

		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: 0035196

Facility Name: Tibstra House

Address: 271 East 161st Street South Holland 60473
 Number City Zip Code

County: Cook

Telephone Number: (708) 596-4442 **Fax #** (708) 596-4486

HFS ID Number: 363038592003

Date of Initial License for Current Owners: 1/24/90

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>501 (c)(3)</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: Steve Goudzwaard **Telephone Number:** (708) 371-0800

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>Steven J. Goudzwaard</u>	
	(Title) <u>Director of Finance</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 Tibstra House# 0035196 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 _____

	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>5,347</u>			<u>5,347</u>
14	TOTALS	<u>5,347</u>			<u>5,347</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.56%

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

493 (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)

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 1/24/90

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 2006 Fiscal Year: 2006

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

Facility Name & ID Number Tibstra House # 0035196 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	30,365	1,689	4,260	36,314		36,314	36,314			1
2	Food Purchase		41,512		41,512		41,512	41,512			2
3	Housekeeping	24,898	3,396	478	28,772		28,772	28,772			3
4	Laundry		791		791		791	791			4
5	Heat and Other Utilities			12,880	12,880		12,880	12,880			5
6	Maintenance	15,707	2,953	6,619	25,279		25,279	25,279			6
7	Other (specify):* Scavenger			1,179	1,179		1,179	1,179			7
8	TOTAL General Services	70,970	50,341	25,416	146,727		146,727	146,727			8
	B. Health Care and Programs										
9	Medical Director			3,300	3,300		3,300	3,300			9
10	Nursing and Medical Records	253,077	2,962	1,635	257,674		257,674	257,674			10
10a	Therapy	2,727		976	3,703		3,703	3,703			10a
11	Activities	32,742	4,754		37,496		37,496	37,496			11
12	Social Services	1,986			1,986		1,986	1,986			12
13	CNA Training										13
14	Program Transportation		8,956		8,956		8,956	8,956			14
15	Other (specify):* Program Director	31,189			31,189		31,189	31,189			15
16	TOTAL Health Care and Programs	321,721	16,672	5,911	344,304		344,304	344,304			16
	C. General Administration										
17	Administrative	25,799			25,799		25,799	25,799			17
18	Directors Fees										18
19	Professional Services			4,385	4,385		4,385	4,385			19
20	Dues, Fees, Subscriptions & Promotions			4,055	4,055		4,055	4,055			20
21	Clerical & General Office Expenses	21,114	2,310	2,968	26,392		26,392	(2,406)	23,986		21
22	Employee Benefits & Payroll Taxes			86,902	86,902	1,696	88,598	(652)	87,946		22
23	Inservice Training & Education			691	691		691	691			23
24	Travel and Seminar			594	594		594	(69)	525		24
25	Other Admin. Staff Transportation			904	904	(45)	859	859			25
26	Insurance-Prop.Liab.Malpractice			9,930	9,930		9,930	9,930			26
27	Other (specify):* Miscellaneous		2,198		2,198	(1,651)	547	547			27
28	TOTAL General Administration	46,913	4,508	110,429	161,850		161,850	(3,127)	158,723		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	439,604	71,521	141,756	652,881		652,881	(3,127)	649,754		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.

Tibstra House
ID #0035196
Schedule V, ISFR Reclassifications
FY2006

To:	Employee Benefits	Sch V, Ln 22	Staff employment physicals	\$	45
From:	Other Admin. Staff Transp	Sch V, Ln 25			
To:	Employee Benefits	Sch V, Ln 22	Staff gifts, parties, dinners, etc.	\$	1,651
From:	Miscellaneous	Sch V, Ln 27			

Facility Name & ID Number Tibstra House #0035196 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			28,936	28,936		28,936		28,936			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			28,936	28,936		28,936		28,936			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			45,616	45,616		45,616		45,616			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			45,616	45,616		45,616		45,616			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	439,604	71,521	216,308	727,433		727,433	(3,127)	724,306			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 Tibstra House

0035196

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	(2,406)	21		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	(721)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,127)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,127)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Tibstra House

ID# 0035196
 Report Period Beginning: 7/1/05
 Ending: 6/30/06

Sch. V Line
 Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Non direct care seminars	\$ (69)	24 1
2	Fundraising Employee Benefits	(652)	22 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	(721)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tibstra House

0035196

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	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(2,406)	0	0	0	0	0	0	0	0	0	0	(2,406)	21
22	Employee Benefits & Payroll Taxes	(652)	0	0	0	0	0	0	0	0	0	0	(652)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(69)	0	0	0	0	0	0	0	0	0	0	(69)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(3,127)	0	0	0	0	0	0	0	0	0	0	(3,127)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,127)	0	0	0	0	0	0	0	0	0	0	(3,127)	29

STATE OF ILLINOIS

Facility Name & ID Number Tibstra House

0035196

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	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	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)	(3,127)	0	(3,127)	45									

Facility Name & ID Number Tibstra House

0035196

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
Bethshan Association	100	Bethshan I & Bethshan II	Palos Heights	Bethshan Foundation	Palos Heights	Charitable Corp

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

TIBSTRA HOUSE

ID 0035196

Period 7/1/05 through 6/30/06

Schedule VII-A Attachment

Board of Trustees 2005-2006

Brian Dobben	President	819 Argyle	Flossmoor	IL	60422
Donald Poortenga	Secretary	1135 Stommel Place	Dyer	IN	46311
Timothy Eriks	Treasurer	1208 Ballybunion Ct.	Dyer	IN	46311
Bob Payne	Vice President	13617 Arrowhead Ct	Orland Park	IL	60462
Marge Boerman	Director	2258 W 111th Place	Chicago	IL	60643
John Groenboom	Director	N1525 Oak Shores Ln	Fontana	WI	53125
Jim Hofman	Director	12212 S 89th Ave	Palos Park	IL	60464
James Van Dyke	Director	11 N 215 Capullet Cr	Elgin	IL	60123
James VanKampen	Director	1 S 437 Lewis	Lombard	IL	60148
Neil VerHagen	Director	16930 Avalon Ct.	South Holland	IL	60473
Gerald VanProoyen	Director	1336 Inverness Lane	Schererville	IN	46375
Burdette Zandstra	Director	2705 Parkway Drive	Highland	IN	46322

None of the above Board Members directly provided services to Bethshan Association other than their voluntary, non-compensated duties as members of the Board of Directors. Nor has any Board member ownership in any entity that conducted business transactions with Bethshan during this reporting period.

Facility Name & ID Number

Tibstra House

#

0035196

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									\$		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 Tibstra House

0035196

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Maintenance	# beds 128	11	\$ 123,604	\$ 120,412	16	\$ 15,451	1
2	12	Social Services	# clients 70	11	27,613	27,613	5	1,972	2
3	14	Program Transportation	# beds 128	11	38,055		16	4,757	3
4	17	Administrator	# beds 128	11	206,392	206,392	16	25,799	4
5	19	Professional Services	# beds 128	11	26,311		16	3,289	5
6	20	dues/Fees/Subscriptions	# beds 128	11	28,235		16	3,529	6
7	21	Clerical & General Office	# beds 128	11	189,976	168,825	16	23,747	7
8	22	Workers Comp	budgeted salaries 4,271,152	11	53,454		447,148	5,596	8
9	22	Pension	# beds 128	11	10,416		16	1,302	9
10	23	In Service Training	# beds 128	11	3,611		16	451	10
11	24	Seminars & Workshop	# beds 128	11	1,136		16	142	11
12	25	Staff Travel	# beds 128	11	6,715		16	839	12
13	26	Liability Insurance	# beds 128	11	22,787		16	2,848	13
14	27	Miscellaneous	# beds 128	11	12,349		16	1,544	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 750,654	\$ 523,242		\$ 91,266	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Tibstra House

0035196 Report Period Beginning: 7/1/05

Ending: 6/30/06

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
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.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
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.)			\$	5
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.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2001	_____	8		
2002	_____	9		
2003	_____	10		
2004	_____	11		
2005	_____	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2005	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

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 Tibstra House COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035196

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 Tibstra House

0035196 Report Period Beginning:

7/1/05 Ending:

6/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 2,985 B. General Construction Type: Exterior brick Frame wood Number of Stories 1 w/basement

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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>16 bed ICF w/garage</u>	<u>18,000</u>	<u>1989</u>	<u>\$ 25,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	18,000		\$ 25,000	3

Facility Name & ID Number Tibstra House

0035196

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 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		1990	1990	\$ 408,781	\$ 10,220	40	\$ 10,220	\$	\$ 167,998	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Garage			1992	9,830	491	20	491		6,646	9
10	Landscaping			1990	2,503	63	40	63		994	10
11	Driveway; Parking			1990	33,639	54	15	54		33,638	11
12	Washroom remodeling			1996	20,165	1,008	20	1,008		9,693	12
13	Kitchen sink & counter tops			2001	2,635	263	10	263		1,406	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

*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 Tibstra House

0035196

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)	\$ 477,553	\$ 12,099		\$ 12,099	\$	\$ 220,375	70

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

Facility Name & ID Number Tibstra House # 0035196 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	\$ 21,619	\$ 3,906	\$ 3,906	\$		\$ 13,287	71
72	Current Year Purchases	475	10	10			10	72
73	Fully Depreciated Assets	79,487	1,070	1,070			79,487	73
74								74
75	TOTALS	\$ 101,581	\$ 4,986	\$ 4,986	\$		\$ 92,784	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	client transportation	Ford GCII Bus/Ford Windstar	2001/2002	\$ 58,877	\$ 10,435	\$ 10,435	\$	5	\$ 53,534	76
77	Executive Director	Mazda Tribute	2003	2,956	591	591		5	1,976	77
78	Maintenance	Ford F250 pickup w/plow	2000	4,090	182	182		5	4,090	78
79	Maintenance	Chevy Silverado 4x4 w/plow	2005	3,213	643	643		5	926	79
80	TOTALS			\$ 69,136	\$ 11,851	\$ 11,851	\$		\$ 60,526	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)	\$ 673,270	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 28,936	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 28,936	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)	\$ 373,685	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 Tibstra House

0035196

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: _____

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.

Facility Name & ID Number Tibstra House # 0035196 Report Period Beginning: 7/1/05 Ending: 6/30/06

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3 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	4					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number Tibstra House# 0035196Report 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	\$ 686,691	\$ 337,782	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	144,150	771,148	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,599	87,319	6
7	Other Prepaid Expenses		2,170	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 839,440	\$ 1,198,419	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000	459,750	13
14	Buildings, at Historical Cost	477,553	5,046,650	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	170,717	1,788,632	16
17	Accumulated Depreciation (book methods)	(373,685)	(3,530,889)	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)	\$ 299,585	\$ 3,764,143	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,139,025	\$ 4,962,562	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 33,859	\$ 178,463	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	32,520	291,264	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,420	10,623	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		7,174	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>403(B) Contributinos Payable</u>	389	2,483	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 68,188	\$ 490,007	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		193,200	39
40	Mortgage Payable		519,479	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)	\$	\$ 712,679	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 68,188	\$ 1,202,686	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,070,837	\$ 3,759,876	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,139,025	\$ 4,962,562	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,004,643	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,004,643	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	65,719	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)	\$ 65,719	17
B. Transfers (Itemize):			
18	Computer Software	475	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 475	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,070,837	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Tibstra House# 0035196Report 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	\$ 774,287	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 774,287	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		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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DT Transportation	18,865	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,865	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 793,152	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	146,727	31
32	Health Care	344,304	32
33	General Administration	161,850	33
B. Capital Expense			
34	Ownership	28,936	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	45,616	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 727,433	40
41	Income before Income Taxes (line 30 minus line 40)**	65,719	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 65,719	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 Tibra House

0035196

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	319	434	10,317	23.77	3
4	Licensed Practical Nurses	305	305	7,086	23.23	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	101	131	2,727	20.82	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,992	2,180	32,742	15.02	9
10	Activity Assistants					10
11	Social Service Workers	49	56	1,986	35.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,828	2,117	30,365	14.34	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	778	843	15,707	18.63	17
18	Housekeepers	1,754	2,039	24,898	12.21	18
19	Laundry					19
20	Administrator	220	260	16,194	62.28	20
21	Assistant Administrator					21
22	Other Administrative	237	247	9,605	38.89	22
23	Office Manager					23
24	Clerical	1,027	1,160	21,114	18.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,014	2,277	53,127	23.33	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	14,595	16,078	182,547	11.35	30
31	Medical Records					31
32	Other Health Care Program Director	889	1,013	31,189	30.79	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	26,108	29,140	\$ 439,604 *	\$ 15.09	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	71	\$ 4,260	1-3	35
36	Medical Director		3,300	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	2	112	10a-3	40
41	Occupational Therapy Consultant	6	318	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	14	546	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Podiatrist</u>	6	720	10-3	46
47	<u>Psychiatrist</u>	5	915	10-3	47
48					48
49	TOTAL (lines 35 - 48)	104	\$ 10,171		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

**TIBSTRA HOUSE
SCHEDULE OF STAFF TRAVEL
FY 2006**

	<u>TRAVEL EXPENSE</u>	<u>SEMINARS COST</u>	
	Staff intra-agency travel for meetings at central office, etc.		
<u>675 Allocation</u>			
9/27-29/05			IARF/ICAN Annual Conference Joseph Lanenga, Executive Director Janet Herrmann, Program Director Chad Colyer, Training Coordinator Springfield, IL
	31.54		
1/24/2006			ARC of IL Annual QMRP Leadership Conference Amy Tiemersma, LSCW Michelle Gabrielse, QMRP Peggy Mollema, QMRP Alsip, IL
	7.50	13.75	
		110.00	
3/2/2006			IL Healthcare Assoc Therapeutic Activities Efren Cantu, Activities Marie Inczauskis, Activities Utica, IL
		200.00	
4/12/2006			Bureau of Best Practices DHS Nurse Trainer Program & MA/SAMA Erica Ogden Elgin, IL
	52.80		
4/26-27/06			OIG Training Basic Investigative Skills Frea Mars, Program Director Dave Tiemersma Oak Lawn, IL
	29.02		
6/13/2006			Debie Fuess Water Safety Course Efren Cantu, Activity Director Valerie Poulos, DSP Kevin Gruzewski, Activity Director Marie Inczauskis, Activity Director Tina Cucci, DSP
		80.00	
TOTAL AFTER ADJUSTMENTS			
	120.86	403.75	524.61

Tibstra House
ID # 0035196
Schedule XX (12) Explanation of Salary Allocation
FY2006

Dave Tiemersma	(Ln 15-5)	Program Director Salary	\$	34,140
	(Ln 10-1)	QMRP Salary	\$	9,457

Facility Name & ID Number Tibstra House

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount. _____
- (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? 5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ n/a 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. \$ 45,616
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? yes 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. \$ 612 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? 100%
- d. Have vehicle usage logs been maintained? no
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
- g. Does the facility transport residents to and from day training? yes**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 18,865
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Dreyer, Ooms, & VanDrunen Ltd 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.