

		FOR BHF USE					

LL1

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

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

**I. IDPH Facility ID Number:** 0045872

**Facility Name:** Lakeland Rehab & HCC

**Address:** 800 West Temple Avenue Effingham 62401  
 Number City Zip Code

**County:** Effingham

**Telephone Number:** (217) - 342 - 2171 Fax # (217) - 342 - 2258

**HFS ID Number:** 51-0271905005

**Date of Initial License for Current Owners:** 5/1/1984

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input 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 checked="" 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:** Ken Marx, BKD, LLP **Telephone Number:** (314) - 231 - 5544

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2006 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>Clark Ribordy, THCSLLC, Mgmt. Co.</u>	
	(Title) _____	
<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 Lakeland Rehab & HCC# 0045872 Report Period Beginning: 1/1/2006 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>123</u>	Skilled (SNF)	<u>123</u>	<u>44,895</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>123</u>	TOTALS	<u>123</u>	<u>44,895</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>19,934</u>	<u>13,483</u>	<u>7,139</u>	<u>40,556</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>19,934</u>	<u>13,483</u>	<u>7,139</u>	<u>40,556</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.34%

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 - NoneF. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 &amp; 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 06/08/1994

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

YES  Date 06/08/1994 NO 

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

YES  NO  If YES, enter number of beds certified 123 and days of care provided 7,139Medicare Intermediary Mututal of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Lakeland Rehab & HCC # 0045872 Report Period Beginning: 1/1/2006 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	160,702	13,743	9,062	183,507		183,507	(2,884)	180,623			1
2	Food Purchase		201,564		201,564		201,564	(1,955)	199,609			2
3	Housekeeping		12,282	91,703	103,985		103,985		103,985			3
4	Laundry		16,444	61,096	77,540		77,540		77,540			4
5	Heat and Other Utilities			134,295	134,295		134,295		134,295			5
6	Maintenance	70,781	25,468	62,124	158,373		158,373		158,373			6
7	Other (specify):* <b>Trash Removal</b>			4,388	4,388		4,388		4,388			7
8	<b>TOTAL General Services</b>	<b>231,483</b>	<b>269,501</b>	<b>362,668</b>	<b>863,652</b>		<b>863,652</b>	<b>(4,839)</b>	<b>858,813</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			8,935	8,935		8,935		8,935			9
10	Nursing and Medical Records	1,617,204	76,327	8,131	1,701,662		1,701,662		1,701,662			10
10a	Therapy			412,900	412,900		412,900		412,900			10a
11	Activities	67,193	1,994	6,220	75,407		75,407		75,407			11
12	Social Services	83,987		2,870	86,857		86,857		86,857			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>1,768,384</b>	<b>78,321</b>	<b>439,056</b>	<b>2,285,761</b>		<b>2,285,761</b>		<b>2,285,761</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	77,212	203		77,415		77,415		77,415			17
18	Directors Fees											18
19	Professional Services			417,334	417,334		417,334		417,334			19
20	Dues, Fees, Subscriptions & Promotions			44,630	44,630		44,630	(26,021)	18,609			20
21	Clerical & General Office Expenses	84,111	35,321	135,398	254,830		254,830	(80,567)	174,263			21
22	Employee Benefits & Payroll Taxes			331,139	331,139		331,139		331,139			22
23	Inservice Training & Education			370	370		370		370			23
24	Travel and Seminar			5,131	5,131		5,131		5,131			24
25	Other Admin. Staff Transportation			10,878	10,878		10,878		10,878			25
26	Insurance-Prop.Liab.Malpractice			109,575	109,575		109,575		109,575			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	<b>161,323</b>	<b>35,524</b>	<b>1,054,455</b>	<b>1,251,302</b>		<b>1,251,302</b>	<b>(106,588)</b>	<b>1,144,714</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,161,190</b>	<b>383,346</b>	<b>1,856,179</b>	<b>4,400,715</b>		<b>4,400,715</b>	<b>(111,427)</b>	<b>4,289,288</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 Lakeland Rehab & HCC #0045872 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			147,015	147,015		147,015		147,015		30
31	Amortization of Pre-Op. & Org.			14,198	14,198		14,198	(14,198)			31
32	Interest			143,024	143,024		143,024	(163)	142,861		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			7,963	7,963		7,963		7,963		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			312,200	312,200		312,200	(14,361)	297,839		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		215,690	51,860	267,550		267,550		267,550		39
40	Barber and Beauty Shops	102,005	(90,107)		11,898		11,898		11,898		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			77,223	77,223		77,223		77,223		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>	102,005	125,583	129,083	356,671		356,671		356,671		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,263,195	508,929	2,297,462	5,069,586		5,069,586	(125,788)	4,943,798		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 Lakeland Rehab & HCC

# 0045872

Report Period Beginning: 1/1/2006

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	(2,884)	1		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	(163)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,955)	2		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		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(52,307)	21		24
25	Fund Raising, Advertising and Promotional	(26,021)	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	(313)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (83,663)</b>		<b>\$</b>	<b>30</b>

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	(14,198)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(27,927)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (42,125)</b>		<b>36</b>
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (125,788)</b>		<b>37</b>

\*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>			<b>\$</b>		<b>47</b>

BHF USE ONLY						
48		49		50		51
						52

Lakeland Rehab & HCC

ID# 0045872

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Miscellaneous Income	\$ (313)	21
2			
3			
4			
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12			
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48			
49	<b>Total</b>	(313)	

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Lakeland Rehab &amp; HCC

# 0045872

Report Period Beginning:

1/1/2006

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	(2,884)	0	0	0	0	0	0	0	0	0	0	(2,884)	1
2	Food Purchase	(1,955)	0	0	0	0	0	0	0	0	0	0	(1,955)	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	<b>TOTAL General Services</b>	<b>(4,839)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(4,839)</b>	<b>8</b>
	<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	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(26,021)	0	0	0	0	0	0	0	0	0	0	(26,021)	20
21	Clerical & General Office Expenses	(52,640)	(27,927)	0	0	0	0	0	0	0	0	0	(80,567)	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>	<b>(78,661)</b>	<b>(27,927)</b>	<b>0</b>	<b>(106,588)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(83,500)</b>	<b>(27,927)</b>	<b>0</b>	<b>(111,427)</b>	<b>29</b>								

STATE OF ILLINOIS

Facility Name & ID Number Lakeland Rehab & HCC

# 0045872

Report Period Beginning:

1/1/2006 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.	(14,198)	0	0	0	0	0	0	0	0	0	0	(14,198)	31
32	Interest	(163)	0	0	0	0	0	0	0	0	0	0	(163)	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>	<b>(14,361)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(14,361)</b>	<b>37</b>
	<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>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(97,861)</b>	<b>(27,927)</b>	<b>0</b>	<b>(125,788)</b>	<b>45</b>								

**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
Midwest Care Centers	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	21 Clerical & Other Gen Office	\$ 55,553	Midwest Care Centers, Inc	100.00%	\$ 27,626	\$ (27,927)	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		\$ 55,553			\$ 27,626	\$ * (27,927)	14

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

Facility Name &amp; ID Number

Lakeland Rehab &amp; HCC

#

0045872

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

## VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Lakeland Rehab & HCC

# 0045872 Report Period Beginning: 1/1/2006

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	21	Clerican & Other Gen Office	Direct Costs	14,230,876	3	\$ 78,484	\$ 0	5,014,031	\$ 27,653	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					\$ 78,484	\$		\$ 27,653	25

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Effingham Calss 4 (D) Bonds		X	Mortgage	Varies	4/1/1983	\$ 4,750,000	\$ 82,113	12/1/2014	0.1300	\$	1								
2			X	Operational	Varies	4/10/2002	2,000,000	1,848,206	12/31/2007	0.0475	143,024	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Interest Income		X	Working Capital							(163)	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 6,750,000	\$ 1,930,319			\$ 142,861	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>						\$ 6,750,000	\$ 1,930,319			\$ 142,861	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 Lakeland Rehab & HCC COUNTY Effingham

FACILITY IDPH LICENSE NUMBER 0045872

CONTACT PERSON REGARDING THIS REPORT Junior Fostster, THCSLLC, Management Co.

TELEPHONE (816) - 444 - 0900 FAX #: (816) - 822 - 1723

**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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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 Lakeland Rehab & HCC

# 0045872 Report Period Beginning:

1/1/2006 Ending: 12/31/2006

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 50,500 B. General Construction Type: Exterior Brick Frame Block 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).

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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: 42,593 2. Number of Years Over Which it is Being Amortized: Various  
3. Current Period Amortization: 14,198 4. Dates Incurred: Various

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>30,248</u>	1
2					2
3	<b>TOTALS</b>			\$ <b>30,248</b>	3

Facility Name &amp; ID Number Lakeland Rehab &amp; HCC

# 0045872

Report Period Beginning:

1/1/2006

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			2002	71	\$ 1,840,770	\$ 61,359	30	\$ 61,359	\$	\$ 281,229	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Nurse Call System	2002		13,503	1,350	10	1,350		5,964	9
10		Cove Base for 21 rooms	2002		1,148	77	15	77		337	10
11		Carpet for office complex	2002		1,199	240	5	240		1,019	11
12		Nurse station	2002		7,950	795	10	795		3,379	12
13		Tile floor	2002		1,751	88	20	88		358	13
14		Air condition units	2002		66,357	3,318	20	3,318		13,548	14
15		New tile floor	2002		9,144	457	20	457		2,019	15
16		Carpet for front office	2003		1,118	224	5	224		876	16
17		Mixing valve/hot water heater	2003		977	98	10	98		358	17
18		Steel exit door	2003		661	33	20	33		113	18
19		Resident room flooring	2003		585	59	10	59		200	19
20		Resident room flooring	2003		621	62	10	62		248	20
21		Resident room tile	2004		1,746	175	10	175		510	21
22		Tile for shower	2004		845	84	10	84		232	22
23		Upgrade HVAC system	2004		23,133	2,313	10	2,313		6,361	23
24		Remaining balance on a/c units	2004		5,530	276	20	276		737	24
25		Remodel soffit	2004		284	28	10	28		62	25
26		Window replacement	2004		11,863	791	15	791		2,109	26
27		Floor covering	2004		22,061	2,206	10	2,206		4,780	27
28		Shower wall repair & flooring	2004		12,157	608	20	608		1,317	28
29		Convert 5 stalls to handicapped	2004		13,572	679	20	679		1,810	29
30		Wall repair, wall paper, paint	2004		12,626	2,525	5	2,525		5,471	30
31		ADA site visit for stall conversion	2004		4,594	919	5	919		2,450	31
32		Remodel resident rooms	2004		2,730	273	10	273		569	32
33		Floor covering	2004		735	74	10	74		153	33
34		Floor covering	2004		735	73	10	73		184	34
35		Door locks	2004		761	152	5	152		406	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 Lakeland Rehab &amp; HCC

# 0045872

Report Period Beginning:

1/1/2006

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	Front door	2004	\$ 728	\$ 73	10	\$ 73	\$	\$ 188	37
38	Double doors for entrance	2004	5,735	573	10	573		1,482	38
39	Drop in lighting	2004	7,363	736	10	736		1,718	39
40	Wallpaper dining room & hallways	2004	13,798	2,760	5	2,760		5,979	40
41	Ceiling tiles	2004	14,025	1,402	10	1,402		3,623	41
42	Ceiling tiles	2004	6,134	613	10	613		1,789	42
43	Boiler room doors	2004	5,445	363	15	363		817	43
44	Landscaping	2004	4,500	450	10	450		1,200	44
45	Sign	2004	4,380	438	10	438		1,022	45
46	Fire suppression system	2005	1,675	67	25	67		101	46
47	Parking lot paving	2005	36,630	4,579	8	4,579		5,342	47
48	Labor to renovations re: patient rooms	2005	6,900	690	10	690		1,265	48
49	Fountain restoration	2005	4,501	300	15	300		338	49
50	Painting	2005	5,408	1,082	5	1,082		1,262	50
51	Painting window trim	2005	750	150	5	150		175	51
52	Sidewalk	2006	1,455	30	15	30		30	52
53	Smoke Detector	2006	658	66	10	66		71	53
54	Framework and painting of exterior doors	2006	675	135	5	135		157	54
55	Louvered shutters	2006	871	114	7	114		114	55
56	Parking blocks and pins	2006	956	159	5	159		159	56
57	remodeled rooms	2006	1,152	76	7	76		76	57
58	roof replacement	2006	172,157	11,477	10	11,477		11,477	58
59	fire alarm equipment for halls	2006	8,385	559	10	559		559	59
60	pocket doors	2006	3,646	58	20	58		58	60
61	doors and frames	2006	1,976	66	20	66		66	61
62	carpet for front entrance	2006	550	37	5	37		37	62
63	outside lighting	2006	13,133	288	10	288		288	63
64	hall shower/bathroom	2006	1,063	7	12	7		7	64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 2,383,805	\$ 106,684		\$ 106,684	\$	\$ 376,199	70

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

Facility Name & ID Number Lakeland Rehab & HCC # 0045872 Report Period Beginning: 1/1/2006 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	\$ 266,552	\$ 38,018	\$ 38,018	\$	various	\$ 122,577	71
72	Current Year Purchases	21,938	2,225	2,225		various	2,284	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 288,490	\$ 40,243	\$ 40,243	\$		\$ 124,861	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 2,702,543	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 146,927	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 146,927	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)	\$ 501,060	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 Lakeland Rehab & HCC

# 0045872

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

**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:	<u>N/A</u>			\$ _____			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: \$ 7,530 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	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	\$	2,033	\$ 123,130	\$	2,033	\$ 123,130	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		318	23,274		318	23,274	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		4,427	252,836		4,427	252,836	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	<b>TOTAL</b>			\$	6,778	\$ 399,240	\$	6,778	\$ 399,240	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 Lakeland Rehab & HCC# 0045872Report Period Beginning: 1/1/2006

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	\$ 390,787	\$	1
2	Cash-Patient Deposits	15,178		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	912,566		3
4	Supply Inventory (priced at )	14,352		4
5	Short-Term Investments			5
6	Prepaid Insurance	27,190		6
7	Other Prepaid Expenses	1,285		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,361,358	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	30,248		13
14	Buildings, at Historical Cost	2,373,470		14
15	Leasehold Improvements, at Historical Cost	10,335		15
16	Equipment, at Historical Cost	288,490		16
17	Accumulated Depreciation (book methods)	(501,060)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	42,593		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(28,395)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>work in progress</u>	7,900		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,223,581	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,584,939	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 262,317	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,178		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	117,783		30
31	Accrued Taxes Payable (excluding real estate taxes)	53,705		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Other Accrued Expenses</u>	32,943		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 481,926	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,930,320		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,930,320	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,412,246	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,172,693	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,584,939	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 690,984	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 690,984	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	481,709	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 481,709	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)	\$ 1,172,693	24 *

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

Facility Name & ID Number Lakeland Rehab & HCC# 0045872Report Period Beginning: 1/1/2006Ending: 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	\$ 4,606,200	1
2	Discounts and Allowances for all Levels	(347,627)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,258,573	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	807,722	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 807,722	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	180	13
14	Non-Patient Meals	2,884	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	390,392	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	36,408	19
20	Radiology and X-Ray		20
21	Other Medical Services	56,401	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 486,265	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	163	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 163	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Miscellaneous Income</b>	(1,428)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (1,428)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,551,295	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	863,652	31
32	Health Care	2,285,761	32
33	General Administration	1,251,302	33
<b>B. Capital Expense</b>			
34	Ownership	312,200	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	356,671	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>	\$ 5,069,586	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	481,709	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 481,709	43

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

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

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

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

Facility Name & ID Number Lakeland Rehab & HCC

# 0045872

Report Period Beginning:

1/1/2006

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	11,100	11,297	\$ 248,581	\$ 22.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,678	8,753	204,351	23.35	3
4	Licensed Practical Nurses	21,005	21,177	349,349	16.50	4
5	CNAs & Orderlies	68,744	69,226	732,991	10.59	5
6	CNA Trainees	4,960	5,035	64,571	12.82	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,462	5,993	67,193	11.21	10
11	Social Service Workers	5,876	5,964	83,987	14.08	11
12	Dietician	18,849	18,960	160,702	8.48	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,863	5,935	70,781	11.93	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,016	2,032	76,481	37.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,600	6,659	85,006	12.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,809	1,853	17,197	9.28	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	160,962	162,884	\$ 2,161,190 *	\$ 13.27	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	120	\$ 9,062	1,3	35
36	Medical Director				36
37	Medical Records Consultant	51	2,309	10,3	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	57	2,870	11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	228	\$ 14,241		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 Lakeland Rehab & HCC

# 0045872

Report Period Beginning: 1/1/2006

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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			
Stephen Hopkins	Administrator		\$ 77,212	Workers' Compensation Insurance	\$ 112,038	IDPH License Fee	\$			
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	661			
				FICA Taxes	167,751	Health Care Worker Background Check				
				Employee Health Insurance	21,583	(Indicate # of checks performed _____)				
				Employee Meals		<b>Dues and Subscriptions</b>	15,698			
				Illinois Municipal Retirement Fund (IMRF)*		<b>Advertising &amp; PR</b>	26,021			
				<b>Other Benefits</b>	29,767	<b>Licenses</b>	2,250			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 77,212							
(List each licensed administrator separately.)										
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		
	\$					\$	Out-of-State Travel	\$		
							In-State Travel	5,131		
							Seminar Expense			
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 331,139	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 18,609
(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			
Please See Attached...	Purchased Services	\$ 27,046			\$	Out-of-State Travel	\$			
Tutera Health Care Services	Management Fees	333,316								
BKD, LLP	Accounting Fees	19,697								
Michael Flanagan	Legal Fees	18,500				In-State Travel	5,131			
Dan Maher	Legal Fees	200								
Shook Hardy & Bacon	Legal Fees	270								
Emdeon Business Services	Data Processing Fees	591								
Galaxy Hosted Software	Data Processing Fees	13,200				Seminar Expense				
Method Design	Data Processing Fees	1,350								
Mututal Of Omaha	Data Processing Fees	239								
E Health Data	Data Processing Fees	2,100								
Pinnacle Consulting	Professional Fees	825				Entertainment Expense	( )			
TOTAL (agree to Schedule V, line 19, column 3)			\$ 417,334	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 5,131
(If total legal fees exceed \$5,000, attach copy of invoices.)										

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Lakeland Rehab &amp; HCC

**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. 7783- Illinois Health Care Association
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,332 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 77,223  
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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,884
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A 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. N/A
- (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? No  
Attach invoices and a summary of services for all architect and appraisal fees.