



Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE

# 0035659 Report Period Beginning: 01/01/2006 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	70	Intermediate (ICF)	70	25,550	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,550	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	22,837	1,291		24,128
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	22,837	1,291		24,128

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.43%**

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

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

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

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

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

**I. On what date did you start providing long term care at this location?**  
Date started 07/01/89

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date 07/01/89 NO

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

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **TAMMERLANE HEALTH CARE CENTRE** # **0035659** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	110,487	9,567	4,760	124,814		124,814	0	124,814		1
2	Food Purchase		115,371		115,371	(5,512)	109,859	(284)	109,575		2
3	Housekeeping	66,487	11,696	0	78,183		78,183	0	78,183		3
4	Laundry	20,995	4,389	759	26,143	0	26,143	0	26,143		4
5	Heat and Other Utilities			48,021	48,021		48,021	1,037	49,058		5
6	Maintenance	42,536	3,969	20,955	67,460		67,460	6,609	74,069		6
7	Other (specify):*			4,271	4,271		4,271	0	4,271		7
8	<b>TOTAL General Services</b>	<b>240,505</b>	<b>144,992</b>	<b>78,766</b>	<b>464,263</b>	<b>(5,512)</b>	<b>458,751</b>	<b>7,362</b>	<b>466,113</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		36,000	36,000		36,000	0	36,000		9
10	Nursing and Medical Records	483,442	21,070	2,890	507,402		507,402	0	507,402		10
10a	Therapy	0		3,888	3,888		3,888	0	3,888		10a
11	Activities	57,289	1,728	0	59,017		59,017	0	59,017		11
12	Social Services	138,517		2,093	140,610		140,610	0	140,610		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			560	560	7,584	8,144	0	8,144		14
15	Other (specify):*				0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	<b>679,248</b>	<b>22,798</b>	<b>45,431</b>	<b>747,477</b>	<b>7,584</b>	<b>755,061</b>	<b>0</b>	<b>755,061</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	79,185		120,000	199,185		199,185	(53,123)	146,062		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			54,288	54,288		54,288	(15,551)	38,737		19
20	Dues, Fees, Subscriptions & Promotions			16,688	16,688		16,688	(1,748)	14,940		20
21	Clerical & General Office Expenses	18,851	7,931	30,581	57,363		57,363	2,421	59,784		21
22	Employee Benefits & Payroll Taxes			179,026	179,026	5,512	184,538	0	184,538		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			2,602	2,602		2,602	540	3,142		24
25	Other Admin. Staff Transportation			8,922	8,922	(7,584)	1,338	1,338	2,676		25
26	Insurance-Prop.Liab.Malpractice			43,674	43,674		43,674	1,986	45,660		26
27	Other (specify):*			0	0		0	16,180	16,180		27
28	<b>TOTAL General Administration</b>	<b>98,036</b>	<b>7,931</b>	<b>455,781</b>	<b>561,748</b>	<b>(2,072)</b>	<b>559,676</b>	<b>(47,957)</b>	<b>511,719</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,017,789</b>	<b>175,721</b>	<b>579,978</b>	<b>1,773,488</b>	<b>0</b>	<b>1,773,488</b>	<b>(40,595)</b>	<b>1,732,893</b>		<b>29</b>

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	4,760
	REPAIRS & MAINTENANCE	0
		0
		4,760
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	759
		0
		759
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	17,018
	ELECTRICITY	17,874
	WATER	12,576
	CABLE TV - LOBBY	553
		0
		48,021
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	559
	PAINTING & DECORATING	269
	BUILDING REPAIRS	1,301
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	9,913
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	993
	FIRE SERVICE	7,920
		0
		0
		0
		0
		20,955
7	<b>OTHER</b>	
	SCAVENGER	4,271
	SECURITY SERVICE	0
		0
		0
		4,271
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	36,000
		36,000

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	391
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	650
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	1,849
		0
		0
		2,890
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	3,888
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		3,888
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
		0
		0
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	813
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	1,280
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,093
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	560
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	120,000
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	14,161
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	40,127
		0
		54,288
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	0
	EMPLOYEE WANT ADS XIX F	757
	CONTRIBUTIONS VI 20 XIX F	700
	DUES & SUBSCRIPTIONS XIX F	9,972
	LICENSES & PERMITS XIX F	2,346
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	366
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	950
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,597
	PATIENT BACKGROUND CHECKS XIX F	0
		16,688
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	4,676
	EQUIPMENT REPAIR & MAINTENANCE	202
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	483
	HOME OFFICE EXPENSE	12,000
	THEFT & DAMAGE LOSS	0
	TELEPHONE	13,220
	MESSENGER SERVICE	0
		0
		30,581

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	77,861
	UNEMPLOYMENT COMPENSATION XIX D	13,935
	WORKERS COMPENSATION INSURANC XIX D	36,034
	HOSPITALIZATION INSURANCE XIX D	46,424
	EMPLOYEE BENEFITS - OTHER XIX D	4,772
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		179,026
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	2,602
	TRAVEL XIX G	0
		2,602
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	8,922
		8,922
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	43,674
		43,674
27	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

579,978

TAMMERLANE HEALTH CARE CENTRE  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2006

TOTAL FOOD PURCHASE	115,371	PATIENT MEALS	72384
LESS SALES TAX	(284)	ADD EMPLOYEE MEALS	3650
	-----		-----
NET FOOD	115,087	TOTAL MEALS/YEAR	76034
TOTAL PATIENT CENSUS	24,128	NET FOOD	115087
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	76034
	-----		
TOTAL PATIENT MEALS	72384	COST PER MEAL	1.51
		TIME EMPLOYEE MEALS	3650
ADD # EMPLOYEE MEALS/DAY	10		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	5512
	-----		=====
TOTAL EMPLOYEE MEALS	3650		

Facility Name &amp; ID Number TAMMERLANE HEALTH CARE CENTRE

#0035659

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			25,230	25,230		25,230	29,380	54,610			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			17,213	17,213		17,213	140,303	157,516			32
33	Real Estate Taxes			15,819	15,819		15,819	473	16,292			33
34	Rent-Facility & Grounds			169,035	169,035		169,035	(169,035)	0			34
35	Rent-Equipment & Vehicles			8,829	8,829		8,829	0	8,829			35
36	Other (specify):*			0	0		0	0	0			36
37	<b>TOTAL Ownership</b>			236,126	236,126	0	236,126	1,121	237,247			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			0	0		0	0	0			38
39	Ancillary Service Centers			0	0		0	0	0			39
40	Barber and Beauty Shops			0	0		0	0	0			40
41	Coffee and Gift Shops			0	0		0	0	0			41
42	Provider Participation Fee			38,325	38,325		38,325	0	38,325			42
43	Other (specify):*			0	0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	0	38,325	38,325	0	38,325	0	38,325			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,017,789	175,721	854,429	2,047,939	0	2,047,939	(39,474)	2,008,465			45

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

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	(4,377)	30		9
10	Interest and Other Investment Income	(1,352)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(284)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(483)	21		18
19	Entertainment	0	20		19
20	Contributions	(1,650)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(225)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	0	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(366)	20		28
29	Other-Attach Schedule	(21,649)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (30,386)		\$ 0	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)	(9,088)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (9,088)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (39,474)		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					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0035659

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1,027	6	1
2	BANK CHARGES	(4,676)	21	2
3	HEALTHCARE HORIZONS	(18,000)	19	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	<b>Total</b>	(21,649)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number TAMMERLANE HEALTH CARE CENTRE

# 0035659

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(284)	0	0	0	0	0	0	0	0	0	0	(284)	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	1,037	0	0	0	0	0	0	0	0	0	1,037	5
6	Maintenance	1,027	5,582	0	0	0	0	0	0	0	0	0	6,609	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>743</b>	<b>6,619</b>	<b>0</b>	<b>7,362</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(53,123)	0	0	0	0	0	0	0	0	0	(53,123)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,225)	2,674	0	0	0	0	0	0	0	0	0	(15,551)	19
20	Fees, Subscriptions & Promotions	(2,016)	268	0	0	0	0	0	0	0	0	0	(1,748)	20
21	Clerical & General Office Expenses	(5,159)	7,580	0	0	0	0	0	0	0	0	0	2,421	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	540	0	0	0	0	0	0	0	0	0	540	24
25	Other Admin. Staff Transportation	0	1,338	0	0	0	0	0	0	0	0	0	1,338	25
26	Insurance-Prop.Liab.Malpractice	0	1,986	0	0	0	0	0	0	0	0	0	1,986	26
27	Other (specify):*	0	16,180	0	0	0	0	0	0	0	0	0	16,180	27
28	<b>TOTAL General Administration</b>	<b>(25,400)</b>	<b>(22,557)</b>	<b>0</b>	<b>(47,957)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(24,657)</b>	<b>(15,938)</b>	<b>0</b>	<b>(40,595)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(4,377)	0	738	33,019	0	0	0	0	0	0	0	29,380	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,352)	0	1,948	139,707	0	0	0	0	0	0	0	140,303	32
33	Real Estate Taxes	0	0	473	0	0	0	0	0	0	0	0	473	33
34	Rent-Facility & Grounds	0	0	0	(169,035)	0	0	0	0	0	0	0	(169,035)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(5,729)</b>	<b>0</b>	<b>3,159</b>	<b>3,691</b>	<b>0</b>	<b>1,121</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(30,386)</b>	<b>(15,938)</b>	<b>3,159</b>	<b>3,691</b>	<b>0</b>	<b>(39,474)</b>	<b>45</b>						

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WILLIAM IRVINE	50					
ROBERT HEDGES	50			HI CARE MGMT.	SPRINGFIELD	MANAGEMENT
		SEE ATTACHED SCHEDULE				
				H&I PROPERTIES	SPRINGFIELD	REAL ESTATE

**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	17 MANAGEMENT FEES	\$ 120,000	HI CARE MANAGEMENT		\$	\$ (120,000)	1
2	V	21 HOME OFFICE EXPENSE	12,000				(12,000)	2
3	V	5 UTILITIES				1,037	1,037	3
4	V	6 MAINTENANCE				5,582	5,582	4
5	V	17 ADMINISTRATIVE				66,877	66,877	5
6	V	19 PROFESSIONAL FEES				2,674	2,674	6
7	V	20 DUES & SUBSCRIPTIONS				268	268	7
8	V	21 OFFICE EXPENSE				19,580	19,580	8
9	V	24 TRAVEL & SEMINARS				540	540	9
10	V	25 TRANSPORTATION				1,338	1,338	10
11	V	26 INSURANCE				1,986	1,986	11
12	V	27 PAYROLL TAXES & GRP INS				16,180	16,180	12
13	V							13
14	Total		\$ 132,000			\$ 116,062	\$ * (15,938)	14

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

**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	30 DEPRECIATION	\$	H & I PROPERTIES (HOME OFFICE)		\$ 738	\$ 738	15
16	V	32 INTEREST				1,948	1,948	16
17	V	33 REAL ESTATE				473	473	17
18	V							18
19	V							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	<b>Total</b>		\$			\$ 3,159	\$ * 3,159	39

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

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	34 RENT	\$ 169,035	H & I PROPERTIES (FACILITY)		\$	(169,035)	15
16	V	30 DEPRECIATION				33,019	33,019	16
17	V	32 INTEREST				139,707	139,707	17
18	V							18
19	V							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		\$ 169,035			\$ 172,726	\$ * 3,691	39

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

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRI # 0035659 Report Period Beginning: 01/01/2006 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	ROBERT HEDGES	PRESIDENT	OFFICE MGMT.					SALARY	\$ 22,183	17-7	1
2	TOTAL ALLOWABLE SALARY RECEIVED FROM HI CARE \$170,000										2
3											3
4	WILLIAM IRVINE	VICE-PRESIDENT	OFFICE MGMT.					SALARY	22,183	17-7	4
5	TOTAL ALLOWABLE SALARY RECEIVED FROM HI CARE \$170,000										5
6											6
7	MARTHA IRVINE	BOOKKEEPING						SALARY	1,124	21-7	7
8	TOTAL SALARY RECEIVED FROM HI CARE \$8,615										8
9											9
10	DEREK HEDGES							SALARY	3,523	17-7	10
11	TOTAL SALARY RECEIVED FROM HI CARE \$27,000										11
12											12
13								TOTAL	\$ 49,013		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 TAMMERLANE HEALTH CARE CENTRE

# 0035659

Report Period Beginning:

01/01/2006

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 HI CARE MANAGEMENT  
 Street Address 827 S. FIFTH STREET  
 City / State / Zip Code SPRINGFIELD, IL 62703  
 Phone Number ( 217 ) 528-0044  
 Fax Number ( 217 ) 528-3412

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	5	UTILITIES	PER RESIDENT DAY	184,904	7	\$ 7,946	24,128	\$ 1,037	1	
2	6	MAINTENANCE	PER RESIDENT DAY	184,904	7	42,775	36,113	24,128	5,582	2
3	17	OFFICER SALARY	PER RESIDENT DAY	184,904	7	340,000	340,000	24,128	44,366	3
4	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	184,904	7	68,050	68,050	24,128	8,880	4
5	17	DIRECTOR OF FINANCE	PER RESIDENT DAY	184,904	7	77,460	77,460	24,128	10,108	5
6	17	SPECIAL PROJECTS MNGR	PER RESIDENT DAY	184,904	7	27,000	27,000	24,128	3,523	6
7	19	PROFESSIONAL FEES	PER RESIDENT DAY	184,904	7	20,492		24,128	2,674	7
8	20	DUES & SUBSCRIPTIONS	PER RESIDENT DAY	184,904	7	2,057		24,128	268	8
9	21	OFFICE EXPENSE	PER RESIDENT DAY	184,904	7	150,049	112,536	24,128	19,580	9
10	24	TRAVEL & SEMINARS	PER RESIDENT DAY	184,904	7	4,140		24,128	540	10
11	25	TRANSPORTATION	PER RESIDENT DAY	184,904	7	10,252		24,128	1,338	11
12	26	INSURANCE	PER RESIDENT DAY	184,904	7	15,218		24,128	1,986	12
13	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	184,904	7	123,996		24,128	16,180	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					\$ 889,435	\$ 661,159		\$ 116,062	25

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE

# 0035659

Report Period Beginning:

01/01/2006

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

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

Name of Related Organization H & I PROPERTIES-HOME OFFICE  
 Street Address 1625 S SIXTH STREET  
 City / State / Zip Code SPRINGFIELD IL 62703  
 Phone Number ( 217 )528-0044  
 Fax Number ( 217 )528-0412

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	30	DEPRECIATION	639	7	\$ 6,741	\$ 0	70	\$ 738	1
2	32	INTEREST	639	7	17,780	0	70	1,948	2
3	33	REAL ESTATE	639	7	4,317	0	70	473	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				\$ 28,838	\$		\$ 3,159	25

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE

# 0035659

Report Period Beginning:

01/01/2006

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

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

Name of Related Organization H & I PROPERTIES-FACILITY  
 Street Address 1625 S SIXTH STREET  
 City / State / Zip Code SPRINGFIELD IL 62703  
 Phone Number ( 217 )528-0044  
 Fax Number ( 217 )528-0412

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	30	DEPRECIATION	DIRECT	1	1	\$ 33,019	\$ 0	1	\$ 33,019	1
2	32	INTEREST	DIRECT	1	1	139,707	0	1	139,707	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 172,726	\$		\$ 172,726	25

Facility Name &amp; ID Number

TAMMERLANE HEALTH CARE CENTRE

# 0035659

Report Period Beginning:

01/01/2006

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		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	COLE TAYLOR( HI PROP)		X	MORTGAGE ( Facility)	\$13,098.68	8/03/05	\$ 1,689,500	\$ 1,637,681	8/01/10	0.0700	\$ 139,707	1						
2	US BANK (HI PROP)		X	MORTGAGE ( Home Office)		6/29/05			6/12/12	0.0635	1,948	2						
3												3						
4												4						
5	ILLINI BANK		X	AUTO LOAN	\$255.00	2/17/04	10,750	3,424	12/17/08	0.0650	319	5						
<b>Working Capital</b>																		
6	ILLINI BANK		X	WORKING CAPITAL	INTEREST	REVOLV		178,973	REVOLV	PRIME +	16,413	6						
7	ILLINI BANK		X	BOILER	\$271.00	11/12/03	8,500	0	11/12/06	0.0913	129	7						
8	GMAC		X	AUTO LOAN	\$699.00	11/18/02	28,556	0	12/03/06	0.0799	352	8						
9	TOTAL Facility Related				\$14,323.68		\$ 1,737,306	\$ 1,820,078			\$ 158,868	9						
<b>B. Non-Facility Related*</b>																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14						
15	TOTALS (line 9+line14)						\$ 1,737,306	\$ 1,820,078			\$ 158,868	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.		\$	<b>16,417</b>	<b>1</b>
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.)		\$	<b>16,118</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(299)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>16,118</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>15,819</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2001</b>	<b>14,537</b>	<b>8</b>
	<b>2002</b>	<b>15,117</b>	<b>9</b>
	<b>2003</b>	<b>15,483</b>	<b>10</b>
	<b>2004</b>	<b>16,417</b>	<b>11</b>
	<b>2005</b>	<b>16,118</b>	<b>12</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.**

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2005	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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 TAMMERLANE HEALTH CARE CENTRE COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0035659

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

**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.	<u>11-10-329-006</u>	<u>NURSING HOME</u>	\$ <u>16,117.98</u>	\$ <u>16,117.98</u>
2.	<u>                  </u>	<u>                  </u>	\$ <u>                  </u>	\$ <u>                  </u>
3.	<u>                  </u>	<u>                  </u>	\$ <u>                  </u>	\$ <u>                  </u>
4.	<u>                  </u>	<u>                  </u>	\$ <u>                  </u>	\$ <u>                  </u>
5.	<u>                  </u>	<u>                  </u>	\$ <u>                  </u>	\$ <u>                  </u>
6.	<u>                  </u>	<u>                  </u>	\$ <u>                  </u>	\$ <u>                  </u>
7.	<u>                  </u>	<u>                  </u>	\$ <u>                  </u>	\$ <u>                  </u>
8.	<u>                  </u>	<u>                  </u>	\$ <u>                  </u>	\$ <u>                  </u>
9.	<u>                  </u>	<u>                  </u>	\$ <u>                  </u>	\$ <u>                  </u>
10.	<u>                  </u>	<u>                  </u>	\$ <u>                  </u>	\$ <u>                  </u>
		<b>TOTALS</b>	\$ <u>16,117.98</u>	\$ <u>16,117.98</u>

**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   X   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: 17,130 B. General Construction Type: Exterior BRICK Frame \_\_\_\_\_ Number of Stories 2

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).  
N/A

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	217,800	1998	\$ 111,500	1
2	HOME OFFICE		2005	6,322	2
3	TOTALS	217,800		\$ 117,822	3

Facility Name &amp; ID Number TAMMERLANE HEALTH CARE CENTRE

# 0035659

Report Period Beginning:

01/01/2006 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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	70	1998	1958	\$ 887,968	\$ 22,769	39	\$ 22,769	\$	\$ 190,690	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	IMPROVEMENTS		1992	14,227	452	31.5	452		6,444	9
10	IMPROVEMENTS		1993	3,670	94	39	94		1,242	10
11	IMPROVEMENTS		1994	7,850	201	39	201		2,434	11
12	PLUMBING WORK		1995	3,302	85	39	85		988	12
13	INSTALLED BOILER TANK		1995	600	15	39	15		175	13
14	INSTALLED 2 PUMPS		1995	2,289	59	39	59		681	14
15	PLUMBING WORK		1995	10,752	276	39	276		3,163	15
16	DOORS		1995	2,094	54	39	54		605	16
17	TWO DOORS		1995	1,055	27	39	27		300	17
18	INSTALLED ATTIC FAN & DUCT		1995	2,412	62	39	62		685	18
19	PARKING LOT		1995	32,070	2,138	39	2,138		24,142	19
20	WALL PROTECTOR		1997	3,328	85	39	85		833	20
21	SEPTIC FIELD-PLUMBING WORK		1998	25,965	666	39	666		5,411	21
22	2 NEW WATER HEATERS		1999	12,083	310	39	310		2,337	22
23	CIRCUIT BREAKER PANELS		1999	2,230	57	39	57		430	23
24	ELECTRICAL WORK		1999	2,374	61	39	61		460	24
25	BREAKER PANELS		2001	2,542	92	27.5	92		510	25
26	BLACKTOP		2001	11,161	744	15	744		4,123	26
27	BOILER		2003	9,911	360	37.5	360		1,095	27
28	WINDOWS		2005	1,832	67	27.5	67		75	28
29	MAIN BREAKER PANEL		2005	13,684	498	27.5	498		561	29
30	ALARM SYSTEM		2005	20,688	752	27.5	752		783	30
31	CONCRETE WALKWAY		2005	1,800	120	15	120		145	31
32	FIRE SYSTEM		2005	1,769	64	27.5	64		64	32
33	OUTDOOR WIRELESS MONITORING SYSTEM		2006	7,405	146	27.5	146		146	33
34	ELECTRICAL WORK		2006	2,379	47	27.5	47		47	34
35	WANDER GUARD SYSTEM		2006	5,893	116	27.5	116		116	35
36	DOORS		2006	2,321	46	27.5	46		46	36

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

See Page 12A, Line 70 for total

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

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 WATER HEATER	2006	\$ 7,399	\$ 146	27.5	\$ 146	\$	\$ 146	37
38								38
39 H & I PROPERTIES - OFFICE BUILDING	2005	28,783	738	39	738		1,310	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)		\$ 1,131,836	\$ 31,347		\$ 31,347	\$ 0	\$ 250,187	70

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

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	\$ 62,148	\$ 12,026	\$ 5,112	\$ (6,914)	10 YRS	\$ 28,605	71
72	Current Year Purchases	903	181	45	(136)	10 YRS	45	72
73	Fully Depreciated Assets	32,065			0	10 YRS	32,065	73
74	RELATED PARTY (facility)	102,500	10,250	10,250	0	10 YRS	87,125	74
75	TOTALS	\$ 197,616	\$ 22,457	\$ 15,407	\$ (7,050)		\$ 147,840	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	HSKP, NSG,ACT	2000 CHEVY TRUCK	2002	\$ 28,556	\$ 3,124	\$ 5,711	\$ 2,587	5	\$ 25,700	76
77	HSKP, NSG,ACT	2001 DODGE VAN	2004	10,725	2,059	2,145	86	5	6,435	77
78							0			78
79							0			79
80	TOTALS			\$ 39,281	\$ 5,183	\$ 7,856	\$ 2,673		\$ 32,135	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)	\$ 1,486,555	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 58,987	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 54,610	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,377)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 430,162	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: \_\_\_\_\_

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:		70		\$ 169,035			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		70		\$ 169,035			7

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: \$ **8,829** Description: **SEE SCHEDULE ATTACHED**

(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			\$	\$ 0	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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 \$ 169,035

13. \_\_\_\_\_/2008 \$

14. \_\_\_\_\_/2009 \$

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	<b>TOTALS</b>	\$ 0	\$ 0	\$ 0	\$ 0
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 0			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 0	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			0				2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			0				4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				0			9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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 &amp; ID Number TAMMERLANE HEALTH CARE CENTRE

# 0035659

Report Period Beginning: 01/01/2006

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 9,060	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (15,000) )	395,037		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,309		6
7	Other Prepaid Expenses	1,401		7
8	Accounts Receivable (owners or related parties)	121,071		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 563,878	\$ 0	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	215,085		15
16	Equipment, at Historical Cost	141,845		16
17	Accumulated Depreciation (book methods)	(175,943)		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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 180,987	\$ 0	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 744,865	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 134,650	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	181,914		29
30	Accrued Salaries Payable	32,414		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,524		31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,118		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 378,620	\$ 0	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	22,483		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 22,483	\$ 0	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 401,103	\$ 0	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 343,762	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 744,865	\$ 0	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 356,470	1
2	Restatements (describe):		2
3	ROUNDING	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 356,471	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(12,709)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (12,709)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 343,762	24 *

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

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,033,941	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,033,941	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 0	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 0	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	1,352	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,352	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 0	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,035,293	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	464,263	31
32	Health Care	747,477	32
33	General Administration	561,748	33
	<b>B. Capital Expense</b>		
34	Ownership	236,126	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers		35
36	Provider Participation Fee	38,325	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,047,939	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(12,646)	41
42	<b>Income Taxes</b>	(63)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (12,709)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

\*\*\* 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 TAMMERLANE HEALTH CARE CENTRE

# 0035659

Report Period Beginning: 01/01/2006

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	1,822	2,080	\$ 54,080	\$ 26.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,566	2,708	74,120	27.37	3
4	Licensed Practical Nurses	7,381	8,126	144,212	17.75	4
5	CNAs & Orderlies	19,809	21,245	175,003	8.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,831	2,091	19,429	9.29	9
10	Activity Assistants	3,070	3,541	24,062	6.80	10
11	Social Service Workers	13,453	14,546	138,517	9.52	11
12	Dietician					12
13	Food Service Supervisor	1,893	2,080	20,714	9.96	13
14	Head Cook	9,524	9,955	68,569	6.89	14
15	Cook Helpers/Assistants	2,936	3,110	21,204	6.82	15
16	Dishwashers					16
17	Maintenance Workers	4,754	5,221	42,536	8.15	17
18	Housekeepers	8,409	9,166	66,487	7.25	18
19	Laundry	2,866	3,079	20,995	6.82	19
20	Administrator	1,884	2,080	79,185	38.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,071	1,309	18,851	14.40	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>MDS</u>	1,742	2,016	36,027	17.87	32
33	Other(specify) <u>transportation</u>	1,919	2,054	13,798	6.72	33
34	TOTAL (lines 1 - 33)	86,930	94,407	\$ 1,017,789 *	\$ 10.78	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	M	\$ 4,760	1-3	35
36	Medical Director	O	36,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	1,849	10-3	38
39	Pharmacist Consultant	H	650	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	3,888	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	1,280	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 48,427		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses	11	391	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	11	\$ 391		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
SHELLY REESE	ADMINISTRATOR	0.00%	\$ 79,185	Workers' Compensation Insurance	\$ 36,034	IDPH License Fee	\$ 1,990	
			0	Unemployment Compensation Insurance	13,935	Advertising: Employee Recruitment	757	
				FICA Taxes	77,861	Health Care Worker Background Check	368	
				Employee Health Insurance	46,424	(Indicate # of checks performed 23 )		
				Employee Meals	5,512	Patient Background Checks	1,229	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,650	
				EMPLOYEE BENEFITS - OTHER	4,772	MARKETING/ADV/PROMO	366	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	10,328	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	268	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(1,650)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	( 0 )	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	( 0 )	
						Yellow page advertising	(366)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 79,185				\$ 184,538			\$ 14,940	
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
HI-CARE MANAGEMENT			\$ 120,000				Out-of-State Travel	\$
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense	
\$ 120,000							2,602	
C. Professional Services							MGMT ALLOC	
Vendor/Payee	Type		Amount				540	
HEALTHCARE HORIZONS	P.A. CONSULTANT		\$ 18,000				Entertainment Expense	
ACHIEVE SOFTWARE	DATA PROCESSING		5,284				( )	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	
NIHAN & MARTIN	DATA PROCESSING		2,335				\$ 3,142	
KBKB	ACCOUNTING		19,050					
STRATTON GIGANTI	LEGAL		9,394					
	LEGAL		225					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL				
\$ 54,288				\$				

\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 Amount of Expense Amortized Per Year								
					6								
					7 FY2003	8 FY2004	9 FY2005	10 FY2006	11 FY2007	12 FY2008	13 FY2009	14 FY2010	15 FY2011
1	PAINT/DECORATING	06/00	\$ 1,588	3 YRS	\$ 529	\$ 265	\$	\$	\$	\$	\$	\$	\$
2	PAINT/DECORATING	06/02	1,485	3 YRS	495	495	247						
3	PAINT/DECORATING	06/05	3,083	3 YRS			515	1,027	1,027	514			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 6,156		\$ 1,024	\$ 760	\$ 762	\$ 1,027	\$ 1,027	\$ 514	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. ICLTC \$4074, IL HEALTH CARE \$4,200
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (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? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 38,325  
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. \$ 5,512 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
  - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
  - 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? YES
  - 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: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ 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