

		FOR BHF USE				

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

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

I. IDPH Facility ID Number: 0014753

Facility Name: Twin Willows Nursing Center

Address: 1600 North Broadway Salem 62881
 Number City Zip Code

County: Marion

Telephone Number: (618) 548-0542 **Fax #** (618) 548-5893

HFS ID Number: 37-098-79472001

Date of Initial License for Current Owners: 05/02/73

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input checked="" 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: Todd C. Woodruff **Telephone Number:** (618) 548-0542

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01-01-2006 to 12-31-06 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) _____	<u>3-30-2008</u>
	(Type or Print Name) <u>Todd C. Woodruff</u>	(Date)
Paid Preparer	(Title) <u>Administrator</u>	
	(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 Twin Willows Nursing Center# 0014753 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>29</u>	Skilled (SNF)	<u>29</u>	<u>10,585</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>45</u>	Intermediate (ICF)	<u>45</u>	<u>16,425</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>74</u>	TOTALS	<u>74</u>	<u>27,010</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	Total	
8	SNF	<u>4,020</u>	<u>2,671</u>	<u>2,859</u>	<u>9,550</u>	8
9	SNF/PED					9
10	ICF	<u>12,792</u>	<u>2,911</u>	<u>47</u>	<u>15,750</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,812</u>	<u>5,582</u>	<u>2,906</u>	<u>25,300</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.67%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

n/aF. 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 01/01/73

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 29 and days of care provided 2,859Medicare Intermediary Administar Federal Kentucky

IV. ACCOUNTING BASIS

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

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

Facility Name & ID Number Twin Willows Nursing Center # 0014753 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

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

	Operating Expenses	Costs Per General Ledger				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	124,144	12,688	4,660	141,492		141,492		141,492		1
2	Food Purchase		139,566		139,566		139,566	(5,952)	133,614		2
3	Housekeeping	40,534	9,543		50,077		50,077		50,077		3
4	Laundry	21,933	6,743		28,676		28,676		28,676		4
5	Heat and Other Utilities			68,493	68,493		68,493	(3,003)	65,490		5
6	Maintenance	26,898	11,268	24,044	62,210		62,210		62,210		6
7	Other (specify):*										7
8	TOTAL General Services	213,509	179,808	97,197	490,514		490,514	(8,955)	481,559		8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	739,056	75,147	5,968	820,171		820,171		820,171		10
10a	Therapy										10a
11	Activities	24,137	4,149		28,286		28,286		28,286		11
12	Social Services	11,999		2,270	14,269		14,269		14,269		12
13	CNA Training	1,761			1,761		1,761		1,761		13
14	Program Transportation			2,946	2,946		2,946		2,946		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	776,953	79,296	12,384	868,633		868,633		868,633		16
	C. General Administration										
17	Administrative	55,000			55,000		55,000		55,000		17
18	Directors Fees										18
19	Professional Services			18,897	18,897		18,897		18,897		19
20	Dues, Fees, Subscriptions & Promotions			27,868	27,868		27,868	(19,681)	8,187		20
21	Clerical & General Office Expenses		15,955	4,044	19,999		19,999		19,999		21
22	Employee Benefits & Payroll Taxes			197,168	197,168		197,168		197,168		22
23	Inservice Training & Education										23
24	Travel and Seminar			574	574		574		574		24
25	Other Admin. Staff Transportation		2,946		2,946		2,946		2,946		25
26	Insurance-Prop.Liab.Malpractice			59,195	59,195		59,195		59,195		26
27	Other (specify):*										27
28	TOTAL General Administration	55,000	18,901	307,746	381,647		381,647	(19,681)	361,966		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,045,462	278,005	417,327	1,740,794		1,740,794	(28,636)	1,712,158		29

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

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

Facility Name & ID Number Twin Willows Nursing Center #0014753 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			24,447	24,447		24,447		24,447			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,173	29,173		29,173	(10,441)	18,732			32
33	Real Estate Taxes			25,766	25,766		25,766		25,766			33
34	Rent-Facility & Grounds			1,200	1,200		1,200		1,200			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			80,586	80,586		80,586	(10,441)	70,145			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		65,832	252,184	318,016		318,016		318,016			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		7,496		7,496		7,496		7,496			41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		73,328	292,699	366,027		366,027		366,027			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,045,462	351,333	790,612	2,187,407		2,187,407	(39,077)	2,148,330			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 Twin Willows Nursing Center# 0014753Report Period Beginning: 1/1/2006Ending: 12/31/2006

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	5,724	2-7		4
5	Telephone, TV & Radio in Resident Rooms	3,003	5-7		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	7,458	32-7		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	228	2-7		13
14	Non-Care Related Interest	2,983	32-7		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	10,542	20-7		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	9,139	20-7		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 39,077		\$	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))	\$ 39,077		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	
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Twin Willows Nursing Center

ID# 0014753

Report Period Beginning: 01-01-2006

Ending: 12-31-06

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Facility Name & ID Number Twin Willows Nursing Center

0014753

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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
Helen Woodruff	95	n/a	n/a	Motel Developments	Salem	motel
Jeffrey Woodruff	5	n/a	n/a	Woodruff Services	Carbondale	ac/heaters

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	34 office storage	\$ 1,200	motel developments	100.00%	\$ 1,200	\$	1
2	V	20 background checks	1,400	woodruff services	100.00%	1,400		2
3	V	30 equipment	4,117	woodruff services	100.00%	4,117		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		\$ 6,717			\$ 6,717	\$ *	14

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

Facility Name & ID Number Twin Willows Nursing Center # 0014753 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Todd Woodruff	Administrator	Management	0.00	0	60	100.00	Interest	\$ 18,994	1
2	Tood Woodruff	Administrator	Management	0.00	0	60	100.00	Wages	55,000	2
3	Helen Woodruff	audit accounting		95.00	0	20	30.00	fees	16,697	3
4										4
5	Jeffrey Woodruff	n/a		5.00	0			interest	968	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 91,659	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 Twin Willows Nursing Center

0014753

Report Period Beginning: 1/1/2006

Ending: 12/31/06

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	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	Bonds		x	working capital	n/a	11-2-72	\$ 8,000	\$ 8,000	12-31-84	10.0000	\$ 800	1								
2	Bonds		x	purchase facility	n/a	11-2-72	36,450	5,150	12-31-84	10.0000	515	2								
3	Todd Woodruff	x		working capital	n/a	1-87	252,097	43,742	12-31-05	8.7500	18,994	3								
4												4								
5												5								
Working Capital																				
6	Financing Charges		x	insurance policy finance	n/a					9.7400	1,726	6								
7	Jeffrey Woodruff/acc.pay	x		accounts payable/working cap	n/a						1,165	7								
8	Guardian Insurance		x	working capital	n/a	8/4/05	41,215			7.4000	2,990	8								
9	TOTAL Facility Related						\$ 337,762	\$ 56,892			\$ 26,190	9								
B. Non-Facility Related*																				
10	Motel Developments	x		purchase office building		4-1-86	56,000	22,278	12-31-05	8.7500	2,983	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$ 56,000	\$ 22,278			\$ 2,983	14								
15	TOTALS (line 9+line14)						\$ 393,762	\$ 79,170			\$ 29,173	15								

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

* 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ 30,010	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.)		\$ 27,380	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (2,630)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 28,396	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.		\$ 25,766	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	24,406	8
	2002	25,003	9
	2003	24,940	10
	2004	26,513	11
	2005	27,380	12
<u>actual bill for 2006</u>			

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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 Twin Willows Nursing Center COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0014753

CONTACT PERSON REGARDING THIS REPORT Todd C. Woodruff

TELEPHONE (618) 548-0542 FAX #: (618) 548-5893

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>11-02000-027</u>	<u>pt.se.ne.</u>	\$ <u>27,380.00</u>	\$ <u>27,380.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>27,380.00</u>	\$ <u>27,380.00</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.

Facility Name & ID Number Twin Willows Nursing Center

0014753 Report Period Beginning:

1/1/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,250 B. General Construction Type: Exterior brick Frame fireproof construction Number of Stories 1

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

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

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

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

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

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>facility</u>	<u>87,000</u>	<u>1973</u>	<u>\$ 28,000</u>	1
2					2
3	TOTALS	87,000		\$ 28,000	3

Facility Name & ID Number Twin Willows Nursing Center

0014753

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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

	1 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	74		1973	1966	\$ 380,183	\$ 3,785	33.33	\$ 3,785	\$	\$ 380,183	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9											9
10											10
11		water heater		1977	1,024		10			1,024	11
12		fire exit lights		1978	695		5			695	12
13		emergency power		1978	1,695		5			1,695	13
14		emergency power		1979	1,359		5			1,395	14
15		compressor		1979	372		5			372	15
16		battery units		1980	570		5			570	16
17		compressor		1980	533		3			533	17
18		mixing valve		1981	780		10			780	18
19		central air		1982	771		10			771	19
20		disposal		1982	745		10			745	20
21		storage shed		1983	600		8			600	21
22		3 heat pumps		1983	2,245		10			2,245	22
23		phone system		1985	3,318		20			3,318	23
24		2 heat pumps		1985	1,400		8			1,400	24
25		driveway		1988	2,767		3			2,767	25
26		seal coat patch driveway		1997	1,850		3			1,850	26
27		door monitor system		1999	7,590	759	10	759		5,503	27
28		3 central air systems		1999	12,588		5			12,588	28
29		roof		1999	64,580	4,305	15	4,305		30,494	29
30		asphalt top coat driveway		1999	16,136	2,017	8	2,017		14,371	30
31		outside walkway lights		1999	600		5			600	31
32		south wing sewer line		2000	1,046	105	10	105		691	32
33		3 outside hydrants		2000	525	52	10	52		316	33
34		asphalt sidewalks-wings		2005	6,270	71	8	784		855	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 Twin Willows Nursing Center

0014753

Report Period Beginning:

01-01-2006 Ending:

12-31-06

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)	\$ 510,242	\$ 11,807		\$ 11,807	\$	\$ 466,325	70

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

Facility Name & ID Number Twin Willows Nursing Center # 0014753 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 104,575	\$ 11,880	\$ 11,880	\$		\$ 71,844	71
72	Current Year Purchases	7,540	401	401		6	401	72
73	Fully Depreciated Assets	143,794					134,111	73
74		1,556	311	311			438	74
75	TOTALS	\$ 257,465	\$ 12,592	\$ 12,592	\$		\$ 206,794	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			2006	\$ 41,318	\$ 48	\$ 48	\$	7	\$ 48	76
77										77
78										78
79										79
80	TOTALS			\$ 41,318	\$ 48	\$ 48	\$		\$ 48	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 837,025	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,447	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 24,447	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)	\$ 673,167	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	aluminum trailer	\$ 10,000	\$	\$ 10,000	86
87	216 S. Broadway	56,000		56,000	87
88	schedule	12,307	258	11,826	88
89	driveway 216	6,119	285	3,606	89
90					90
91	TOTALS	\$ 84,426	\$ 543	\$ 81,432	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: Motel Developments Inc. rents storage space

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>1,200</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>1,200</u>			7

10. Effective dates of current rental agreement:

Beginning 01/01/06

Ending 12/31/06

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

Fiscal Year Ending Annual Rent

12.	<u>/2007</u>	\$ <u> </u>
13.	<u>/2008</u>	\$ <u> </u>
14.	<u>/2009</u>	\$ <u> </u>

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

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

9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ n/a Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ <u> </u>	\$ <u> </u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u> </u>	\$ <u> </u>	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 Twin Willows Nursing Center # 0014753 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>87.3</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>42.3</u></p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		1,186		1,186
4	Clinical Wages (b)		575		575
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,761	\$	\$ 1,761
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,761		

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

- (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		hrs	\$	5,400	\$ 92,570	\$	5,400	\$ 92,570	1
2	Licensed Speech and Language Development Therapist		hrs		794	27,003		794	27,003	2
3	Licensed Recreational Therapist		hrs		6,695	132,611		6,695	132,611	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			59,618			59,618	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>x-ray/lab</u>					6,214			6,214	13
14	TOTAL			\$	12,889	\$ 318,016	\$	12,889	\$ 318,016	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 Twin Willows Nursing Center# 0014753Report Period Beginning: 1/1/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of #####

(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	\$ 212,813	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	718,815		3
4	Supply Inventory (priced at)	12,700		4
5	Short-Term Investments			5
6	Prepaid Insurance	11,091		6
7	Other Prepaid Expenses	919		7
8	Accounts Receivable (owners or related parties)	13,933		8
9	Other(specify): <u>tax deosit</u>	14,679		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 984,950	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	42,375		11
12	Long-Term Investments			12
13	Land	32,000		13
14	Buildings, at Historical Cost	436,183		14
15	Leasehold Improvements, at Historical Cost	95,077		15
16	Equipment, at Historical Cost	362,191		16
17	Accumulated Depreciation (book methods)	(754,599)		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)	\$ 213,227	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,198,177	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 112,101	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	31,193		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,103		31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,645		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 172,042	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	128,349		39
40	Mortgage Payable			40
41	Bonds Payable	13,150		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>stock</u>	3,500		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 144,999	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 317,041	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 881,136	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,198,177	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 756,502	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 756,502	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	316,868	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)	\$ 316,868	17
B. Transfers (Itemize):			
18	dividend	(100,000)	18
19	tax	(87,056)	19
20	A. Additions (deductions):	(5,178)	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (192,234)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 881,136	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Twin Willows Nursing Center# 0014753Report Period Beginning: 1/1/2006Ending: 12/31/2006**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	\$ 2,861,576	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,861,576	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	1,492	11
12	Gift and Coffee Shop	7,376	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,724	14
15	Telephone, Television and Radio	2,601	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	463	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)	\$ 17,656	23
D. Non-Operating Revenue			
24	Contributions	300	24
25	Interest and Other Investment Income***	6,289	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,589	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>lawn care</u>	675	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 675	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,886,496	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	481,559	31
32	Health Care	868,633	32
33	General Administration	361,966	33
B. Capital Expense			
34	Ownership	70,145	34
C. Ancillary Expense			
35	Special Cost Centers	325,512	35
36	Provider Participation Fee	40,515	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,148,330	40
41	Income before Income Taxes (line 30 minus line 40)**	738,166	41
42	Income Taxes	(222,942)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 515,224	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.

*** 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 Twin Willows Nursing Center

0014753

Report Period Beginning: 1/1/2006

Ending:

12/31/2006

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,016	2,248	\$ 61,618	\$ 27.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,435	10,731	193,134	18.00	3
4	Licensed Practical Nurses	9,286	9,591	145,490	15.17	4
5	CNAs & Orderlies	41,889	42,588	321,637	7.55	5
6	CNA Trainees	259	259	1,761	6.80	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,060	1,174	8,917	7.60	9
10	Activity Assistants	1,939	2,131	15,220	7.14	10
11	Social Service Workers	1,471	1,581	11,999	7.59	11
12	Dietician					12
13	Food Service Supervisor	1,711	1,804	15,205	8.43	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,514	7,656	53,380	6.97	15
16	Dishwashers	7,765	7,969	55,559	6.97	16
17	Maintenance Workers	1,654	2,022	26,898	13.30	17
18	Housekeepers	5,746	5,877	40,534	6.90	18
19	Laundry	2,709	2,915	21,933	7.52	19
20	Administrator	2,915	2,963	55,000	18.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					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	1,907	2,014	17,177	8.53	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	100,276	103,523	\$ 1,045,462 *	\$ 10.10	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	96	\$ 4,660	1-3	35
36	Medical Director	12	1,200	9-3	36
37	Medical Records Consultant	19	487	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	1,800	10-3	39
40	Physical Therapy Consultant	63	3,481	10-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	200	10-3	43
44	Activity Consultant				44
45	Social Service Consultant	42	2,410	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	282	\$ 14,238		49

C. CONTRACT NURSES

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

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? yes
If YES, give association name and amount. IHCA 2966
- (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? 6
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,788 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (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. \$ 40,515
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. \$ n/a Has any meal income been offset against related costs? yes Indicate the amount. \$ 5,724
- (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? >50%
- 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. \$ na
- (17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: n/a The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? na If no, please explain. na
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.