

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENTER# 0045948 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	91	Skilled (SNF)	91	33,215	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	91	TOTALS	91	33,215	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		Other	Total	
		Recipient	Private Pay			
8	SNF	16,503	6,890	2,149	25,542	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,503	6,890	2,149	25,542	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.90%

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 & 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 6/1/1998

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

YES Date 6/1/1998 NO

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

YES NO If YES, enter number of beds certified 91 and days of care provided 2,149Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

STATE OF ILLINOIS

Facility Name & ID Number **LEE COUNTY NURSING & REHAB CENT** # **0045948** 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				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	147,868	7,339	7,929	163,136		163,136	(5,946)	157,190		1
2	Food Purchase		135,568		135,568		135,568	(475)	135,093		2
3	Housekeeping		11,293	85,048	96,341		96,341		96,341		3
4	Laundry		10,467	58,578	69,045		69,045		69,045		4
5	Heat and Other Utilities			112,092	112,092		112,092		112,092		5
6	Maintenance	58,443	9,685	63,365	131,493		131,493		131,493		6
7	Other (specify):*										7
8	TOTAL General Services	206,311	174,352	327,012	707,675		707,675	(6,421)	701,254		8
B. Health Care and Programs											
9	Medical Director			7,762	7,762		7,762		7,762		9
10	Nursing and Medical Records	1,249,179	53,875	5,378	1,308,432		1,308,432		1,308,432		10
10a	Therapy			133,817	133,817		133,817		133,817		10a
11	Activities	72,521	395	4,785	77,701		77,701		77,701		11
12	Social Services	69,105	9	3,390	72,504		72,504		72,504		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,390,805	54,279	155,132	1,600,216		1,600,216		1,600,216		16
C. General Administration											
17	Administrative	59,490			59,490		59,490	9,617	69,107		17
18	Directors Fees										18
19	Professional Services			262,645	262,645		262,645		262,645		19
20	Dues, Fees, Subscriptions & Promotions			30,514	30,514		30,514	(17,413)	13,101		20
21	Clerical & General Office Expenses	61,748	20,513	26,011	108,272		108,272	(58,146)	50,126		21
22	Employee Benefits & Payroll Taxes			323,145	323,145		323,145		323,145		22
23	Inservice Training & Education			2,394	2,394		2,394		2,394		23
24	Travel and Seminar			5,138	5,138		5,138		5,138		24
25	Other Admin. Staff Transportation			11,686	11,686		11,686		11,686		25
26	Insurance-Prop.Liab.Malpractice			74,268	74,268		74,268		74,268		26
27	Other (specify):*										27
28	TOTAL General Administration	121,238	20,513	735,801	877,552		877,552	(65,942)	811,610		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,718,354	249,144	1,217,945	3,185,443		3,185,443	(72,363)	3,113,080		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 LEE COUNTY NURSING & REHAB CENTER #0045948 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	
30	D. Ownership											
	Depreciation			25,664	25,664		25,664	35,740	61,404			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,147	20,147		20,147	249,403	269,550			32
33	Real Estate Taxes			32,102	32,102		32,102		32,102			33
34	Rent-Facility & Grounds			248,404	248,404		248,404	(241,174)	7,230			34
35	Rent-Equipment & Vehicles			1,536	1,536		1,536	3,352	4,888			35
36	Other (specify):*											36
37	TOTAL Ownership			327,853	327,853		327,853	47,321	375,174			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		84,379	23,578	107,957		107,957		107,957			39
40	Barber and Beauty Shops		936	8	944		944		944			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,068	53,068		53,068		53,068			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		85,315	76,654	161,969		161,969		161,969			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,718,354	334,459	1,622,452	3,675,265		3,675,265	(25,042)	3,650,223			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 **LEE COUNTY NURSING & REHAB CENTER**

0045948

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	(5,946)	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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(475)	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	(2,275)	21		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	(17,309)	21		24
25	Fund Raising, Advertising and Promotional	(17,413)	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	(5,430)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (48,848)		\$	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)	23,806	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 23,806		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (25,042)		37

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

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

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

LEE COUNTY NURSING & REHAB CENTER

ID# 0045948

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Miscellaneous Income	\$ (5,430)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48	Total	(5,430)		48
49				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENTER# 0045948

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)	
	A. General Services													
1	Dietary	(5,946)	0	0	0	0	0	0	0	0	0	0	(5,946)	1
2	Food Purchase	(475)	0	0	0	0	0	0	0	0	0	0	(475)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,421)	0	0	0	0	0	0	0	0	0	0	(6,421)	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	9,617	0	0	0	0	0	0	0	0	0	9,617	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	(17,413)	0	0	0	0	0	0	0	0	0	0	(17,413)	20
21	Clerical & General Office Expenses	(25,014)	(33,132)	0	0	0	0	0	0	0	0	0	(58,146)	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	TOTAL General Administration	(42,427)	(23,515)	0	(65,942)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(48,848)	(23,515)	0	(72,363)	29								

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
Tutera Health Care Services LLC	100					
TI Dixon, LLC	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:
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	34 Building & Fixtures	\$	Tutera Health Care Services LLC	100.00%	\$ 7,230	\$ 7,230 1
2	V	35 Moveable Equipment		Tutera Health Care Services LLC	100.00%	3,352	3,352 2
3	V	21 Non-Capital	193,616	Tutera Health Care Services LLC	100.00%	160,484	(33,132) 3
4	V	30 Depreciation		TI Dixon, LLC	100.00%	35,740	35,740 4
5	V	34 Building Rent	248,404	TI Dixon, LLC	100.00%		(248,404) 5
6	V	32 Interest		TI Dixon, LLC	100.00%	249,403	249,403 6
7	V	17 Administrative and General		TI Dixon, LLC	100.00%	9,617	9,617 7
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 442,020			\$ 465,826	\$ * 23,806 14

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

Facility Name & ID Number LEE COUNTY NURSING & REHAB CEN. # 0045948 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	N/A								\$	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 LEE COUNTY NURSING & REHAB CENTER # 0045948 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 Tutera Health Care Services, LLC
 Street Address 7611 State Line road, Ste 301
 City / State / Zip Code Kansas City, MO 64114
 Phone Number (816-444-0900
 Fax Number (816-444-0900

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	Non-Capital	Direct Cost	97,645,359	12	\$ 4,929,488	\$ 3,178,915	\$ 160,483	1
2	34	Capital Building	Direct Cost	97,645,359	12	222,080	3,178,915	7,230	2
3	35	Capital Equipment	Direct Cost	97,645,359	12	102,951	3,178,915	3,352	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					\$ 5,254,519	\$	\$ 171,065	25

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENT # 0045948 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	LaSalle National Bank		X	Capital	\$5,357.00	8/2/2001	\$ 450,000	\$ 295,482			\$ 20,147	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$5,357.00		\$ 450,000	\$ 295,482			\$ 20,147	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 450,000	\$ 295,482			\$ 20,147	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,

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LEE COUNTY NURSING & REHAB CENTER COUNTY LEE

FACILITY IDPH LICENSE NUMBER 0045948

CONTACT PERSON REGARDING THIS REPORT Junior Foster, THCSLLC, Mgmt Co.

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

A. Summary of Real Estate Tax Costs

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>07-08-04-376-011</u>	<u>Building</u>	\$ <u>29,371.74</u>	\$ <u>29,371.74</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>29,371.74</u>	\$ <u>29,371.74</u>

B. Real Estate Tax Cost Allocation:

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,700 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 ground (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	Facility	28,700	2002	\$ 92,000	1
2					2
3	TOTALS	28,700		\$ 92,000	3

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	91	2002		\$ 983,365	\$ 24,584	40	\$ 24,584	\$	\$ 98,337	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Water Heater	2002		4,130	413	10	413		1,721	9
10	Water Softner	2003		5,536	554	10	554		2,214	10
11	Door Alarms	2003		3,577	358	10	358		1,431	11
12	Main entry landscaping	2004		5,482	548	10	548		1,371	12
13	Wallpaper entryway, living room	2004		9,997	1,999	5	1,999		4,832	13
14	12.5 ton heating and cooling unit	2005		8,250	825	10	825		1,306	14
15	Remodel of Alz. Unit	2005		38,517	3,852	10	3,852		5,136	15
16	Wallpaper	2005		2,271	454	5	454		606	16
17	Roof	2005		9,400	470	20	470		627	17
18	Flooring	2005		6,940	694	10	694		1,085	18
19	Handrails	2005		1,627	108	15	108		127	19
20	Storm sewer project	2005		4,329	433	10	433		469	20
21	Roof	2006		139,820	6,991	10	6,991		6,991	21
22	Asphalt	2006		9,300	484	8	484		484	22
23	Electrical line to bldg	2006		6,495	180	15	180		180	23
24	replace concrete	2006		8,710	194	15	194		193	24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENTER

0045948

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			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 1,247,746	\$ 43,141		\$ 43,141	\$	\$ 127,110		70

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

Facility Name & ID Number **LEE COUNTY NURSING & REHAB CENTER** # **0045948** 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	\$ 114,063	\$ 16,620	\$ 16,620	\$	Var	\$ 59,228	71
72	Current Year Purchases	13,093	1,149	1,149		Var	1,149	72
73	Fully Depreciated Assets							73
74	Amortization		494	494			494	74
75	TOTALS	\$ 127,156	\$ 18,263	\$ 18,263	\$		\$ 60,871	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)	\$ 1,466,902	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 61,404	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 61,404	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)	\$ 187,981	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
 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	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: N/A *

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	<u>N/A</u>		\$	\$	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? <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			Total
		1 Drop-outs	2 Completed	3 Contract	
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)	\$			

- (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.

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	

- (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	10a, 3	hrs	\$	1,063	\$ 58,928						1,063	\$ 58,928	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		39	2,047						39	2,047	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10a, 3	hrs		1,546	72,843						1,546	72,843	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			\$	2,648	\$ 133,818						2,648	\$ 133,818	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 LEE COUNTY NURSING & REHAB CENTER

0045948

Report 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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 20,556	\$	1
2	Cash-Patient Deposits	16,749		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	624,769		3
4	Supply Inventory (priced at)	9,100		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,661		6
7	Other Prepaid Expenses	1,510		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 692,345	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	234,395		14
15	Leasehold Improvements, at Historical Cost	29,987		15
16	Equipment, at Historical Cost	53,927		16
17	Accumulated Depreciation (book methods)	(46,476)		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)	\$ 271,833	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 964,178	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 46,530	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,749		28
29	Short-Term Notes Payable	436,522		29
30	Accrued Salaries Payable	45,983		30
31	Accrued Taxes Payable (excluding real estate taxes)	57,155		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Expenses</u>	254,686		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 857,625	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	295,482		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 295,482	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,153,107	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (188,929)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 964,178	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 248,660	1
2	Restatements (describe):		2
3	Adjustment to PY net income	10,860	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 259,520	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(448,449)	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)	\$ (448,449)	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)	\$ (188,929)	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENTER # 0045948

Report Period Beginning: 1/1/2006

Page 19
Ending: 12/31/2006

VII. 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	\$ 3,178,291	1
2	Discounts and Allowances for all Levels	(471,070)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,707,221	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	290,555	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 290,555	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	5,945	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	171,945	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,299	19
20	Radiology and X-Ray		20
21	Other Medical Services	35,603	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 223,792	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	40	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 40	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	5,208	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,208	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,226,816	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	707,675	31
32	Health Care	1,600,216	32
33	General Administration	877,552	33
B. Capital Expense			
34	Ownership	327,853	34
C. Ancillary Expense			
35	Special Cost Centers	108,901	35
36	Provider Participation Fee	53,068	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,675,265	40
41	Income before Income Taxes (line 30 minus line 40)**	(448,449)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (448,449)	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 **LEE COUNTY NURSING & REHAB CENTER**

0045948

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	8,106	8,194	\$ 198,474	\$ 24.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,461	4,509	104,751	23.23	3
4	Licensed Practical Nurses	16,201	16,330	385,195	23.59	4
5	CNAs & Orderlies	45,628	46,037	519,394	11.28	5
6	CNA Trainees	2,672	2,725	32,546	11.94	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,607	5,877	72,521	12.34	10
11	Social Service Workers	3,834	3,875	69,105	17.83	11
12	Dietician	15,528	15,611	147,868	9.47	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,583	3,599	58,443	16.24	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,936	1,976	59,094	29.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,797	3,853	62,204	16.14	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	995	1,043	8,760	8.40	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	112,348	113,629	\$ 1,718,355 *	\$ 15.12	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	179	\$ 7,929	1,3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	235	7,762	10,3	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	97	3,142	11,3	44
45	Social Service Consultant	50	3,390	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	561	\$ 22,223		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 **LEE COUNTY NURSING & REHAB CENTER**

0045948

Report Period Beginning: **1/1/2006**

Ending: **12/31/2006**

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	
Sherry Gillihan	Administrator		\$ 59,490	Workers' Compensation Insurance	\$ 81,236	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	5,751	
				FICA Taxes	183,335	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	50,124	Patient Background Checks		
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	6,345	
						Licenses	1,005	
				Other Benefits	8,450	Advertising & PR	17,413	
						Less: Public Relations Expense (
						Non-allowable advertising	(17,413)	
						Yellow page advertising (
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 59,490	TOTAL (agree to Schedule V, line 22, col.8)	\$ 323,145	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 13,101	
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	5,138
							Seminar Expense	
							Entertainment Expense (
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL	\$ 5,138
C. Professional Services								
Vendor/Payee	Type		Amount					
Tutera Health Care Services	Management Fees		\$ 193,616					
Pinnacle Consulting	Legal Fees		11,375					
BKD, LLP	Accounting Fees		5,100					
Pinnacle Consulting	Professional Fees		555					
Mutual of Omaha	Data Processing Fees		130					
Tutera Health Care Services	Data Processing Fees		14,300					
3rd Millenium Group	Data Processing Fees		17,706					
Please See Attached...	Purchased Services		19,863					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 262,645					

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political 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? N/A
What was the average life used for new equipment added during this period? 6
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,455 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 NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 53,068
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 benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 5,946
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation. NO
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? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.