

		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.

<p>I. IDPH Facility ID Number: <u>0010637</u></p> <p>Facility Name: <u>LASALLE COUNTY NURSING HOME</u></p> <p>Address: <u>1380 NORTH 27TH ROAD</u> <u>OTTAWA</u> <u>61350</u> Number City Zip Code</p> <p>County: <u>LA SALLE</u></p> <p>Telephone Number: <u>(815) 433-0476</u> Fax # <u>(815) 433-9321</u></p> <p>HFS ID Number: <u>69-03333027001</u></p> <p>Date of Initial License for Current Owners: <u>1945</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input checked="" type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>ADRIENNE ERICKSON</u> Telephone Number: <u>(815) 433-0476</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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 checked="" type="checkbox"/> County	IRS Exemption Code _____	<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 _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/01/05</u> to <u>11/30/06</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ <u>2/27/07</u> (Date)</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>ADRIENNE ERICKSON</u></td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td></td> <td>(Signed) _____ <u>02/27/07</u> (Date)</td> </tr> <tr> <td>Paid Preparer</td> <td>(Print Name and Title) <u>CARRIE ECHOLS</u> <u>CPA</u></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>ECHOLS, MACK & ASSOCIATES, P.C.</u> <u>116 E WASHINGTON, STE ONE, MORRIS, IL 60450</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(815) 942-3306</u> Fax # <u>(815) 942-9430</u></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____ <u>2/27/07</u> (Date)		(Type or Print Name) <u>ADRIENNE ERICKSON</u>		(Title) _____		(Signed) _____ <u>02/27/07</u> (Date)	Paid Preparer	(Print Name and Title) <u>CARRIE ECHOLS</u> <u>CPA</u>		(Firm Name & Address) <u>ECHOLS, MACK & ASSOCIATES, P.C.</u> <u>116 E WASHINGTON, STE ONE, MORRIS, IL 60450</u>		(Telephone) <u>(815) 942-3306</u> Fax # <u>(815) 942-9430</u>
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Facility Name & ID Number LASALLE COUNTY NURSING HOME

0010637 Report Period Beginning: 12/01/05 Ending: 11/30/06

III. STATISTICAL DATA

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

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	104	Intermediate/DD	104	37,960	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	104	TOTALS	104	37,960	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Medicaid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	15,834	14,695		30,529	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,834	14,695		30,529	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.42%

D. How many bed-hold days during this year were paid by the Department? NONE (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO

I. On what date did you start providing long term care at this location? Date started 11/1/1965

J. Was the facility purchased or leased after January 1, 1978? YES Date _____ NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: N/A Fiscal Year: 12/01/05-11/30/06

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

STATE OF ILLINOIS

Facility Name & ID Number LASALLE COUNTY NURSING HOME # 0010637 Report Period Beginning: 12/01/05 Ending: 11/30/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary		3,913		3,913		3,913		3,913		1
2	Food Purchase		605,283		605,283		605,283	(11,704)	593,579		2
3	Housekeeping	147,855	18,293	11,207	177,355		177,355		177,355		3
4	Laundry	71,700	11,869	53,195	136,764		136,764		136,764		4
5	Heat and Other Utilities			131,740	131,740		131,740		131,740		5
6	Maintenance	224,289	15,307	29,788	269,384		269,384	53,088	322,472		6
7	Other (specify):*										7
8	TOTAL General Services	443,844	654,665	225,930	1,324,439		1,324,439	41,384	1,365,823		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,496,217	73,249	340,220	1,909,686		1,909,686		1,909,686		10
10a	Therapy										10a
11	Activities	105,166	8,249		113,415		113,415		113,415		11
12	Social Services	68,990			68,990		68,990		68,990		12
13	CNA Training										13
14	Program Transportation		389		389		389		389		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,670,373	81,887	340,220	2,092,480		2,092,480		2,092,480		16
	C. General Administration										
17	Administrative	88,754			88,754		88,754	31,543	120,297		17
18	Directors Fees										18
19	Professional Services							35,123	35,123		19
20	Dues, Fees, Subscriptions & Promotions			41,517	41,517		41,517	(35,123)	6,394		20
21	Clerical & General Office Expenses	128,727	5,814		134,541		134,541	28,675	163,216		21
22	Employee Benefits & Payroll Taxes			611,244	611,244		611,244	11,704	622,948		22
23	Inservice Training & Education			16,126	16,126		16,126	(15,328)	798		23
24	Travel and Seminar							15,328	15,328		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*				(47)		(47)		(47)		27
28	TOTAL General Administration	217,481	5,814	668,887	892,135		892,135	71,922	964,057		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,331,698	742,366	1,235,037	4,309,054		4,309,054	113,306	4,422,360		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

LASALLE COUNTY NURSING HOME

#0010637

Report Period Beginning:

12/01/05

Ending:

11/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			136,460	136,460		136,460		136,460			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			136,460	136,460		136,460		136,460			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		6,688		6,688		6,688		6,688			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			947,104	947,104		947,104		947,104			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		6,688	947,104	953,792		953,792		953,792			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,331,698	749,054	2,318,601	5,399,306		5,399,306	113,306	5,512,612			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 **LASALLE COUNTY NURSING HOME**

0010637

Report Period Beginning: **12/01/05**

Ending: **11/30/06**

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

BHF USE ONLY					
48		49	50	51	52

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))	\$		37

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

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

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

LASALLE COUNTY NURSING HOME

ID# 0010637

Report Period Beginning: 12/01/05

Ending: 11/30/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
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28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LASALLE COUNTY NURSING HOME

0010637

Report Period Beginning:

12/01/05

Ending:

11/30/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	53,088	0	0	0	0	0	0	0	0	0	53,088	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	53,088	0	0	0	0	0	0	0	0	0	53,088	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	31,543	0	0	0	0	0	0	0	0	0	31,543	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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	28,675	0	0	0	0	0	0	0	0	0	28,675	21
22	Employee Benefits & Payroll Taxes	0	126,132	0	0	0	0	0	0	0	0	0	126,132	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	TOTAL General Administration	0	186,350	0	0	0	0	0	0	0	0	0	186,350	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	239,438	0	0	0	0	0	0	0	0	0	239,438	29

Facility Name & ID Number LASALLE COUNTY NURSING HOME

0010637

Report Period Beginning:

12/01/05

Ending:

11/30/06

VII. RELATED PARTIES

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

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

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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	6 MAINTENANCE	\$		N/A	\$ 53,088	\$ 53,088 1
2	V	17 ADMIN SERVICES			N/A	31,543	31,543 2
3	V	21 CLERICAL SERVICES			N/A	28,675	28,675 3
4	V	22 UNEMPLOYMENT COMP			N/A	16,020	16,020 4
5	V	22 WORKER'S COMP			NA	110,112	110,112 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		\$			\$ 239,438	\$ * 239,438 14

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

Facility Name & ID Number LASALLE COUNTY NURSING HOME # 0010637 Report Period Beginning: 12/01/05 Ending: 11/30/06

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number LASALLE COUNTY NURSING HOME # 0010637 Report Period Beginning: 12/01/05 Ending: 11/30/06

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization COUNTY OF LASALLE
 Street Address 707 ETNA ROAD
 City / State / Zip Code OTTAWA, ILLINOIS 61350
 Phone Number (815) 433-0476
 Fax Number ()

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE-COUNTY	DAYS	250	\$ 189,601	\$	70	\$ 53,088	1
2	17	ADMIN - COUNTY	DAYS	250	112,653		70	31,543	2
3	21	CLERICAL-COUNTY	DAYS	250	102,410		70	28,675	3
4	22	UNEMPLOYMENT COMP	DIRECT COST	100	16,020		100	16,020	4
5	22	WORKER'S COMP	DIRECT COST	100	110,112		100	110,112	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				\$ 530,796	\$		\$ 239,438	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
	A. Directly Facility Related																			
	Long-Term																			
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
	Working Capital																			
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$	\$			\$	9								
	B. Non-Facility Related*																			
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$	\$			\$	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 LASALLE COUNTY NURSING HOME COUNTY LA SALLE

FACILITY IDPH LICENSE NUMBER 0010637

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 LASALLE COUNTY NURSING HOME# 0010637 Report Period Beginning:12/01/05 Ending:11/30/06**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 47,592 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2C. 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	<u>GROUND</u>	<u>513,000</u>	<u>1960</u>	<u>\$ 9,950</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	513,000		\$ 9,950	3

Facility Name & ID Number LASALLE COUNTY NURSING HOME# 0010637

Report Period Beginning:

12/01/05

Ending:

11/30/06**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	104		1965	\$ 480,000	\$		\$	\$	\$ 480,000	4
5			1965	280,000					280,000	5
6			1967	51,675					51,675	6
7			1969	123,087					123,087	7
8			1970	164,927					164,927	8
Improvement Type**										
9	Building improvements		1966	4643		30			4,643	9
10	Building improvements		1968	35441		30			35,441	10
11	Building improvements		1969	9575		30			9,575	11
12	Landscaping		1970	12456		20			12,456	12
13	Garage & Blacktopping		1971	22125		20			22,125	13
14	Blacktop seal		1972	1487		20			1,487	14
15	Kitchen Fire System		1974	985		25			985	15
16	Fire door & fire detectors & roof section		1975	6381		30			6,391	16
17	Boil & roof repairs & fire doors		1976	24443		20			24,443	17
18	Roof repairs & generator & plumbing repairs		1977	28326		20			28,326	18
19	Roof repairs & cable installation & painting		1978	25471		20			25,471	19
20	Roof repairs and painting water tower		1979	40012		20			40,012	20
21	Shower, mixing valve, roof repair, road asphalt, fence		1980	54262		20			54,262	21
22	Signs, sewer, retubing boiler		1981	31671		20			31,671	22
23	New boiler, air cndtr, windows, door alarm, sprinklers		1982	289413		20			289,413	23
24	Sprinkler system, hydrantd, water tank, closet doors, chimney		1983	23135		20			23,135	24
25	Boiler room, roof repairs, paint in A & B wings		1984	17164		20			17,164	25
26	Swer repairs, call page system, telephone, curtains		1985	38629		20			38,629	26
27	Swewer improvements		1986	182002	6,067	30	6,067		122,348	27
28	Sewer improvements		1987	62084	2,069	30	2,069		40,866	28
29	Water tower paint and sidewalks		1989	43548	1,452	30	1,452		8,819	29
30	Generator, fire line, linen cooler, chimney, roof, arch		1990	269784	13,489	20	13,489		199,225	30
31	Painting, carpet, chimney, blacktop, water line, trees		1991	36959	1,848	20	1,848		31,164	31
32	Asphalt driveway, roof arch repairs		1992	4120	206	20	206		2,736	32
33	Building and land improvements		1993	60542	3,027	20	3,027		37,838	33
34	Building improvements		1994	104162		20			104,162	34
35	Fixtures		1994	3037		10			3,037	35
36										36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number LASALLE COUNTY NURSING HOME

0010637

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	WINDOW PROJECT	1995	\$ 293,711	\$ 14,686	20	\$ 14,686	\$	\$ 99,723		37
38	Cement Pad #1	1995	2,750	138	20	138		1,309		38
39	Cement Pad #2	1996	5,330	267	20	267		2,534		39
40	Porch, oxygen room	1996	33,252	1,663	20	1,663		11,639		40
41	Door alarms/ smock dectector	1996	3,110	156	20	156		2,644		41
42	Fire sprinkler system	1998	169,013	8,451	20	8,451		63,380		42
43	Code alert system	1999	26,004	1,300	20	1,300		12,571		43
44	Water tower	2000	621,990	31,100	20	31,100		186,599		44
45	Building improvements	2001	22,718	1,136	20	1,136		5,681		45
46	Emergency generator	2002	71,896	3,595	20	3,595		14,380		46
47	Water treatment system	2002	6,203	310	20	310		1,240		47
48	Water treatment system	2002	49,440	2,472	20	2,472		7,416		48
49	Water treatment system RO	2003	12,000	600	20	600		1,500		49
50	Water treatment system RO	2004	6,553	328	20	328		819		50
51	Fiber Optic improvement	2004	14,776	739	20	739		1,847		51
52	Water treatment system	2004	124,767	6,238	20	6,238		15,596		52
53	Water treatment system	2005	24,524	1,226	20	1,226		2,452		53
54	Water treatment system	2005	4,328	216	20	216		289		54
55	Sewer	2005	9,747	487	20	487		731		55
56	Manhold	2005	965	48	20	48		76		56
57	Dining room blinds	2005	3,331	333	10	333		527		57
58	Sidewalk improvements	2005	3,584	179	20	179		299		58
59	ACCU-MED clinical software	2006	4,887	407	3	407		407		59
60	1 Dell	2006	4,040	337	3	337		337		60
61	1 DeLL Dimension	2006	1,200	367	3	367		367		61
62	1 DeLL Dimension	2006	1,215	371	3	371		371		62
63	1 DeLL Dimension	2006	732	81	3	81		81		63
64	1 DeLL Dimension	2006	732	81	3	81		81		64
65	1 DeLL Dimension	2006	732	81	3	81		81		65
66	1 DeLL Dimension	2006	732	81	3	81		81		66
67	1 DeLL Dimension	2006	732	81	3	81		81		67
68	1 HP LJ printer	2006	698	194	3	194		194		68
69	Code alert system	2006	3,360	672	5	672		672		69
70	TOTAL (lines 4 thru 69)		\$ 4,060,598	\$ 106,579		\$ 106,579	\$	\$ 2,751,518		70

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

STATE OF ILLINOIS

Facility Name & ID Number LASALLE COUNTY NURSING HOME

0010637

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 4,060,598	\$ 106,579		\$ 106,579		\$ 2,751,518		1
2	Snow blower	2006 649	130	5	130		130		2
3	Printer	2006 890	247	3	247		247		3
4	Carpeting-front office	2006 2,259	75	20	75		75		4
5	Pressure Washer	2006 223	15	5	15		15		5
6	Dell comp	2006 472	13	3	13		13		6
7	Copier	2006 291	8	3	8		8		7
8	New Carpeting	2006 1,599	7	20	7		7		8
9	Appliances	2006 1,820	91	5	91		91		9
10	New Equip, home depot	2006 7,541	126	5	126		126		10
11	Equip under \$200	2006 1,706	47	3	47		47		11
12	1 vertical blind	2006 3,330	333	10	333		333		12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 4,081,378	\$ 107,671		\$ 107,671		\$ 2,752,610		34

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

Facility Name & ID Number LASALLE COUNTY NURSING HOME

0010637

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 612,569	\$ 14,449	\$ 14,449	\$		\$ 739,516	71
72	Current Year Purchases	39,840	3,845	3,845			3,845	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 652,409	\$ 18,294	\$ 18,294	\$		\$ 743,361	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	TRANSPORT RESIDENTS	2005 FORD VAN	2005	\$ 58,741	\$ 8,392	\$ 8,392	\$	7	\$ 12,587	76
77	TRANSPORT RESIDENTS	DODGE GRND CARAVAN	2006	15,775	2,103	2,103		7	2,103	77
78										78
79										79
80	TOTALS			\$ 74,516	\$ 10,495	\$ 10,495	\$		\$ 14,690	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,818,253	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 136,460	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 136,460	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)	\$ 3,510,661	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	PARKING IMPROVEMENTS 1972	\$ 11,751	\$	\$ 11,751	86
87	IMPROVEMENTS G2 1974	4,900		4,900	87
88	AUTO 1994	3,600		3,600	88
89					89
90					90
91	TOTALS	\$ 20,251	\$	\$ 20,251	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
 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.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

STATE OF ILLINOIS

Page 17

Facility Name & ID Number LASALLE COUNTY NURSING HOME

0010637

Report Period Beginning: 12/01/05

Ending:

11/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/06

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 424,821	\$	1
2 Cash-Patient Deposits	2,318		2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	376,277		3
4 Supply Inventory (priced at)	11,188		4
5 Short-Term Investments	419,689		5
6 Prepaid Insurance			6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)	57,683		8
9 Other(specify): EMPLOYEE TRUST	20,675		9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,312,651	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	9,950		13
14 Buildings, at Historical Cost	4,047,638		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	780,927		16
17 Accumulated Depreciation (book methods)	(3,530,916)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify):			23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,307,599	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,620,250	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 258,988	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	2,318		28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	84,665		30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 EMPLOYEE TRUST	20,675		36
37 DUE TO OTHER CO FUNDS	164,141		37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 530,787	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43 Compensated absences	362,066		43
44			44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 362,066	\$	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 892,853	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ 1,727,397	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,620,250	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,560,109	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,560,109	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	167,290	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	(2)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 167,288	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)	\$ 1,727,397	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number LASALLE COUNTY NURSING HOME

0010637

Report Period Beginning: 12/01/05

Ending:

11/30/06

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,992,211	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,992,211	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	535	5
6	Therapy		6
7	Oxygen	4,676	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,211	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,361	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)	\$ 7,361	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	12,982	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,982	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PROPERTY TAX REVENUE	1,348,849	28
28a	RISK REIMBURSE	199,982	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,548,831	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,566,596	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,323,551	31
32	Health Care	2,079,062	32
33	General Administration	906,441	33
B. Capital Expense			
34	Ownership	136,460	34
C. Ancillary Expense			
35	Special Cost Centers	6,688	35
36	Provider Participation Fee	947,104	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,399,306	40
41	Income before Income Taxes (line 30 minus line 40)**	167,290	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 167,290	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 **LASALLE COUNTY NURSING HOME**

0010637

Report Period Beginning: **12/01/05**

Ending:

11/30/06

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,741	2,093	\$ 52,759	\$ 25.21	1
2	Assistant Director of Nursing	1,284	1,744	41,287	23.67	2
3	Registered Nurses	11,930	14,031	339,563	24.20	3
4	Licensed Practical Nurses	14,708	17,721	377,839	21.32	4
5	CNAs & Orderlies	46,201	54,314	501,322	9.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,520	3,158	43,667	13.83	8
9	Activity Director	1,904	2,126	45,236	21.28	9
10	Activity Assistants	6,503	7,339	59,930	8.17	10
11	Social Service Workers	3,581	4,040	68,990	17.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	8,891	10,580	224,289	21.20	17
18	Housekeepers	8,624	9,837	147,855	15.03	18
19	Laundry	3,548	4,189	71,700	17.12	19
20	Administrator	800	1,040	37,529	36.09	20
21	Assistant Administrator	1,856	2,040	51,225	25.11	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,900	6,931	128,727	18.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	1,856	2,192	32,844	14.98	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>UNIT ATTENDANT</u>	5,674	6,997	106,936	15.28	33
34	TOTAL (lines 1 - 33)	128,521	150,372	\$ 2,331,698 *	\$ 15.51	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director			36
37	Medical Records Consultant	n/a	21,748	Line 10,col 3 37
38	Nurse Consultant	n/a	1,341	Line 10,col 3 38
39	Pharmacist Consultant	n/a	1,518	Line 10,col 3 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	23	1,080	Line 10,col 3 44
45	Social Service Consultant	47	2,304	Line 10,col 3 45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	70	\$ 27,991	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	15,299	312,227	Line 10, col 1 52
53	TOTAL (lines 50 - 52)	15,299	\$ 312,227	53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
ADRIENNE ERICKSON	ADMINISTRATOR	0	\$ 37,529	Workers' Compensation Insurance	\$	IDPH License Fee	\$ 1,125	
CATHY HARVEY	ASST ADMIN	0	51,225	Unemployment Compensation Insurance		Advertising: Employee Recruitment	4,645	
				FICA Taxes		Health Care Worker Background Check	624	
				Employee Health Insurance	246,462	(Indicate # of checks performed <u>39</u>)		
				Employee Meals	11,704			
				Illinois Municipal Retirement Fund (IMRF)*	353,995			
				UNIFORMS PER UNION CONTRACT	10,787			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 88,754					
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
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
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							GENERAL TRAINING	15,328
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 15,328

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. CO NURSING HOME - \$1,125
- (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? 3
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 53,195 Line 10,col 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 NO 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. \$ 947,104
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. \$ YES Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Echols, Mack & Associates, P.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

LA SALLE COUNTY NURSING HOME

12/01/2005 - 11/30/2006

ATTACHMENT

Detail of Schedule V, line 24 (travel and seminar)

MDS/ SECTION S	195.00
IL CNCL LTC -FEED	100.00
INHAA	25.00
IAPA	270.00
ACCUMED TRAINING	3,596.00
DIRECTOR TRAINING	<u>11,142.00</u>
	15328