

Facility Name & ID Number Galena Stauss Hospital SNU# 8007866 Report Period Beginning: 10/01/2006 Ending: 09/30/2007

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	<u>57</u>	Intermediate (ICF)	<u>57</u>	<u>20,805</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>57</u>	TOTALS	<u>57</u>	<u>20,805</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	<u>5,971</u>	<u>14,211</u>		<u>20,182</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>5,971</u>	<u>14,211</u>		<u>20,182</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 97.01%

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)

NoneF. Does the facility maintain a daily midnight census? YesG. 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 01/01/70

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

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: N/A Fiscal Year: 09/30/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Hospital SNU # 8007866 Report Period Beginning: 10/01/2006 Ending: 09/30/2007

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	192,556		158,983	351,539	351,539		351,539			1
2	Food Purchase		64,617		64,617	64,617		64,617			2
3	Housekeeping	123,061		22,429	145,490	145,490		145,490			3
4	Laundry	9,993		30,031	40,024	40,024		40,024			4
5	Heat and Other Utilities			54,019	54,019	54,019		54,019			5
6	Maintenance	70,632		19,740	90,372	90,372		90,372			6
7	Other (specify):*										7
8	TOTAL General Services	396,242	64,617	285,202	746,061	746,061		746,061			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,166,037		23,856	1,189,893	1,189,893		1,189,893			10
10a	Therapy										10a
11	Activities										11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Incontinent Supplies		38,347		38,347	38,347		38,347			15
16	TOTAL Health Care and Programs	1,166,037	38,347	23,856	1,228,240	1,228,240		1,228,240			16
	C. General Administration										
17	Administrative	78,379		74,278	152,657	152,657		152,657			17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	27,538		26,098	53,636	53,636		53,636			21
22	Employee Benefits & Payroll Taxes			250,785	250,785	250,785		250,785			22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			18,882	18,882	18,882		18,882			26
27	Other (specify):*										27
28	TOTAL General Administration	105,917		370,043	475,960	475,960		475,960			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,668,196	102,964	679,101	2,450,261	2,450,261		2,450,261			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			70,507	70,507	70,507	70,507				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			70,507	70,507	70,507	70,507	70,507			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			31,208	31,208	31,208	31,208	31,208			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			31,208	31,208	31,208	31,208	31,208			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,668,196	102,964	780,816	2,551,976	2,551,976	2,551,976	2,551,976			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$		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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ID# 8007866

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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 Galena Stauss Hospital SNU

8007866

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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

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Hospital SNU # 8007866 Report Period Beginning: 10/01/2006 Ending: 09/30/2007

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Hospital SNU

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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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Galena Stauss Hospital SNU COUNTY Jo Daviess

FACILITY IDPH LICENSE NUMBER 8007866

CONTACT PERSON REGARDING THIS REPORT Tracy Kiley-Bauer

TELEPHONE (815) 776-1340 FAX #: (815) 776-7274

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Galena Stauss Hospital SNU

8007866 Report Period Beginning:

10/01/2006 Ending:

09/30/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,191 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

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

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

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

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

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

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				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Hospital SNU

8007866

Report Period Beginning:

10/01/2006

Ending:

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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	57		1962	1962	\$ 140,187	\$ 3,186	47	\$ 3,186	\$	\$ 135,803	4
5				1971	172,407	4,205	41	4,205		172,006	5
6				1981	57,844	2,314	Various	2,314		53,409	6
7				1988	171,482	4,287	Various	4,287		83,240	7
8											8
Improvement Type**											
9		VARIOUS ADDITIONS		04/01/68	2,827	-	7	-		2,827	9
10		VAR. ADD.		04/01/69	63	-	7	-		63	10
11		VAR. ADD.		04/01/71	7,134	-	7	-		7,134	11
12		VAR. ADD.		04/01/72	229	-	15	-		229	12
13		VAR. ADD.		04/01/73	151	-	10	-		151	13
14		CURB.GUTTER&SDWLK-FRONT ENT		04/01/81	1,003	-	12	-		1,003	14
15		PARKING LOT EXPAN.		04/01/81	7,150	-	12	-		7,150	15
16		LANDSCAPING-HARMS		04/01/83	489	-	10	-		489	16
17		GRAVEL PARKING LOT		04/01/88	3,096	-	5	-		3,096	17
18		SIDEWALK		04/01/88	185	-	10	-		185	18
19		FENCE AROUND CHILLER		04/01/89	226	-	15	-		226	19
20		SIDEWALKS & CEMENT SLAB		04/01/89	801	-	15	-		801	20
21		CHAIN LINK FENCE		04/01/89	330	-	15	-		330	21
22		CONCRETE PARKING LOT		04/01/89	1,376	-	15	-		1,376	22
23		GAZEBO		04/01/89	1,282	-	15	-		1,282	23
24		SIDEWALKS-SPROULE		04/01/90	716	-	15	-		716	24
25		LANDSCAPING		03/31/04	1,209	121	10	121		423	25
26		CONCRETE DRIVEWAY		04/01/91	720	-	15	-		720	26
27		LANDSCAPING COURTYARD		04/01/91	1,261	-	10	-		1,261	27
28		PAVE PARKING LOT		04/01/94	1,902	-	12	-		1,902	28
29		PHYSICAL THERAPY/HELIO PAD		04/01/95	2,284	-	8	-		2,284	29
30		14 CAR BUMPERS		04/01/96	222	-	5	-		222	30
31		PARKING LOT		06/01/00	25,239	1,683	15	1,683		12,269	31
32		CEDAR PRIVACY FENCE		04/01/01	1,885	236	8	236		1,531	32
33		132 SHRUBS		03/01/02	1,421	142	5	142		1,421	33
34		LANDSCAPING		03/31/02	929	93	10	93		511	34
35		2 TREES		03/31/02	132	7	20	7		36	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Hospital SNU

8007866

Report Period Beginning:

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09/30/2007

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	WOODEN FENCE AROUND HVAC	03/31/02	\$ 593	\$ 74	8	\$ 74	\$	\$ 407	37
38	MOVING/FLATING OF BACKFILL	03/31/02	1,704	170	5	170		1,704	38
39	HANDICAP ENTRANCE	03/31/02	739	49	15	49		271	39
40	REPAIR TO SIDEWALK (CLINIC/NH)	03/31/02	1,136	76	15	76		416	40
41	MOVING/FLATTENING OF BACKFILL	11/29/02	373	75	5	75		336	41
42	TWO BRONZE PLAQUES	03/20/03	324	32	10	32		146	42
43	SHRUBS/LANDCAPING/MULCHING	06/05/03	1,672	167	10	167		752	43
44	RESURFACE PARKING LOT	07/08/03	1,392	116	12	116		522	44
45	LANDSCAPING/SHRUBS/MULCH	07/23/03	406	41	10	41		183	45
46	PARKING LOT	07/25/05	2,848	356	8	356		890	46
47	LANDSCAPING & PARKING LOT	06/01/00	39,208	2,614	15	2,614		19,060	47
48	9 SHRUBS	03/31/02	98	10	5	10		98	48
49	2 TREES	03/31/02	75	4	20	4		21	49
50	LANDSCAPING	03/31/02	538	54	10	54		296	50
51	MULCH	03/31/02	64	6	10	6		35	51
52	BULLET EDGING	07/31/03	264	53	5	53		237	52
53	LANDSCAPING	07/31/03	1,185	119	10	119		533	53
54	SHRUBS	07/31/03	1,378	276	5	276		1,240	54
55	VARIOUS ADDITIONS	04/01/62	9,558	-	30	-		9,558	55
56	VAR. ADD.	04/01/69	471	-	20	-		471	56
57	STOREROOM	04/01/70	11,787	281	42	281		11,767	57
58	AIR CONDITIONING	04/01/70	5,137	-	20	-		5,137	58
59	AIR CONDITIONING	04/01/74	6,324	-	20	-		6,324	59
60	VARIOUS ADDITIONS	04/01/74	1,317	38	35	38		1,260	60
61	STOREROOM & MTC-GENERAL	04/01/75	35,868	1,055	34	1,055		34,291	61
62	STOREROOM & MTC-ELECTRICAL	04/01/75	3,825	-	20	-		3,825	62
63	STOREROOM & MTC-MECHANICAL	04/01/75	8,222	-	25	-		8,222	63
64	STOREROOM & MTC-SPRINKLER	04/01/75	1,481	-	25	-		1,481	64
65	VARIOUS ADDITIONS	04/01/75	111	-	25	-		111	65
66	ELECTRICAL 1975 ADDN	04/01/77	268	-	18	-		268	66
67	STORM WINDOWS & SCREENS-1962	04/01/77	1,031	32	32	32		982	67
68	REMODEL X-RAY ROOM	04/01/81	11,235	401	28	401		10,633	68
69	HEATING, VENTING, & AIR COND	04/01/82	1,150	-	8	-		1,150	69
70	TOTAL (lines 4 thru 69)		\$ 757,962	\$ 22,370		\$ 22,370	\$	\$ 616,726	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Galena Stauss Hospital SNU

8007866

Report Period Beginning:

10/01/2006 Ending: 09/30/2007

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

1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Totals from Page 12A, Carried Forward		\$ 757,962	\$ 22,370		\$ 22,370	\$	\$ 616,726	37
38	INSULATION	04/01/82	5,661	-	15	-		5,661	38
39	ENCLOSED PORCH PATIO	04/01/82	2,975	-	15	-		2,975	39
40	RENOVATION OF C.S. AREA	04/01/83	1,067	-	20	-		1,067	40
41	LIGHT FIXTURES	04/01/84	530	-	10	-		530	41
42	VINYL WALL COVERING	04/01/84	3,975	-	10	-		3,975	42
43	224 CORRIDOR HANDRAIL	04/01/84	1,435	57	25	57		1,349	43
44	DIETARY REMODELING	04/01/84	1,384	55	25	55		1,301	44
45	MEDICAL RECORDS REMODELING	04/01/84	603	24	25	24		567	45
46	ELECTRICAL WORK	04/01/85	275	-	20	-		275	46
47	REMOTE THERMOSTATS	04/01/85	1,587	-	20	-		1,587	47
48	WALL COVERINGS	04/01/85	3,769	-	10	-		3,769	48
49	GENERAL CONTRACT	04/01/85	32,281	1,345	24	1,345		30,263	49
50	ELECTRICAL	04/01/85	19,623	-	20	-		19,623	50
51	MECHANICAL	04/01/85	29,729	-	20	-		29,729	51
52	MILLWORK	04/01/85	11,688	-	20	-		11,688	52
53	FLOORING	04/01/85	3,847	-	5	-		3,847	53
54	PAINTING	04/01/85	6,443	-	5	-		6,443	54
55	NEW ROOM-GIESE	04/01/86	11,426	-	10	-		11,426	55
56	REMODELING-NURSERY	04/01/86	223	-	10	-		223	56
57	PAINTING-TIEGS	04/01/87	1,551	-	5	-		1,551	57
58	12-NEW WINDOWS-GREENCO	04/01/87	3,873	-	12	-		3,873	58
59	ROOF REPLACEMENT	04/01/88	1,090	-	10	-		1,090	59
60	REMODELING-OLD N.H.	04/01/88	1,308	65	20	65		1,275	60
61	FLOOR COVERINGS-BLDG ADD'N	05/01/88	3,860	-	10	-		3,860	61
62	PAINTING-BLDG ADD'N	05/01/88	7,644	-	5	-		7,644	62
63	MILLWORK-BLDG ADD'N	05/01/88	5,952	298	20	298		5,778	63
64	PLUMBING-BLDG ADD'N	05/01/88	24,990	1,249	20	1,249		24,261	64
65	HEATING & A/C-BLDG ADD'N	05/01/88	24,438	1,222	20	1,222		23,725	65
66	ELECTRICAL-BLDG ADD'N	05/01/88	29,353	1,468	20	1,468		28,497	66
67	FIRE ALARM SYSTEM	04/01/89	9,342	-	15	-		9,342	67
68	AIR CONDITIONING REPLACEMENT	04/01/89	8,507	-	10	-		8,507	68
69	BOILER REPLACEMENT	04/01/89	21,149	1,057	20	1,057		19,562	69
70	TOTAL (lines 4 thru 69)		\$ 1,039,536	\$ 29,212		\$ 29,212	\$	\$ 891,987	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

STATE OF ILLINOIS

Facility Name & ID Number Galena Stauss Hospital SNU

8007866

Report Period Beginning:

10/01/2006

Ending:

09/30/2007

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Totals from Page 12B, Carried Forward	\$ 1,039,536	\$ 29,212		\$ 29,212	\$ 0	\$ 891,987		37
38	INSULATION	04/01/90 948	-	10	-		948		38
39	NEW DOORS-GREENCO	04/01/90 2,740	-	15	-		2,740		39
40	PAINTING-STRUB	04/01/90 601	-	5	-		601		40
41	DOOR ALARM SYSTEM	04/01/91 750	-	15	-		750		41
42	REMODELING-N.H.	04/01/92 536	-	10	-		536		42
43	GARAGE DOOR	04/01/92 513	-	10	-		513		43
44	REMODELING-N.H.	04/01/94 2,881	144	20	144		1,945		44
45	NEW ROOF-GIESE	04/01/94 2,767	-	10	-		2,767		45
46	NEW ROOF	04/01/96 20,694	-	10	-		20,694		46
47	DRAIN LINE UNDER FLOOR	04/01/96 1,819	-	10	-		1,819		47
48	ELECTRICAL-RADIOLOGY REMODEL	04/01/96 13,502	750	18	750		8,626		48
49	HVAC-RADIOLOGY REMODEL	04/01/96 18,432	1,229	15	1,229		14,131		49
50	GENERAL-RADIOLOGY REMODELING	04/01/96 31,216	1,561	20	1,561		17,949		50
51	HELIPORT LIGHTING	04/01/96 1,511	101	15	101		1,159		51
52	ROOF IMPROVEMENT	04/01/97 856	43	10	43		856		52
53	PHYSICAL THERAPY ROOM REMODEL	04/01/97 4,169	208	20	208		2,189		53
54	HEATING AND A/C UNITS	04/01/99 1,649	165	10	165		1,402		54
55	2 STANLEY MAGIC AUTOMATIC DOORS	04/01/99 1,221	122	10	122		1,038		55
56	REBUILD CHILLER	04/01/99 3,666	367	10	367		3,116		56
57	FIRE ALARM IMPROVEMENTS	04/01/00 1,376	138	10	138		1,032		57
58	ARMSTRONG TILE FLOORING FOR DIETARY	04/01/00 1,287	64	20	64		483		58
59	FIRE ALARM SYSTEM-ADMINISTRATION	04/01/01 905	60	15	60		392		59
60	REMODELING-BUSINESS OFFICE	04/01/01 63,452	4,230	15	4,230		27,496		60
61	HOOD & EXHAUST WORK - DIETARY	04/01/01 907	45	20	45		295		61
62	RADIOLOGY REMODEL	03/31/02 23,995	1,600	15	1,600		8,798		62
63	NURSING HOME NEW CEILING	03/31/02 2,789	279	10	279		1,534		63
64	NURSING HOME SHOWER FLOORS	03/31/02 471	24	20	24		130		64
65	CARPET-HALLWAY	03/31/02 5,451	545	5	545		5,451		65
66	NURSING HOME REMODEL	11/04/02 3,088	309	10	309		1,390		66
67	NURSING HOME CARPET	11/20/02 4,742	948	5	948		4,268		67
68	NURSING HOME THERMOSTATS & ELECTRIC	01/09/03 2,428	243	10	243		1,092		68
69	AUTOMATIC ENTRANCE MED-SURG	01/28/03 7,501	1,500	5	1,500		6,751		69
70	TOTAL (lines 4 thru 69)	\$ 1,268,400	\$ 43,886		\$ 43,886	\$ 0	\$ 1,034,877		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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STATE OF ILLINOIS

Facility Name & ID Number Galena Stauss Hospital SNU

8007866

Report Period Beginning:

10/01/2006

Ending:

09/30/2007

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Totals from Page 12C, Carried Forward	\$ 1,268,400	\$ 43,886		\$ 43,886	\$ 0	\$ 1,034,877		37
38	ADMINISTRATION REMODEL	03/26/03 5,491	366	15	366		1,647		38
39	NURSING HOME FIRE DOOR	03/31/03 1,310	131	10	131		589		39
40	HOSPITAL GENERATOR POWER SOURCE	03/31/03 4,990	998	5	998		4,491		40
41	ELECTRICAL WORK	10/31/03 3,736	187	20	187		654		41
42	WATER HEATERS	10/31/03 844	84	10	84		296		42
43	FLOORING	10/31/03 927	185	5	185		649		43
44	DENSITOMETER ROOM	03/31/04 4,102	820	5	820		2,872		44
45	CIRCULATING BOOSTER PUMP	04/30/04 2,708	271	10	271		948		45
46	PT REMODEL	05/01/04 8,044	536	15	536		1,877		46
47	AUTOMATIC DOOR	07/01/04 778	78	10	78		272		47
48	CT REMODEL	05/20/05 58,451	2,923	20	2,923		7,306		48
49	CARPET-EDUCATION ROOM	07/19/05 464	93	5	93		232		49
50	WOOD FLOORING-DINING ROOMS	07/19/05 781	78	10	78		195		50
51	MAMMOGRAM ROOM REMODEL	08/30/05 3,430	229	15	229		572		51
52	REMODELING-GENERAL	04/01/94 52,851	1,957	27	1,957		26,425		52
53	PLUMBING	04/01/94 4,680	234	20	234		3,159		53
54	HEATING,VENTING,AIR COND.	04/01/94 11,049	552	20	552		7,458		54
55	ELECTRICAL	04/01/94 21,537	1,077	20	1,077		14,537		55
56	PAINTING	04/01/94 650	-	10	-		650		56
57	SUSPENDEd CEILING	04/01/94 2,919	-	12	-		2,919		57
58	CABINETS	04/01/94 7,332	367	20	367		4,949		58
59	FLOOR COVERINGS	04/01/94 4,840	-	10	-		4,840		59
60	ELEVATOR	04/01/94 11,876	594	20	594		8,016		60
61	HAND RAIL FOR PHYSICAL THERAPY	12/17/02 303	20	15	20		91		61
62	EXTENSION JOINT	11/03/04 530	106	5	106		265		62
63	ELEVATOR PROCESSOR BOARD	12/01/05 981	196	5	196		351		63
64	ER REMODEL/SHOWER ROOM	01/01/06 1,671	111	15	111		190		64
65	GARAGE DOOR	07/01/06 436	44	10	44		53		65
66	FLOORING	09/22/06 233	23	10	23		35		66
67	HEATING	09/30/07 2,126	71	15	71		71		67
68	SPRINKLER SYSTEM	09/30/07 22,634	453	25	453		453		68
69	SPRINKLER SYSTEM	09/30/07 2,220	44	25	44		44		69
70		\$ 1,513,325	\$ 56,715		\$ 56,715	\$ 0	\$ 1,131,985		70

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STATE OF ILLINOIS

Facility Name & ID Number Galena Stauss Hospital SNU

8007866

Report Period Beginning:

10/01/2006

Ending:

09/30/2007

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Totals from Page 12D, Carried Forward		\$ 1,513,325	\$ 56,715		\$ 56,715	\$ 0	\$ 1,131,985	37
38	HVAC UNIT	09/30/07	7,044	235	15	235		235	38
39	PLASTIC CULVERT PIPE	09/30/07	1,470	37	20	37		37	39
40									40
41									41
42									42
43									43
44									44
45									45
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70			\$ 1,521,838	\$ 56,986		\$ 56,986	\$ 0	\$ 1,132,257	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Galena Stauss Hospital SNU # 8007866 Report Period Beginning: 10/01/2006 Ending: 09/30/2007

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 74,871	\$ 12,460	\$ 12,460	\$		\$ 39,301	71
72	Current Year Purchases	7,981	854	854			854	72
73	Fully Depreciated Assets	28,757	383	383			28,757	73
74								74
75	TOTALS	\$ 111,609	\$ 13,697	\$ 13,697	\$		\$ 68,912	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	Reference	2	
			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,391,410	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 70,683	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 70,683	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)	\$ 1,201,169	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input 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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Hospital SNU # 8007866 Report Period Beginning: 10/01/2006 Ending: 09/30/2007

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/2007 (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	\$ 651,987	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>915,000</u>)	1,453,035		3
4	Supply Inventory (priced at)	101,290		4
5	Short-Term Investments	2,208,717		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	93,333		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other receivables</u>	214,471		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,722,833	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	18,379,250		12
13	Land	558,706		13
14	Buildings, at Historical Cost	40,213,653		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,001,652		16
17	Accumulated Depreciation (book methods)	(6,532,153)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	4,057		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Financing Costs</u>	751,772		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 57,376,937	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 62,099,770	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,049,338	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	102,668		29
30	Accrued Salaries Payable	383,753		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,535,119		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Deferred Revenue</u>	53,322		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,124,200	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	169,853		39
40	Mortgage Payable			40
41	Bonds Payable	45,485,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 45,654,853	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 48,779,053	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 13,320,717	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 62,099,770	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 12,119,517	1
2	Restatements (describe):		2
3	Adjustment to IPA NH Cost Report to make net assets	1,391,285	3
4	match audited financial statements at year-end.		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 13,510,802	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(233,904)	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) Temp Restricted Contributions	55,118	15
16	Other (describe) Loans forgiven from Temp Restricted Net Assc	(11,299)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (190,085)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 13,320,717	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Hospital SNU# 8007866Report Period Beginning: 10/01/2006Ending: 09/30/2007**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	\$ 3,087,929	1
2	Discounts and Allowances for all Levels	(902,041)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,185,888	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	Hospital Net Income	132,184	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 132,184	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,318,072	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	746,061	31
32	Health Care	1,228,240	32
33	General Administration	475,960	33
B. Capital Expense			
34	Ownership	70,507	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	31,208	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,551,976	40
41	Income before Income Taxes (line 30 minus line 40)**	(233,904)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (233,904)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Galena Stauss Hospital SNU

8007866

Report Period Beginning: 10/01/2006

Ending:

09/30/2007

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	9,152	214,207	23.19	3
4	Licensed Practical Nurses	8,931	163,625	18.15	4
5	CNAs & Orderlies	50,195	577,242	11.39	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants	3,751	29,275	7.73	10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers				18
19	Laundry				19
20	Administrator				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				31
32	Other Health Care(specify)				32
33	Other(specify) <u>Ward Clerk</u>	1,556	16,596	10.57	33
34	TOTAL (lines 1 - 33)	73,585	1,000,945 *	13.48	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant			35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)			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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Hospital SNU

Report Period Beginning: 10/01/2006 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Galena Stauss Hospital SNU

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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 38,347 Line 15
- (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. \$ 31,208
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? _____ 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? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Wipfli LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? X 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 \$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.

SEE ACCOUNTANTS' COMPILATION REPORT