

		FOR BHF USE					

LL1

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

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

I. IDPH Facility ID Number: 0038505

Facility Name: Ninth Street Place

Address: 2850 9th Street Rock Island 61201
 Number City Zip Code

County: Rock Island

Telephone Number: (309) 786-6474 **Fax #** (309)786-9861

HFS ID Number: 362615996003

Date of Initial License for Current Owners: 2/5/93

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501c3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: David Daugherty **Telephone Number:** (309) 786-6474

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/05 to 6/30/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Jane O'Melia</u>	
	(Title) <u>First Associate Executive Director</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

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

Facility Name & ID Number Ninth Street Place

0038505 Report Period Beginning: 7/1/05 Ending: 6/30/06

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 16

	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		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,753</u>			<u>5,753</u>
14	TOTALS	<u>5,753</u>			<u>5,753</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.51%

D. How many bed-hold days during this year were paid by the Department? 87 (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)

No

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 2/5/93

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

YES Date 2/5/93 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 No

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/06 Fiscal Year: 06/30/06

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

Facility Name & ID Number Ninth Street Place # 0038505 Report Period Beginning: 7/1/05 Ending: 6/30/06

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		1,618	1,114	2,732		2,732		2,732		1
2	Food Purchase		35,676		35,676	(3,388)	32,288	64	32,352		2
3	Housekeeping		5,590	1,421	7,011		7,011	24	7,035		3
4	Laundry										4
5	Heat and Other Utilities			14,527	14,527		14,527	431	14,958		5
6	Maintenance		10,722	1,807	12,529		12,529	971	13,500		6
7	Other (specify):*										7
8	TOTAL General Services		53,606	18,869	72,475	(3,388)	69,087	1,490	70,577		8
	B. Health Care and Programs										
9	Medical Director			2,772	2,772		2,772		2,772		9
10	Nursing and Medical Records	272,234	10,030	372	282,636		282,636	215	282,851		10
10a	Therapy										10a
11	Activities		1,309		1,309		1,309		1,309		11
12	Social Services	20,903			20,903		20,903		20,903		12
13	CNA Training	6,561	100		6,661		6,661		6,661		13
14	Program Transportation		4,227		4,227		4,227		4,227		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	299,698	15,666	3,144	318,508		318,508	215	318,723		16
	C. General Administration										
17	Administrative	58,138			58,138		58,138	31,254	89,392		17
18	Directors Fees										18
19	Professional Services							2,057	2,057		19
20	Dues, Fees, Subscriptions & Promotions			1,753	1,753		1,753	1,926	3,679		20
21	Clerical & General Office Expenses	4,434	1,218	2,441	8,093		8,093	848	8,941		21
22	Employee Benefits & Payroll Taxes			86,137	86,137	3,388	89,525	7,758	97,283		22
23	Inservice Training & Education							17	17		23
24	Travel and Seminar			469	469		469		469		24
25	Other Admin. Staff Transportation		2,052		2,052		2,052	746	2,798		25
26	Insurance-Prop.Liab.Malpractice			6,186	6,186		6,186	558	6,744		26
27	Other (specify):*										27
28	TOTAL General Administration	62,572	3,270	96,986	162,828	3,388	166,216	45,164	211,380		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	362,270	72,542	118,999	553,811		553,811	46,869	600,680		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 Ninth Street Place

#0038505

Report Period Beginning:

7/1/05

Ending:

6/30/06

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			19,184	19,184	19,184	1,642	20,826				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						740	740				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			19,184	19,184	19,184	2,382	21,566				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,927	38,927	38,927		38,927				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			38,927	38,927	38,927		38,927				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	362,270	72,542	177,110	611,922	611,922	49,251	661,173				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 Ninth Street Place

0038505

Report Period Beginning: 7/1/05

Ending: 6/30/06

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

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)	49,251		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 49,251		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 49,251		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						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

BHF USE ONLY					
48		49		50	
				51	
					52

Ninth Street Place

ID# 0038505

Report Period Beginning: 7/1/05

Ending: 6/30/06

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
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Ninth Street Place# 0038505

Report Period Beginning:

7/1/05

Ending:

6/30/06

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	64	0	0	0	0	0	0	0	0	0	64	2
3	Housekeeping	0	24	0	0	0	0	0	0	0	0	0	24	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	431	0	0	0	0	0	0	0	0	0	431	5
6	Maintenance	0	971	0	0	0	0	0	0	0	0	0	971	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	1,490	0	0	0	0	0	0	0	0	0	1,490	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	215	0	0	0	0	0	0	0	0	0	215	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	215	0	0	0	0	0	0	0	0	0	215	16
	C. General Administration													
17	Administrative	0	31,254	0	0	0	0	0	0	0	0	0	31,254	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,057	0	0	0	0	0	0	0	0	0	2,057	19
20	Fees, Subscriptions & Promotions	0	1,926	0	0	0	0	0	0	0	0	0	1,926	20
21	Clerical & General Office Expenses	0	848	0	0	0	0	0	0	0	0	0	848	21
22	Employee Benefits & Payroll Taxes	0	7,758	0	0	0	0	0	0	0	0	0	7,758	22
23	Inservice Training & Education	0	17	0	0	0	0	0	0	0	0	0	17	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	746	0	0	0	0	0	0	0	0	746	25
26	Insurance-Prop.Liab.Malpractice	0	0	558	0	0	0	0	0	0	0	0	558	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	43,860	1,304	0	0	0	0	0	0	0	0	45,164	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	45,565	1,304	0	0	0	0	0	0	0	0	46,869	29

STATE OF ILLINOIS

Facility Name & ID Number Ninth Street Place

0038505

Report Period Beginning:

7/1/05

Ending:

6/30/06

Summary B

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	1,642	0	0	0	0	0	0	0	0	1,642	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	740	0	0	0	0	0	0	0	0	740	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	2,382	0	2,382	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	45,565	3,686	0	49,251	45							

Facility Name & ID Number Ninth Street Place

0038505

Report Period Beginning:

7/1/05

Ending:

6/30/06

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
None						

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	2 Food and Beverage	\$	ARC/RIC	100.00%	\$ 64	\$ 64 1
2	V	3 Housekeeping		ARC/RIC	100.00%	24	24 2
3	V	5 Utilities		ARC/RIC	100.00%	431	431 3
4	V	6 Maintenance		ARC/RIC	100.00%	971	971 4
5	V	19 Accountant/Consultant		ARC/RIC	100.00%	1,284	1,284 5
6	V	19 Legal Fees		ARC/RIC	100.00%	773	773 6
7	V	17 Administrative Salaries		ARC/RIC	100.00%	31,254	31,254 7
8	V	20 Sub/Promotion/Printing		ARC/RIC	100.00%	1,926	1,926 8
9	V	21 Office Supplies		ARC/RIC	100.00%	672	672 9
10	V	21 Telephone		ARC/RIC	100.00%	176	176 10
11	V	22 Employee Benefits		ARC/RIC	100.00%	7,758	7,758 11
12	V	10 Medical/Hygiene Supplies		ARC/RIC	100.00%	215	215 12
13	V	23 Staff Training		ARC/RIC	100.00%	17	17 13
14	Total		\$			\$ 45,565	\$ * 45,565 14

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

Facility Name & ID Number Ninth Street Place

0038505

Report Period Beginning: 7/1/05

Ending: 6/30/06

VII. RELATED PARTIES (continued)

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)		
15	V	24	Travel Seminar	\$	ARC/RIC	100.00%			15
16	V	25	Other Administrative, Staff Transportation		ARC/RIC	100.00%	746	746	16
17	V	26	Insurance/Prof/Liability		ARC/RIC	100.00%	558	558	17
18	V	32	Interest Mortgage		ARC/RIC	100.00%	740	740	18
19	V	30	Depreciation		ARC/RIC	100.00%	1,642	1,642	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$ 3,686	\$ * 3,686	39

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

Facility Name & ID Number

Ninth Street Place

#

0038505

Report Period Beginning:

7/1/05

Ending:

6/30/06

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	None								\$	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 Ninth Street Place

0038505

Report Period Beginning:

7/1/05

Ending: 6/30/06

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

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

Name of Related Organization Association for Retarded Citizens
 Street Address 4016 9th Street
 City / State / Zip Code Rock Island IL 61201
 Phone Number (309) 786-6474
 Fax Number (309) 786-9861

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	2	Food and Beverage	Total percent of budgeted	1,084,466	17 programs	\$ 1,157	\$ 60,408	\$ 64	1
2	3	Housekeeping	Administrative costs are	1,084,466	17 programs	422	60,408	24	2
3	5	Utilities	to be allocated based on	1,084,466	17 programs	7,744	60,408	431	3
4	6	Maintenance	percentage of salary	1,084,466	17 programs	17,439	60,408	971	4
5	19	Accountant/Consultant		1,084,466	17 programs	23,042	60,408	1,284	5
6	19	Legal Fees		1,084,466	17 programs	13,882	60,408	773	6
7	17	Administration Salaries		1,084,466	17 programs	561,077	60,408	31,254	7
8	20	Sub/Promotion/Printing		1,084,466	17 programs	34,571	60,408	1,926	8
9	21	Office Expense		1,084,466	17 programs	12,068	60,408	672	9
10	21	Telephone		1,084,466	17 programs	3,154	60,408	176	10
11	22	Employer Benefits		1,084,466	17 programs	139,277	60,408	7,758	11
12	10	Medical/Hygiene Supplies		1,084,466	17 programs	3,853	60,408	215	12
13	23	Staff Training		1,084,466	17 programs	309	60,408	17	13
14	24	Travel Seminar		1,084,466	17 programs	0	60,408	0	14
15	25	Other Administration, Staff Transportation		1,084,466	17 programs	13,389	60,408	746	15
16	26	Insurance/Prof/Liability		1,084,466	17 programs	10,025	60,408	558	16
17	32	Interest Mortgage		1,084,466	17 programs	13,291	60,408	740	17
18	30	Depreciation		1,084,466	17 programs	29,469	60,408	1,642	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 884,169	\$	\$ 49,251	25

Facility Name & ID Number Ninth Street Place # 0038505 Report Period Beginning: 7/1/05 Ending: 6/30/06

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	None									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.)

Facility Name & ID Number Ninth Street Place

0038505 Report Period Beginning: 7/1/05

Ending: 6/30/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																							
1. Real Estate Tax accrual used on 2005 report.		\$ <u>None</u>	<u>1</u>																				
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>2</u>																				
3. Under or (over) accrual (line 2 minus line 1).		\$ <u>#VALUE!</u>	<u>3</u>																				
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>4</u>																				
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	<u>5</u>																				
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	<u>6</u>																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <u>#VALUE!</u>	<u>7</u>																				
<p>Real Estate Tax History:</p> <table border="1"> <tr> <td>Real Estate Tax Bill for Calendar Year:</td> <td>2001</td> <td>_____</td> <td><u>8</u></td> </tr> <tr> <td></td> <td>2002</td> <td>_____</td> <td><u>9</u></td> </tr> <tr> <td></td> <td>2003</td> <td>_____</td> <td><u>10</u></td> </tr> <tr> <td></td> <td>2004</td> <td>_____</td> <td><u>11</u></td> </tr> <tr> <td></td> <td>2005</td> <td>_____</td> <td><u>12</u></td> </tr> </table>				Real Estate Tax Bill for Calendar Year:	2001	_____	<u>8</u>		2002	_____	<u>9</u>		2003	_____	<u>10</u>		2004	_____	<u>11</u>		2005	_____	<u>12</u>
Real Estate Tax Bill for Calendar Year:	2001	_____	<u>8</u>																				
	2002	_____	<u>9</u>																				
	2003	_____	<u>10</u>																				
	2004	_____	<u>11</u>																				
	2005	_____	<u>12</u>																				
<table border="1"> <tr> <td></td> <td colspan="2">FOR BHF USE ONLY</td> <td></td> </tr> <tr> <td><u>13</u></td> <td>FROM R. E. TAX STATEMENT FOR 2005</td> <td>\$</td> <td><u>13</u></td> </tr> <tr> <td><u>14</u></td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td><u>14</u></td> </tr> <tr> <td><u>15</u></td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td><u>15</u></td> </tr> <tr> <td><u>16</u></td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td><u>16</u></td> </tr> </table>					FOR BHF USE ONLY			<u>13</u>	FROM R. E. TAX STATEMENT FOR 2005	\$	<u>13</u>	<u>14</u>	PLUS APPEAL COST FROM LINE 5	\$	<u>14</u>	<u>15</u>	LESS REFUND FROM LINE 6	\$	<u>15</u>	<u>16</u>	AMOUNT TO USE FOR RATE CALCULATION	\$	<u>16</u>
	FOR BHF USE ONLY																						
<u>13</u>	FROM R. E. TAX STATEMENT FOR 2005	\$	<u>13</u>																				
<u>14</u>	PLUS APPEAL COST FROM LINE 5	\$	<u>14</u>																				
<u>15</u>	LESS REFUND FROM LINE 6	\$	<u>15</u>																				
<u>16</u>	AMOUNT TO USE FOR RATE CALCULATION	\$	<u>16</u>																				

NOTES:

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

IMPORTANT NOTICE

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

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

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

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

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ninth Street Place COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0038505

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 Ninth Street Place

0038505 Report Period Beginning:

7/1/05 Ending:

6/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,218 B. General Construction Type: Exterior Vinyl Siding Frame Wood Frame Number of Stories 1

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

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

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

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

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

None

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: None 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>DD Facility</u>	<u>99,015</u>	<u>1997</u>	<u>\$ 25,155</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	99,015		\$ 25,155	3

Facility Name & ID Number Ninth Street Place

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1997	1992	\$ 417,394	\$ 13,521	31.5	\$ 13,521	\$	\$ 112,903	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		Insulation		1994	4,038		31.5				9
10		Final Payment on Retainage Building fee		1995	1,051		31.5				10
11		Engineering and Architecture		1993	16,791		31.5				11
12		Dumpster Enclosure		1994	550	17	31.5	17		215	12
13		Vinyl Floor		1995	875	28	31.5	28		296	13
14		Carpet/Gazebo		1997	5,126	163	31.5	163		1,549	14
15		Fence		1997	2,936	93	31.5	93		791	15
16		Carpet/Gazebo		1998	1,690	54	31.5	54		426	16
17		Wall Protection		1998	1,044	33	31.5	33		281	17
18		Paved Parking Lot		1998	1,600	51	31.5	51		433	18
19		Vinyl Floor		1999	3,300	106	31.5	106		636	19
20		Sidewalk Concrete		2000	3,000	95	31.5	95		619	20
21		Automatic Doors		2000	2,253	72	31.5	72		396	21
22		Sidewalk Handrails		2000	2,706	86	31.5	86		473	22
23		Toilet Toppers		2000	852	27	31.5	27		149	23
24		Interior Handrails		2001	596	19	31.5	19		85	24
25		Vinyl Floor/Tile in Tub Room		2001	1,024	33	31.5	33		115	25
26		Install Interior Handrails		2002	910	29	31.5	29		101	26
27		Vinyl Flooring		2003	1,745	55	31.5	55		138	27
28		Install Vinyl Flooring		2005	1,745	55	31.5	55		83	28
29		Kitchen Cabinets		2005	1,755	56	31.5	56		84	29
30		Install Bathroom Tiles		2005	3,280	104	31.5	104		156	30
31		Install Whirlpool Tub		2005	2,951	94	31.5	94		141	31
32		Install Kitchen Cabinets		2006	675	11	31.5	11		11	32
33		Install Ceramic Tile Floor in Kitchen		2006	4,392	70	31.5	70		70	33
34		New Window Blinds/Installation		2006	880	14	31.5	14		14	34
35		Concrete Sidewalks		2006	3,800	60	31.5	60		60	35
36		Repair Fire Sprinkler System		2006	1,463	23	31.5	23		23	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 Ninth Street Place

0038505

Report Period Beginning:

7/1/05

Ending:

6/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 490,422	\$ 14,969		\$ 14,969	\$	\$ 120,248	70

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

Facility Name & ID Number Ninth Street Place # 0038505 Report Period Beginning: 7/1/05 Ending: 6/30/06

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	\$ 74,107	\$ 3,372	\$ 3,372	\$	5	\$ 66,461	71
72	Current Year Purchases	575	58	58		5	58	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 74,682	\$ 3,430	\$ 3,430	\$		\$ 66,519	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	Patient Care	2000 Ford E350 15pas Ford Van	8/31/2004	\$ 12,143	\$ 2,427	\$ 2,427	\$	5	\$ 3,638	76
77										77
78										78
79										79
80	TOTALS			\$ 12,143	\$ 2,427	\$ 2,427	\$		\$ 3,638	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)	\$ 602,402	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,826	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 20,826	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)	\$ 190,405	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Ninth Street Place

0038505

Report Period Beginning: 7/1/05

Ending: 6/30/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input 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="text" value="60"/></p> <p>IN OTHER FACILITY <input type="text"/></p> <p>COMMUNITY COLLEGE <input type="text"/></p> <p>HOURS PER CNA <u>60</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="text" value="80"/></p> <p>IN OTHER FACILITY <input type="text"/></p> <p>HOURS PER CNA <u>80</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	25	75		100
3	Classroom Wages (a)	425	1,595		2,020
4	Clinical Wages (b)	567	2,126		2,693
5	In-House Trainer Wages (c)	1,344	504		1,848
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 2,361	\$ 4,300	\$	\$ 6,661
10	SUM OF line 9, col. 1 and 2 (e)	\$ 6,661			

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	<u>3</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	<u>1</u>
2. From other facilities (f)	
TOTAL TRAINED	4

- (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.

Facility Name & ID Number Ninth Street Place# 0038505

Report Period Beginning:

7/1/05

Ending:

6/30/06

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units 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 prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number Ninth Street Place# 0038505Report Period Beginning: 7/1/05

Ending:

6/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 137,352	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	176,496		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	592		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 314,440	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,155		13
14	Buildings, at Historical Cost	490,422		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	86,825		16
17	Accumulated Depreciation (book methods)	(190,405)		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)	\$ 411,997	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 726,437	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 12,911	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	90,410		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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 103,321	\$	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 103,321	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 623,116	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 726,437	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 614,377	1
2	Restatements (describe):		2
3	Reclassification of Fixed Assets	(47,242)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 567,135	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	55,981	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)	\$ 55,981	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)	\$ 623,116	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Ninth Street Place# 0038505Report Period Beginning: 7/1/05Ending: 6/30/06**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	\$ 649,120	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 649,120	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education	77	9
10	Other Government Grants	1,697	10
11	CNA Training Reimbursements	9,855	11
12	Gift and Coffee Shop	68	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,053	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)	\$ 12,750	23
D. Non-Operating Revenue			
24	Contributions	2,138	24
25	Interest and Other Investment Income***	2,677	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,815	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Fundraising events</u>	1,218	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,218	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 667,903	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	100,289	31
32	Health Care	299,943	32
33	General Administration	153,579	33
B. Capital Expense			
34	Ownership	19,184	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	38,927	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 611,922	40
41	Income before Income Taxes (line 30 minus line 40)**	55,981	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 55,981	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 Ninth Street Place

0038505

Report Period Beginning: 7/1/05

Ending: 6/30/06

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
2	Assistant Director of Nursing				2
3	Registered Nurses	670	12,454	17.64	3
4	Licensed Practical Nurses	339	5,191	14.54	4
5	CNAs & Orderlies				5
6	CNA Trainees	472	4,713	9.99	6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers				18
19	Laundry				19
20	Administrator	589	13,801	22.22	20
21	Assistant Administrator	2,218	35,926	15.39	21
22	Other Administrative	296	8,411	26.96	22
23	Office Manager				23
24	Clerical	372	4,434	11.31	24
25	Vocational Instruction				25
26	Academic Instruction	180	1,848	9.99	26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	966	20,903	20.55	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	23,465	254,589	10.31	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	29,567	362,270 *	\$ 11.65	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	\$ 1,114	L1c3 35
36	Medical Director	Annual	2,771	L9c3 36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Annual	132	L10c3 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47	Psychological Services	4	240	L10c3 47
48				48
49	TOTAL (lines 35 - 48)	39	\$ 4,256	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 Ninth Street Place# 0038505Report Period Beginning: 7/1/05Ending: 6/30/06**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? No
If YES, give association name and amount. _____
- (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? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ _____
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. \$ 3,388 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey and Pullen LLP 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? 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.