		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License ID Number: 0045948

Facility Name: LEE COUNTY NURSING & REHAB CENTER

Address: 800 DIVISION STREET (Number) DIXON (City) 61021 (Zip Code)

County: LEE

Telephone Number: 815-284-3393 **Fax #** 815-284-2006

HFS ID Number: 47-0885813001

Date of Initial License for Current Owners: 6/1/1998

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: KEN MARX Telephone Number: 314-231-5544

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2007 to 12/31/2007 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	CLARK RIBORDY, THCSLLC, MGT. CO.
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	KEN MARX PARTNER
	(Firm Name & Address)	BKD, LLP 501 N. BROADWAY, STE. 600, ST. LOUIS MO, 63102
	(Telephone)	314-231-5544 Fax # 314-231-9731

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 LEE COUNTY NURSING & REHAB CENTER # 0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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	91	Skilled (SNF)	91	33,215	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	91	TOTALS	91	33,215	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	15,179	8,886	2,282	26,347	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,179	8,886	2,282	26,347	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.32%

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/A - NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 6/1/1998

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/1/1998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 91 and days of care provided 2,282

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENT # 0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	138,152	7,790	7,127	153,069		153,069	(4,625)	148,444			1
2	Food Purchase		138,548		138,548		138,548	(581)	137,967			2
3	Housekeeping		8,919	88,883	97,802		97,802		97,802			3
4	Laundry		13,959	61,086	75,045		75,045		75,045			4
5	Heat and Other Utilities			119,984	119,984		119,984		119,984			5
6	Maintenance	60,960	17,393	75,166	153,519		153,519		153,519			6
7	Other (specify):*											7
8	TOTAL General Services	199,112	186,609	352,246	737,967		737,967	(5,206)	732,761			8
	B. Health Care and Programs											
9	Medical Director			6,751	6,751		6,751		6,751			9
10	Nursing and Medical Records	1,388,080	66,892	5,434	1,460,406		1,460,406		1,460,406			10
10a	Therapy		286	170,401	170,687		170,687		170,687			10a
11	Activities	70,384	200	4,867	75,451		75,451		75,451			11
12	Social Services	72,053	236	3,813	76,102		76,102		76,102			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,530,517	67,614	191,266	1,789,397		1,789,397		1,789,397			16
	C. General Administration											
17	Administrative	63,399	(535)		62,864		62,864	702	63,566			17
18	Directors Fees											18
19	Professional Services			279,299	279,299		279,299		279,299			19
20	Dues, Fees, Subscriptions & Promotions			59,065	59,065		59,065	(22,476)	36,589			20
21	Clerical & General Office Expenses	73,451	25,294	126,976	225,721		225,721	(121,974)	103,747			21
22	Employee Benefits & Payroll Taxes			373,516	373,516		373,516		373,516			22
23	Inservice Training & Education			110	110		110		110			23
24	Travel and Seminar			13,574	13,574		13,574		13,574			24
25	Other Admin. Staff Transportation			9,298	9,298		9,298		9,298			25
26	Insurance-Prop.Liab.Malpractice			74,442	74,442		74,442		74,442			26
27	Other (specify):*											27
28	TOTAL General Administration	136,850	24,759	936,280	1,097,889		1,097,889	(143,748)	954,141			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,866,479	278,982	1,479,792	3,625,253		3,625,253	(148,954)	3,476,299			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 LEE COUNTY NURSING & REHAB CENTER #0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			40,120	40,120		40,120	35,646	75,766			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,771	26,771		26,771	253,129	279,900			32
33	Real Estate Taxes			32,102	32,102		32,102		32,102			33
34	Rent-Facility & Grounds			248,404	248,404		248,404	(241,249)	7,155			34
35	Rent-Equipment & Vehicles			1,425	1,425		1,425	1,558	2,983			35
36	Other (specify):*											36
37	TOTAL Ownership			348,822	348,822		348,822	49,084	397,906			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		84,125	26,620	110,745		110,745		110,745			39
40	Barber and Beauty Shops		41		41		41		41			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,108	53,108		53,108		53,108			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		84,166	79,728	163,894		163,894		163,894			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,866,479	363,148	1,908,342	4,137,969		4,137,969	(99,870)	4,038,099			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 LEE COUNTY NURSING & REHAB CENTER # 0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,625)	1		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	(581)	2		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	(12,935)	21		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	(29,394)	21		24
25	Fund Raising, Advertising and Promotional	(22,476)	20		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 Misc.	(5,434)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (75,445)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 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)**	$ (24,425)	Various	36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (99,870)		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS

LEE COUNTY NURSING & REHAB CENTER

ID# 0045948

Report Period Beginning: 1/1/2007

Ending: 12/31/2007

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc.	$ (5,434)	21	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	(5,434)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENTER # 0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(4,625)	0	0	0	0	0	0	0	0	0	0	(4,625)	1
2	Food Purchase	(581)	0	0	0	0	0	0	0	0	0	0	(581)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,206)	0	0	0	0	0	0	0	0	0	0	(5,206)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	702	0	0	0	0	0	0	0	0	0	702	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(22,476)	0	0	0	0	0	0	0	0	0	0	(22,476)	20
21	Clerical & General Office Expenses	(47,763)	(74,211)	0	0	0	0	0	0	0	0	0	(121,974)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(70,239)	(73,509)	0	0	0	0	0	0	0	0	0	(143,748)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(75,445)	(73,509)	0	0	0	0	0	0	0	0	0	(148,954)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENTER # 0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	35,646	0	0	0	0	0	0	0	0	0	35,646	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	253,129	0	0	0	0	0	0	0	0	0	253,129	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(241,249)	0	0	0	0	0	0	0	0	0	(241,249)	34
35	Rent-Equipment & Vehicles	0	1,558	0	0	0	0	0	0	0	0	0	1,558	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	49,084	0	0	0	0	0	0	0	0	0	49,084	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(75,445)	(24,425)	0	0	0	0	0	0	0	0	0	(99,870)	45

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENTER # 0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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
Tutera Health Care Services LLC	100					
TI Dixon, LLC	100					

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. [X] 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Building & Fixtures	$	Tutera Health Care Services LLC	100.00%	$ 7,155	$ 7,155	1
2	V	35	Moveable Equipment		Tutera Health Care Services LLC	100.00%	1,558	1,558	2
3	V	21	Non-Capital	212,659	Tutera Health Care Services LLC	100.00%	138,448	(74,211)	3
4	V	30	Depreciation		TI Dixon, LLC	100.00%	35,646	35,646	4
5	V	34	Building Rent	248,404	TI Dixon, LLC	100.00%		(248,404)	5
6	V	32	Interest		TI Dixon, LLC	100.00%	253,129	253,129	6
7	V	17	Administrative & General		TI Dixon, LLC	100.00%	702	702	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 461,063			$ 436,638	$ * (24,425)	14

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

Facility Name & ID Number LEE COUNTY NURSING & REHAB CEN # 0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENTER # 0045948 Report Period Beginning: 1/1/2007 Ending: 2/31/2007

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 [X] NO [ ]

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

Name of Related Organization: Tutera Health Care Services
Street Address: 7611 State Line Road, STE 301
City / State / Zip Code: Kansas City, MO 64114
Phone Number: (816-444-0900
Fax Number: (816-444-0900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Non-Capital	Direct Cost	106,261,921	13	$ 4,181,214	$	3,518,586	$ 138,450	1
2	34	Capital Building	Direct Cost	106,261,921	13	216,096		3,518,586	7,155	2
3	35	Capital Equipment	Direct Cost	106,261,921	13	47,053		3,518,586	1,558	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					$ 4,444,363	$		$ 147,163	25

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENT # 0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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	LaSalle National Bank		X	Capital	$5,357.00	8/2/01	$ 450,000	$ 324,550			$ 26,771	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$5,357.00		$ 450,000	$ 324,550			$ 26,771	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 450,000	$ 324,550			$ 26,771	15

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

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

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

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENTER # 0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2006 report.	$ 29,184	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.)	$ 29,853	2
3. Under or (over) accrual (line 2 minus line 1).	$ 669	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 31,433	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.	$ 32,102	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2002	10,650	8
	2003	29,184	9
	2004	28,891	10
	2005	31,810	11
	2006	25,642	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2006	$	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:** 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 LEE COUNTY NURSING & REHAB CENTER COUNTY LEE

FACILITY IDPH LICENSE NUMBER 0045948

CONTACT PERSON REGARDING THIS REPORT Junior Foster, THCSLLC, Mgmt, Co.

TELEPHONE 816-444-0900 FAX #: 816-822-1723

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-08-04-376-011	Building	$ 29,853.38	$ 29,853.38
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 29,853.38	$ 29,853.38

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 LEE COUNTY NURSING & REHAB CENTER # 0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,700 B. General Construction Type: Exterior Brick Frame Block Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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 [X] (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 [X] 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	FACILITY	28,700	2002	$ 92,000	1
2					2
3	TOTALS	28,700		$ 92,000	3

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENTER # 0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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	91		2002		$ 983,365	$ 24,584		$ 24,584	$	$ 122,921	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Main entry landscaping			2004	5,482	548	10	548		1,919	9
10	asphalt patch, repair, s eal			2006	9,300	1,163	8	1,163		1,647	10
11	Main electrical line replaced to building			2006	6,495	433	15	433		613	11
12	Replace concrete in front of building			2006	8,710	581	15	581		774	12
13	Water heater			2002	4,130	413	10	413		2,134	13
14	Water softener			2003	5,536	554	10	554		2,768	14
15	Door Alarms			2003	3,577	358	10	358		1,789	15
16	Wallpaper entryway, living room			2004	9,997	1,999	5	1,999		6,831	16
17	Heating annd cooling unit			2005	8,250	825	10	825		2,131	17
18	Remodel of Alz. Unit			2005	38,517	3,852	10	3,852		8,987	18
19	Wallpaper entryway, living room			2005	2,271	454	5	454		1,060	19
20	Roof			2005	9,400	470	20	470		1,097	20
21	Flooring			2005	6,940	694	10	694		1,779	21
22	Handrails			2005	1,627	108	15	108		235	22
23	Storm Sewer Project			2005	4,329	433	10	433		902	23
24	Roof			2006	139,820	13,982	10	13,982		20,973	24
25	Wermer's Floor Covering			2007	2,229	161	10	161		10	25
26	Remodel			2007	43,912	3,166	20	3,166		193	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENTER # 0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		$ 1,293,887	$ 54,778		$ 54,778	$	$ 178,763	70

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

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENTER # 0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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	$ 134,735	$ 18,396	$ 18,396	$	Various	$ 78,749	71
72	Current Year Purchases	31,996	2,592	2,592		Various	2,592	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 166,731	$ 20,988	$ 20,988	$		$ 81,341	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)	$ 1,552,618	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 75,766	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 75,766	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)	$ 260,104	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENTER # 0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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 [X] 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:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

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	$

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	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENTER # 0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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)	$			

(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.

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	

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

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENTER # 0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	90,073	$ 1,624	$	90,073	$ 1,624	1
2	Licensed Speech and Language Development Therapist		hrs		2,315	44		2,315	44	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		78,014	1,655		78,014	1,655	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	170,402	$ 3,323	$	170,402	$ 3,323	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 LEE COUNTY NURSING & REHAB CENTER # 0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2007 (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	$ 63,389	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	638,685		3
4	Supply Inventory (priced at)	5,756		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	20,341		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 728,171	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	29,987		13
14	Buildings, at Historical Cost	280,536		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	85,923		16
17	Accumulated Depreciation (book methods)	(86,596)		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): Misc.	9,698		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 319,548	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,047,719	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 51,640	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	33,861		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,703		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	23,216		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Notes & Other	611,003		36
37	Due to other funds	1,049,992		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,795,415	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	31,433		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 31,433	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,826,848	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (779,129)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,047,719	$	48

*(See instructions.)

Facility Name & ID Number LEE COUNTY NURSING & REHAB CENTER # 0045948 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (191,226)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (191,226)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(587,903)	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)**	$ (587,903)	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)**	$ (779,129)	24 *

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

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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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,358,091	1
2	Discounts and Allowances for all Levels	(349,230)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,008,861	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	349,379	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 349,379	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	4,060	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	141,156	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,672	19
20	Radiology and X-Ray		20
21	Other Medical Services	5,184	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 174,072	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,758	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,758	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Med Supply Revenue	2,851	28
28a	Other	9,145	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,996	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,550,066	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	737,967	31
32	Health Care	1,789,397	32
33	General Administration	1,097,889	33
	B. Capital Expense		
34	Ownership	348,822	34
	C. Ancillary Expense		
35	Special Cost Centers	110,786	35
36	Provider Participation Fee	53,108	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,137,969	40
41	**Income before Income Taxes (line 30 minus line 40)****	(587,903)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (587,903)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.

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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	9,651	9,854	$ 248,080	$ 25.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,818	3,886	97,710	25.14	3
4	Licensed Practical Nurses	17,177	17,369	428,291	24.66	4
5	CNAs & Orderlies	46,932	47,239	557,970	11.81	5
6	CNA Trainees	3,241	3,294	39,982	12.14	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,758	6,148	70,384	11.45	10
11	Social Service Workers	4,336	4,465	72,053	16.14	11
12	Dietician	14,857	15,086	138,152	9.16	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,725	3,791	60,960	16.08	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,888	1,928	66,909	34.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,857	3,993	69,413	17.38	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	1,030	1,054	10,071	9.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	116,270	118,107	$ 1,859,975 *	$ 15.75	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	161	$ 7,127		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	205	6,751		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	117	3,768		44
45	Social Service Consultant	56	3,813		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	538	$ 21,459		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sherry Gillihan	Administrator		$ 63,399
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 63,399

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Tutera Health Care Services	Management Fees	$ 212,659
BKD, LLP	Accounting Fees	5,100
Smith Rickert & Smith	Legal Fees	509
Daniel Maher	Legal Fees	200
E-Health Data Solutions	Data Processing Fees	2,100
Galaxy Hosted Software	Data Processing Fees	13,200
Mutual of Omaha Medicare	Data Processing Fees	167
WCMC Shared Emp.	Purchased Svcs	22,522
Misc. See Attached….	Misc.	22,842
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 279,299

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	124,660
FICA Taxes	182,095
Employee Health Insurance	62,396
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	4,365
TOTAL (agree to Schedule V, line 22, col.8)	$ 373,516

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	21,741
Health Care Worker Background Check (Indicate # of checks performed ____)	
Licenses	2,254
Advertising & PR	22,476
Dues & Subscriptions	12,594
Less: Public Relations Expense	(22,476)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,589

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	13,574
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,574

**See instructions.

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

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

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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. **N/A**

(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? **N/A**

(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? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **N/A**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,471** 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. **N/A**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **53,108**
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. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **4,625**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
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? **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? **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? **No** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.