10	Activity Assistants	1,889	2,084	15,234	7.31	10
11	Social Service Workers	2,067	3,437	32,571	9.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,976	2,088	19,552	9.36	14
15	Cook Helpers/Assistants	4,477	4,764	33,172	6.96	15
16	Dishwashers	6,657	7,342	52,369	7.13	16
17	Maintenance Workers	15	15	94	6.27	17
18	Housekeepers	6,016	6,512	47,628	7.31	18
19	Laundry	2,519	2,860	24,863	8.69	19
20	Administrator	1,891	2,178	44,305	20.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,966	4,005	42,003	10.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Care Plan Coord.	1,621	2,088	40,914	19.59	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	77,476	86,585	\$ 907,880 *	\$ 10.49	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	124	\$ 4,058	1-3	35
36	Medical Director	Contract	13,415	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	4	427	10-3	38
39	Pharmacist Consultant	Contract	1,800	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	5 Sessions	300	10a-3	43
44	Activity Consultant	Contract	738	11-3	44
45	Social Service Consultant	Contract	738	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	128	\$ 21,476		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 Henderson County Retirement Center

0035246

Report Period Beginning:

Ending:

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			
Richard Clifton	Administrator	0	\$ 44,305	Workers' Compensation Insurance	\$ 36,502	IDPH License Fee	\$			
				Unemployment Compensation Insurance	609	Advertising: Employee Recruitment	138			
				FICA Taxes	67,091	Health Care Worker Background Check	480			
				Employee Health Insurance	39,402	(Indicate # of checks performed <u>30</u>)				
				Employee Meals		Patient Background Checks	80 1,280			
				Illinois Municipal Retirement Fund (IMRF)*		LSN Dues	2,393			
				Adjustment to Vacation Accrual	(3,763)	NAEIR	962			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 44,305			Adv/Promo	11,685			
(List each licensed administrator separately.)						See List Attached	1,570			
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		
N/A			\$ 0	N/A		\$ 0	Out-of-State Travel	\$		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 139,841	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 6,824
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount		
WDM Computer Services, Inc.	Data Processing/Consulting		\$ 19,592	N/A		\$ 0	Out-of-State Travel	\$		
LTC Resources, Inc.	Medicare Consulting		813							
Stoerzbach, Morrison, Robertson	Legal		345							
PK Bhosole	Architect services		2,120				In-State Travel			
TOTAL (agree to Schedule V, line 19, column 3)			\$ 22,870	TOTAL			\$	Seminar Expense		
(If total legal fees exceed \$5,000, attach copy of invoices.)								See List Attached		2,961
								Entertainment Expense		
								(agree to Sch. V, line 24, col. 8)		\$ 2,961

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Henderson County Retirement Center

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, \$2,393
- (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? 8-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,485 Line 10-2
- (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. \$ 29,565
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? N/A
- (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. \$ 149
- (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? 90
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? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm Scheduled
Firm Name: Bennett & Midendorf The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet completed.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.

Henderson County Retirement Center, Inc.

#0035246

01/01/06 to 12/31/06

Board Members

Diana Doran, Pres 2008

Box 417

Carman, IL 61425

Gary Martin, 2007

Box 245

Oquawka, IL 61469

Sally Fisher 2006

RR 1

Lomax, IL 61454

Tom Edmonds, 2006

RR 1, Box 129

Lomax, IL 61454

John Allaman, Treas. 2007

RR 1

Kirkwood, IL 61447

Tony Griepentrog, 2006

Box 111

Stronghurst, IL 61480

Nancy Stevenson, Sec. 2008

RR 1

Gladstone, IL 61437

Bill Towns

P.O. Box 447

Stronghurst, IL 61480

Ralph Tatge, 2007 (Vice Pres.)

Box 535

Stronghurst, IL 61480

Honorary Board Members

Laura Kent Donahue

Zach Stamp

Henderson County Retirement Center, Inc.

#0035246

01/01/06 to 12/31/06

Reclassifications

1. Reclass \$30 Notary Bond from fees to Insurance.
2. Reclass \$9.20 from Seminar to Employee Reimb. Mileage. Coding error in reimb. Of employee mileage.
3. Reclass 99.00 from Seminar to In-service. Coding error in reporting an in-house in-training fee.
4. Reclass \$8.51 from Seminar to Employee Reimb. Mileage. Coding error in reimb. Of employee mileage.
5. Reclass \$443.20 from Seminar to Building Supplies. Coding error in reporting expense of new sign.

Schedule IX

Lender	Related	Purpose	Monthly pay	Date of not	Orig. amt	Balance	Maturity	Interest	Interest Expense
Bank of Stronghurst	No	Cash Flow Interest	O:	4/7/2006	\$45,000.00	\$0.00	5/8/2006	5.2000	\$83.34
Bank of Stronghurst	No	Cash Flow Interest	O:	5/5/2006	\$150,000.00	\$0.00	6/5/2006	5.6000	\$805.47
Bank of Stronghurst	No	Cash Flow Interest	O:	5/5/2006	\$45,000.00	\$0.00	6/5/2006	5.2000	\$224.38
Bank of Stronghurst	No	Cash Flow Interest	O:	4/7/2006	\$150,000.00	\$0.00	5/8/2006	5.6000	\$644.38
Bank of Stronghurst	No	Cash Flow Interest	O:	3/7/2006	\$150,000.00	\$0.00	4/7/2006	5.6000	\$713.42
Bank of Stronghurst	No	Cash Flow Interest	O:	2/7/2006	\$100,000.00	\$0.00	3/9/2006	5.6000	\$429.58
Bank of Stronghurst	No	Cash Flow Interest	O:	1/6/2006	\$100,000.00	\$0.00	2/6/2006	5.6000	\$490.95
Bank of Stronghurst	No	Cash Flow Interest	O:	12/7/2005	\$50,000.00	\$0.00	1/6/2006	5.6000	\$38.38
Bank of Stronghurst	No	Cash Flow Interest	O:	6/9/2006	\$45,000.00	\$0.00	7/10/2006	5.2000	\$38.46
Bank of Stronghurst	No	Cash Flow Interest	O:	11/7/2006	\$100,000.00	\$0.00	12/7/2006	7.1500	\$587.67
Bank of Stronghurst	No	Cash Flow Interest	O:	10/16/2006	\$75,000.00	\$0.00	11/13/2006	7.1500	\$323.21
Bank of Stronghurst	No	Cash Flow Interest	O:	9/13/2006	\$75,000.00	\$0.00	10/13/2006	7.1500	\$484.82
Bank of Stronghurst	No	Cash Flow Interest	O:	8/30/2006	\$150,000.00	\$0.00	9/13/2006	5.6000	\$322.19
Bank of Stronghurst	No	Cash Flow Interest	O:	7/17/2006	\$150,000.00	\$0.00	8/17/2006	5.6000	\$1,012.60
Bank of Stronghurst	No	Cash Flow Interest	O:	6/9/2006	\$150,000.00	\$0.00	7/10/2006	5.6000	\$874.52
Bank of Stronghurst	No	Cash Flow Interest	O:	12/7/2006	\$100,000.00	\$100,000.00	1/6/2007	7.1500	\$528.90
						<u>\$1,635,000.00</u>	<u>\$100,000.00</u>		<u>\$7,602.27</u>

Henderson County Retirement Center, Inc.
#0035246
01/01/06 to 12/31/06

Schedule V. Line 6, Column 3

REPAIRS & MAINT DIETARY	\$589.63
REPAIRS & MAINT BUILDING	\$7,418.46
REPAIRS & MAINT EQUIP	\$5,608.39
REPAIRS & MAINT GROUNDS	\$253.17
REPAIRS & MAINT LAUNDRY	\$741.45
REPAIRS & MAINT HSK	\$0.00
REPAIRS & MAINT CABLE	\$299.85
REPAIRS & MAINT ALARM	\$1,066.99
REPAIRS & MAINT GEN/ADM	\$2,800.96
OUTSIDE SERVICES	\$33,121.31
REFUSE	\$6,739.34
Rent	\$0.00
EXTERMINATOR	\$0.00
TOTAL	<u>\$88,699.55</u>

Schedule V. Line 21, Column 3

TELEPHONE EXPENSE	\$7,302.57
Board Minutes	\$225.00
Software Support	\$7,332.74
IVANS Medicare Billings	\$136.31
TOTAL	<u>\$14,996.62</u>

Schedule V. Line 14 & 25, Column 2 (90% to line 14)

Auto Exp. & Service	\$529.92
Auto Gas & Oil	\$1,480.63
Business Mileage Expense	<u>\$822.47</u>
	\$2,833.02

Schedule V. Line 43, Column 3

Misc. Exp.	\$123.98
Rounding	-\$1.00
Charitable Contributions	<u>\$50.00</u>
	\$172.98

Schedule XX. Question 12

All salaries are allocated on the basis of actual time worked in each department.

Schedule XVII, Line 28a, Column 1

Diaper Income	\$14,541.00
Admissions	\$810.00
Activity Program Income	\$50.00
Rebates	\$9.20
Miscellaneous	\$48.81
Dues	\$725.00
Rounding	<u>\$2.00</u>
	<u>\$16,186.01</u>

Schedule XIX, Section F.

Hawkeye Subscription	\$135.00
MES of IL Subscription	\$38.28
Bank of Stronghurst-Safe Deposit Box Fee	\$9.00
LTCMA Dues	\$70.00
AMNAC Dues	\$110.00
House of White Birch-Subscription	\$40.90
Gary Grimm & Assoc. -Subscription	\$29.95
The Henderson County Quill-Newspaper Subscription	\$24.00
Sentimental Reflections-Subscription	\$96.00
Reiman Publications-Subscriptions	\$547.55
IL Department of Public Health-Shared Housing Lic	\$150.00
IL Department of Public Health-P.S. Sanitation Ce	\$35.00
IL Charity Bureau Fund- IL 990 Fee	\$15.00
CLIA Laboratory Program-Cert. Fee	\$150.00
Sec. of State-Annual Report Fee	\$5.00
Sec. of State-Notary Fee	\$10.00
Henderson County-Health permit	\$100.00
Henderson County Clerk-Notary Seal	\$5.00
Rounding	-\$1.00
	<u>\$1,869.68</u>

