

		FOR BHF USE				

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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: 0008300

Facility Name: Elizabeth Nursing Home

Address: 540 Pleasant Street Elizabeth 61028
 Number City Zip Code

County: JoDaviess

Telephone Number: (815) 858-2275 **Fax #** (815) 858-2596

HFS ID Number: 36-2650434

Date of Initial License for Current Owners: 07/01/1968

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Karen Heidenreich **Telephone Number:** (815) 858-2275
Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/08 to 12/31/08 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.

(Signed) _____ (Date) _____

Officer or Administrator of Provider
 (Type or Print Name) Karen Heidenreich
 (Title) Administrator

(Signed) _____ (Date) _____

Paid Preparer
 (Print Name and Title) Gwen Moser, CPA
Partner
 (Firm Name & Address) Eide Bailly LLP
3999 Pennsylvania Ave., Suite 100, Dubuque, IA 52002
 (Telephone) (563) 556-1790 Fax # (563) 557-7842

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 Elizabeth Nursing Home# 0008300 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	49	Intermediate (ICF)	49	17,934	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,934	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	6,665	9,649		16,314
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	6,665	9,649		16,314

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.97%

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)

Assisted Living Facility, Rental of Clinic SpaceF. 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 07/08/1968

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 N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	162,095	7,645	3,672	173,412		173,412		173,412		1
2	Food Purchase		87,788		87,788		87,788	(2,523)	85,265		2
3	Housekeeping	46,443	13,868		60,311		60,311		60,311		3
4	Laundry	30,637	4,411		35,048		35,048		35,048		4
5	Heat and Other Utilities										5
6	Maintenance	54,511	19,868	53,034	127,413		127,413		127,413		6
7	Other (specify):*										7
8	TOTAL General Services	293,686	133,580	56,706	483,972		483,972	(2,523)	481,449		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	688,048	51,733	33,213	772,994		772,994		772,994		10
10a	Therapy										10a
11	Activities	46,329		405	46,734		46,734		46,734		11
12	Social Services	29,287	4,503	540	34,330		34,330		34,330		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	763,664	56,236	34,158	854,058		854,058		854,058		16
	C. General Administration										
17	Administrative	74,490	15,162	53,204	142,856	(2,322)	140,534	(19,412)	121,122		17
18	Directors Fees			7,050	7,050		7,050		7,050		18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses										21
22	Employee Benefits & Payroll Taxes			268,353	268,353	(42,015)	226,338		226,338		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			88,639	88,639	(31,693)	56,946		56,946		26
27	Other (specify):*										27
28	TOTAL General Administration	74,490	15,162	417,246	506,898	(76,030)	430,868	(19,412)	411,456		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,131,840	204,978	508,110	1,844,928	(76,030)	1,768,898	(21,935)	1,746,963		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 Elizabeth Nursing Home #0008300 Report Period Beginning: 01/01/08 Ending: 12/31/08

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			115,625	115,625	(74,395)	41,230		41,230		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			6,548	6,548		6,548	(6,548)			32
33	Real Estate Taxes			53,990	53,990	(36,824)	17,166	(2,659)	14,507		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			176,163	176,163	(111,219)	64,944	(9,207)	55,737		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										42
43	Other (specify):* Assisted Living	214,768	87,054	94,369	396,191	187,249	583,440		583,440		43
44	TOTAL Special Cost Centers	214,768	87,054	94,369	396,191	187,249	583,440		583,440		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,346,608	292,032	778,642	2,417,282		2,417,282	(31,142)	2,386,140		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 Elizabeth Nursing Home

0008300

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	(2,523)	2		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(17,895)	17		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	(6,548)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(2,659)	33		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	(1,517)	17		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (31,142)		\$	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))	\$ (31,142)		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

Elizabeth Nursing Home

ID# 0008300

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending machine revenue / activity	\$ (1,517)	17	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	(1,517)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elizabeth Nursing Home

0008300

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,523)	0	0	0	0	0	0	0	0	0	0	(2,523)	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	(2,523)	0	0	0	0	0	0	0	0	0	0	(2,523)	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	(19,412)	0	0	0	0	0	0	0	0	0	0	(19,412)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	(19,412)	0	0	0	0	0	0	0	0	0	0	(19,412)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(21,935)	0	0	0	0	0	0	0	0	0	0	(21,935)	29

STATE OF ILLINOIS

Facility Name & ID Number Elizabeth Nursing Home

0008300

Report Period Beginning:

01/01/08 Ending:

Summary B

12/31/08

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,548)	0	0	0	0	0	0	0	0	0	0	(6,548)	32
33	Real Estate Taxes	(2,659)	0	0	0	0	0	0	0	0	0	0	(2,659)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(9,207)	0	(9,207)	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)	(31,142)	0	(31,142)	45									

Facility Name & ID Number Elizabeth Nursing Home

0008300

Report Period Beginning:

01/01/08

Ending:

12/31/08

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.

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	Darlene Read	Shareholder	Board Member	0.05		1.5	0.04	Dir. Fees	\$ 1,200	1
2	Penny Heidenreich	Shareholder	Board Member	0.01		1.5	0.04	Dir. Fees	600	2
3	Nancy Walker	Shareholder	Board Member	0.01		1.5	0.04	Dir. Fees	1,100	3
4	Marvin Wurster	Shareholder	Board Member	0.05		1.5	0.04	Dir. Fees	700	4
5	Ken Haas	Shareholder	Board Member	0.03		1.5	0.04	Dir. Fees	500	5
6	Ted Krohmer	Shareholder	Board Member	0.02		1.5	0.04	Dir. Fees	600	6
7	Wayne Trost	Shareholder	Board Member	0.02		1.5	0.04	Dir. Fees	600	7
8	Carol Rayhorn	Shareholder	Board Member	0.03		1.5	0.04	Dir. Fees	600	8
9	Donald Brudi	Shareholder	Board Member	0.01		1.5	0.04	Dir. Fees	600	9
10	James Harkness	Former Administrator	Former Administrator	0.00		40	100.00	Dir. Fees	200	10
11	James Harkness	Former Administrator	Former Administrator	0.00		40	100.00	Compensation	26,154	11
12	Karen Heidenreich	Administrator	Administrator	0.00		40	100.00	Compensation	39,123	12
13								TOTAL	\$ 71,977	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 Elizabeth Nursing Home

0008300

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										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	Shareholder Loans	X	Assisted Living Facility	Various	Various	1,710,000	1,430,000	08/01/20	5.00-7.50	94,369	10									
11	Elizabeth State Bank		Clinic Building	\$1,050.90	10/15/06	140,000	128,116	07/17/16	1.25/6.37	6,548	11									
12										12										
13										13										
14	TOTAL Non-Facility Related			\$1,050.90		\$ 1,850,000	\$ 1,558,116		\$ 100,917	14										
15	TOTALS (line 9+line14)					\$ 1,850,000	\$ 1,558,116		\$ 100,917	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.)

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 2007 report.		\$	44,000	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.)		\$	48,990	2
3. Under or (over) accrual (line 2 minus line 1).		\$	4,990	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	49,000	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.		\$	53,990	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	<u>26,546</u>	<u>8</u>	
	2004	<u>26,230</u>	<u>9</u>	
	2005	<u>26,779</u>	<u>10</u>	
	2006	<u>43,618</u>	<u>11</u>	
	2007	<u>48,990</u>	<u>12</u>	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elizabeth Nursing Home COUNTY JoDaviess

FACILITY IDPH LICENSE NUMBER 0008300

CONTACT PERSON REGARDING THIS REPORT Karen Heidenreich

TELEPHONE (815) 858-2275 FAX #: (815) 858-2596

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>07-002-348-06</u>	<u>S25 T27 R2E PT NE NE</u>	\$ <u>48,989.64</u>	\$ <u>14,507.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>48,989.64</u>	\$ <u>14,507.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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 Elizabeth Nursing Home

0008300 Report Period Beginning:

01/01/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,294 B. General Construction Type: Exterior Masonry/ Siding Frame Masonry/ Wood 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).

Rented Clinic Area (attached to Nursing Home complex) - 1,400 square feet

Assisted Living Facility (attached to Nursing Home complex) - 22,648 square feet

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			<u>1967</u>	\$ <u>5,275</u>	1
2					2
3	TOTALS			\$ <u>5,275</u>	3

Facility Name & ID Number Elizabeth Nursing Home

0008300

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	49		1985	1985	\$ 151,186	\$	19	\$	\$	\$ 151,186	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Door and Wall Guards		1986	1,063		19			1,063	9
10		Retiling Floor		1986	754		19			754	10
11		B-Label Fire Door		1987	481	15	31.5	15		330	11
12		Rooftop Heat/Cool unit		1987	4,992	158	31.5	158		3,370	12
13		Service Entrance Exit Door		1988	810	26	31.5	26		529	13
14		Windows		1988	12,528	398	31.5	398		8,138	14
15		Retiling Floors		1989	977	31	31.5	31		606	15
16		Vinyl Siding		1989	1,056	34	31.5	34		645	16
17		Front Entrance /Exit Door		1989	860	27	31.5	27		519	17
18		Rooftop Heat/Cool unit		1989	5,555	176	31.5	176		3,355	18
19		Reroof East, North & West		1990	49,329	1,566	31.5	1,566		28,319	19
20		Roof (East & West)		1992	8,194	260	31.5	260		4,291	20
21		Remodel Computer Office		1992	5,872	186	31.5	186		3,073	21
22		Center Structure Roof		1996	7,950	204	39	204		2,481	22
23		26 Toilets		1997	8,443		7			8,443	23
24		A/C & Heater (South Wing)		1997	4,160		7			4,160	24
25		Kitchen Remodeling		1997	22,802	577	39.5	577		6,639	25
26		Exterior Remodeling		1997	20,031	507	39.5	507		5,832	26
27		Hand Rail / Cast Iron Tub base		1998	9,965	252	39.5	252		2,649	27
28		Building Addition		1998	97,742	2,474	39.5	2,474		25,982	28
29		Screen Door System		1999	425	11	39.5	11		102	29
30		140K Heating / Air Conditioning		2000	3,824	98	39	98		829	30
31		Energy Efficient Lighting / Outside Lighting		2000	13,621	349	39	349		2,954	31
32		Koehler Utility Sink		2002	667	89	7	95	6	667	32
33		Tile Project - Dining Room		2003	2,113	67	31.5	67		369	33
34		AO Smith Holding Tank		2004	1,324	189	7	189		1,099	34
35		Ceiling Lights		2004	484	15	31.5	15		62	35
36		Flooring - Nurses' Station area		2004	2,322	74	31.5	74		298	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 Elizabeth Nursing Home

0008300

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	Suspended Ceiling - Hallway	2004	\$ 4,765	\$ 151	31.5	\$ 151	\$	\$ 611	37
38	Carpet / Flooring	2005	1,972	63	31.5	63		243	38
39	Sign	2005	551	79	7	79		389	39
40	Kitchen Fire Supression System	2005	1,200	38	31.5	38		129	40
41	Telephone Wiring	2005	678	22	31.5	22		73	41
42	Door Security System	2006	11,934	306	39	306		752	42
43	Shelves / Cabinets - Activity Room	2006	4,020	574	7	574		2,133	43
44	Garbage Shed	2006	1,437	37	39	37		91	44
45	Fire System	2006	20,553	527	39	527		1,296	45
46	Carbon Monoxide Detecors	2007	570	57	10	57		109	46
47	Boilers	2007	24,648	632	20	1,232	600	1,659	47
48	Garbage Disposal	2007	1,001	200	5	200		300	48
49	Sewer Line	2007	32,350	1,617	20	1,617		2,022	49
50	Flooring-Halls	2007	793	40	20	40		50	50
51	Dumpster	2007	1,169	117	10	117		127	51
52	Vinyl Flooring & Installation	2007	472	47	10	47		47	52
53	Kitchen Sewer Replacement	2008	6,568	301	20	301		301	53
54	Rooftop Airconditioners	2008	11,851	494	10	494		494	54
55	Corridor Door	2008	1,262	42	10	42		42	55
56									56
57	Leasehold Improvements prior to 1981		119,177		10			119,177	57
58	3 Comm Smoke Detectors	1981	603		15			603	58
59	Air Conditioner	1982	931		15			931	59
60	Roof - South Wing	1982	10,500		15			10,500	60
61	8 - Triple Pane Windows	1983	5,131		18			5,131	61
62	15 Triple Pane Windows	1984	9,124		18			9,124	62
63	Thermiser Vent Control System	1985	2,927		19			2,927	63
64	Office Vision Panels	1985	910		19			910	64
65									65
66	Land Improvements prior to 1981		939		10			939	66
67	Landscaping, tiling, sidewalk	1986	3,143		19			3,143	67
68	Landscaping - shurbs & gravel	1988	850		15			850	68
69	Sidewalks & Landscaping	1990	1,845		15			1,845	69
70	TOTAL (lines 4 thru 69)		\$ 723,404	\$ 13,127		\$ 13,733	\$ 606	\$ 435,689	70

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

Facility Name & ID Number Elizabeth Nursing Home

0008300

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	
1	Totals from Page 12A, Carried Forward		\$ 723,404	\$ 13,127		\$ 13,733	\$ 606	\$ 435,689	1
2	Seal Coat Parking Lot	1990	3,500		15			3,500	2
3	Landscaping	1998	995	66	15	66		738	3
4	Tile Work	1998	1,263	84	15	84		937	4
5	Landscaping	1999	1,185	79	15	79		809	5
6	Pavement Work	2001	1,840	123	15	123		920	6
7	Tree	2001	450	30	15	30		225	7
8	Shrubs and Landscaping Rock	2006	618	41	15	41		103	8
9	Parking Lot	2006	64,828	4,322	15	4,322		10,805	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	TOTAL (lines 1 thru 33)		\$ 798,083	\$ 17,872		\$ 18,478	\$ 606	\$ 453,726	34

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

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	\$ 153,324	\$ 18,965	\$ 18,965	\$		\$ 75,297	71
72	Current Year Purchases	11,125	378	378	0		378	72
73	Fully Depreciated Assets	303,705					303,705	73
74								74
75	TOTALS	\$ 468,154	\$ 19,343	\$ 19,343	\$ 0		\$ 379,380	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)	\$ 1,271,512	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 37,215	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 37,821	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 606	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 833,106	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	Building Imp - Assisted Living	\$ 1,088,446	\$ 27,556	\$ 296,223	86
87	Building Imp - Assisted Living	1,645,201	43,285	101,352	87
88	Building - Clinic	140,816	3,611	7,673	88
89	Land Imp - Assisted Living	6,032	402	3,968	89
90	Equipment - Assisted Living	57,806	3,555	35,885	90
91	TOTALS	\$ 2,938,301	\$ 78,408	\$ 445,101	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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.

Facility Name & ID Number Elizabeth Nursing Home# 0008300

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	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	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number Elizabeth Nursing Home # 0008300 Report Period Beginning: 01/01/08 Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (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	\$ 49,050	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	134,312		3
4	Supply Inventory (priced at)	4,995		4
5	Short-Term Investments	135,357		5
6	Prepaid Insurance	8,190		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Deferred income tax benefits</u>	15,575		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 347,479	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,275		13
14	Buildings, at Historical Cost	3,441,786		14
15	Leasehold Improvements, at Historical Cost	236,792		15
16	Equipment, at Historical Cost	525,960		16
17	Accumulated Depreciation (book methods)	(1,278,207)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,931,606	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,279,085	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 31,243	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	108,003		29
30	Accrued Salaries Payable	113,950		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,405		31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,306		35
	Other Current Liabilities(specify):			
36	<u>Accrued Interest</u>	53,636		36
37	<u>Accrued Pension Payable</u>	72		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 364,615	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,450,113		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Income Taxes</u>	16,260		43
44	<u>Assisted Living Security Deposits</u>	17,500		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,483,873	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,848,488	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,430,597	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,279,085	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,344,751	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,344,751	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	100,646	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	(14,800)	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)	\$ 85,846	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)	\$ 1,430,597	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Elizabeth Nursing Home# 0008300Report Period Beginning: 01/01/08Ending: 12/31/08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,489,274	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,489,274	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	1,517	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,523	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)	\$ 4,040	23
D. Non-Operating Revenue			
24	Contributions	31,849	24
25	Interest and Other Investment Income***	2,611	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 34,460	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Clinic Rent</u>	17,895	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17,895	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,545,669	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	483,972	31
32	Health Care	854,058	32
33	General Administration	506,898	33
B. Capital Expense			
34	Ownership	176,163	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	<u>Assisted Living</u>	396,191	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,417,282	40
41	Income before Income Taxes (line 30 minus line 40)**	128,387	41
42	Income Taxes	(27,741)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 100,646	43

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

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

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number Elizabeth Nursing Home

0008300

Report Period Beginning: 01/01/08

Ending:

12/31/08

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 42,508	\$ 20.44	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,949	4,228	79,310	18.76	3
4	Licensed Practical Nurses	9,479	10,192	185,972	18.25	4
5	CNAs & Orderlies	36,953	38,503	380,258	9.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,001	2,089	28,959	13.86	9
10	Activity Assistants	1,511	1,766	17,370	9.84	10
11	Social Service Workers	2,052	2,140	29,287	13.69	11
12	Dietician					12
13	Food Service Supervisor	1,848	2,016	27,736	13.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,967	13,689	134,359	9.82	15
16	Dishwashers					16
17	Maintenance Workers	3,926	4,182	54,511	13.03	17
18	Housekeepers	4,199	4,427	46,443	10.49	18
19	Laundry	3,152	3,311	30,637	9.25	19
20	Administrator	2,080	2,080	53,080	25.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,367	1,504	21,410	14.24	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>Assisted Living</u>	17,790	18,773	214,768	11.44	33
34	TOTAL (lines 1 - 33)	105,354	110,980	\$ 1,346,608 *	\$ 12.13	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	96	\$ 4,482	35
36	Medical Director	0		36
37	Medical Records Consultant	0		37
38	Nurse Consultant	0		38
39	Pharmacist Consultant	48	810	39
40	Physical Therapy Consultant	0		40
41	Occupational Therapy Consultant	0		41
42	Respiratory Therapy Consultant	0		42
43	Speech Therapy Consultant	0		43
44	Activity Consultant	16	540	44
45	Social Service Consultant	16	540	45
46	Other(specify)	0		46
47				47
48				48
49	TOTAL (lines 35 - 48)	176	\$ 6,372	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	583	17,275	52
53	TOTAL (lines 50 - 52)	583	\$ 17,275	53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA dues of \$2,705
- (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? 7.86
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 26,902
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (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? Yes 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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,523
- (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? 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: Eide Bailly 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? No If no, please explain. It will be sent when finalized.
- (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.

Elizabeth Nursing Home
Book - Tax Reconciliation
12/31/2008

Income before income taxes (page 19)	128,387
State Income Taxes	(6,165)
IL Refund	8,369
Accrued Vacation Adjustment	1,389
Contributions Received	(31,849)
Depreciation Adjustment	<u>(12,569)</u>
Federal Taxable Income per tax return	<u><u>87,562</u></u>

Elizabeth Nursing Home
 Property Taxes
 December 31, 2008

	Square Feet
Clinic	1,400
ALU #1	9,824
ALU #2	12,824
Nursing Home	39,294

	Square Feet		Property Taxes
ALU #1	9,824	0.46	\$ 12,471.02
Nursing Home	12,824	0.54	14,507.98
	<u>22,648</u>		<u>\$ 26,979.00</u>

Prior to ALU#2 and Clinic addition, property taxes were \$26,979.

New Property tax bill after new additions is \$43,618

\$ 48,989.64	ALU #2	12,824	19,844.24
(26,979.00)	Clinic	1,400	2,166.40
<u>\$ 22,010.64</u>		<u>14,224</u>	<u>22,010.64</u>

Total ALU allocation of property taxes	32,315.25
Total Clinic allocation of property taxes	2,166.40
Total Nursing Home allocation of property taxes	<u>14,507.98</u>
	<u>48,989.64</u>

For fiscal year 2008, difference with \$48,989.64 and amount expensed on income statement is due to accrual entry made based on increase in property value.

2007 JO DAVIESS COUNTY REAL ESTATE TAX BILL					JO DAVIESS COUNTY COLLECTOR																																													
1ST INSTALLMENT DUE DATE	08/19/2008	2ND INSTALLMENT DUE DATE	09/19/2008	BILL NUMBER	2007005401																																													
AMOUNT	\$24,494.82	AMOUNT	\$24,494.82	TOWNSHIP	ELIZABETH																																													
BACK TAXES	\$0.00	PENALTIES		ACREAGE	0.00																																													
TOTAL PAID	AUG 14 2008	TOTAL PAID		TAX CODE	07002																																													
DESCRIPTION	S25 T27N R2E PT NENE			TAX YEAR:	2007 9798																																													
ASSESSED TO:	ELIZABETH NURSING HOME INC			PARCEL NUMBER:	07-002-348-06																																													
MAIL TO:	ELIZABETH NURSING HOME INC 540 PLEASANT ST ELIZABETH IL 61028			FORMULATION FOR TAX CALCULATION																																														
2006 TAX AMOUNTS				<table border="1"> <tr><td>1977 E.A. VALUE</td><td>0</td></tr> <tr><td>STF BASE VALUE</td><td>0</td></tr> <tr><td>FAIR CASH VALUE</td><td>2,591,814</td></tr> <tr><td>LAND VALUE</td><td>12,161</td></tr> <tr><td>BUILDING VALUE</td><td>851,777</td></tr> <tr><td>TOTAL VALUE</td><td>863,938</td></tr> <tr><td>HOME IMP/VET EXEM</td><td>0</td></tr> <tr><td>STATE MULTIPLIER X</td><td>1.0000</td></tr> <tr><td>EAV</td><td>863,938</td></tr> <tr><td>SENIOR TAX EX</td><td>0</td></tr> <tr><td>FRAT ASSMT EX</td><td>0</td></tr> <tr><td>OWNER OCCUP EXEM</td><td>0</td></tr> <tr><td>SENIOR CITIZEN EX</td><td>0</td></tr> <tr><td>DISABLED VET / PERSON RETURNING VET</td><td>0</td></tr> <tr><td>FARM LAND VALUE +</td><td>150</td></tr> <tr><td>FARM BLDG VALUE +</td><td>0</td></tr> <tr><td>NET TAXABLE VALUE =</td><td>864,088</td></tr> <tr><td>TAX RATE X</td><td>5.66952</td></tr> <tr><td>TOTAL 2007 TAX</td><td>\$48,989.64</td></tr> <tr><td>FORFEITED TAX</td><td>\$0.00</td></tr> <tr><td>TOTAL AMOUNT DUE</td><td>\$48,989.64</td></tr> </table>			1977 E.A. VALUE	0	STF BASE VALUE	0	FAIR CASH VALUE	2,591,814	LAND VALUE	12,161	BUILDING VALUE	851,777	TOTAL VALUE	863,938	HOME IMP/VET EXEM	0	STATE MULTIPLIER X	1.0000	EAV	863,938	SENIOR TAX EX	0	FRAT ASSMT EX	0	OWNER OCCUP EXEM	0	SENIOR CITIZEN EX	0	DISABLED VET / PERSON RETURNING VET	0	FARM LAND VALUE +	150	FARM BLDG VALUE +	0	NET TAXABLE VALUE =	864,088	TAX RATE X	5.66952	TOTAL 2007 TAX	\$48,989.64	FORFEITED TAX	\$0.00	TOTAL AMOUNT DUE	\$48,989.64		
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