

Facility Name & ID Number Prairie City Health Care Center

0045377 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	48	Skilled (SNF)	48	17,520	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	48	TOTALS	48	17,520	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF			911	911	8
9	SNF/PED					9
10	ICF	7,438	3,935		11,373	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,438	3,935	911	12,284	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.11%

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)

Meals on Wheels

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

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 04/30/01

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

YES Date 04/30/01 NO

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

YES NO If YES, enter number of beds certified 9 and days of care provided 365

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	82,457	4,314	5,014	91,785	(1,453)	90,332	90,332			1
2	Food Purchase		55,463		55,463		55,463	55,463			2
3	Housekeeping	62,610	13,058		75,668		75,668	75,668			3
4	Laundry	14,535	7,890		22,425		22,425	22,425			4
5	Heat and Other Utilities			37,160	37,160	(3,733)	33,427	33,427			5
6	Maintenance	10,349	30,757		41,106		41,106	41,106			6
7	Other (specify):*										7
8	TOTAL General Services	169,951	111,482	42,174	323,607	(5,186)	318,421	318,421			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	373,689	62,374	3,238	439,301	(1,091)	438,210	438,210			10
10a	Therapy		324	85,433	85,757		85,757	85,757			10a
11	Activities	32,497	175	1,168	33,840		33,840	33,840			11
12	Social Services	22,325	484	1,664	24,473	(497)	23,976	23,976			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	428,511	63,357	91,503	583,371	(1,588)	581,783	581,783			16
	C. General Administration										
17	Administrative	49,634			49,634		49,634	49,634			17
18	Directors Fees										18
19	Professional Services			37,774	37,774	(23,835)	13,939	13,939			19
20	Dues, Fees, Subscriptions & Promotions			7,683	7,683	(2,839)	4,844	4,844			20
21	Clerical & General Office Expenses	54,074	6,271	5,520	65,865		65,865	65,865			21
22	Employee Benefits & Payroll Taxes			140,947	140,947		140,947	140,947			22
23	Inservice Training & Education					512	512	512			23
24	Travel and Seminar			4,446	4,446	(512)	3,934	3,934			24
25	Other Admin. Staff Transportation			978	978		978	978			25
26	Insurance-Prop.Liab.Malpractice					12,358	12,358	12,358			26
27	Other (specify):*			7,813	7,813	(7,585)	228	228			27
28	TOTAL General Administration	103,708	6,271	205,161	315,140	(21,901)	293,239	293,239			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	702,170	181,110	338,838	1,222,118	(28,675)	1,193,443	1,193,443			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Prairie City Health Care Center #0045377 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			16,363	16,363	(1,624)	14,739	11,363	26,102		30
31	Amortization of Pre-Op. & Org.			1,365	1,365		1,365		1,365		31
32	Interest			11,051	11,051	733	11,784		11,784		32
33	Real Estate Taxes			4,379	4,379		4,379		4,379		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles					1,091	1,091		1,091		35
36	Other (specify):*			12,358	12,358	(12,358)					36
37	TOTAL Ownership			45,516	45,516	(12,158)	33,358	11,363	44,721		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					23,835	23,835		23,835		42
43	Other (specify):*					16,998	16,998	(16,998)			43
44	TOTAL Special Cost Centers					40,833	40,833	(16,998)	23,835		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	702,170	181,110	384,354	1,267,634		1,267,634	(5,635)	1,261,999		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center

0045377

Report Period Beginning: 01/01/05

Ending: 12/31/05

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(997)	43		4
5	Telephone, TV & Radio in Resident Rooms	(3,733)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	11,363	30		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	(217)	43		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	(27)	43		18
19	Entertainment				19
20	Contributions	(608)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,723)	43		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	(2,839)	43		28
29	Other-Attach Schedule see attached schedule	(2,854)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (5,635)		\$	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))	\$ (5,635)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops	X		115		41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule see attached	X		16,883		45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$ 16,998		47

OHF USE ONLY						
48		49		50		51
						52

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie City Health Care Center

ID# 0045377

Report Period Beginning: 01/01/05

Ending: 12/31/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Beauty shop equipment depreciation	\$ (115)	43	1
2	Resident flowers	(497)	43	2
3	Non-care auto depreciation	(1,509)	43	3
4	Special events	(239)	43	4
5	Pet expense	(42)	43	5
6	Other nonallowable	(452)	43	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	(2,854)		49

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie City Health Care Center

0045377

Report Period Beginning:

01/01/05 Ending:

12/31/05

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	11,363	0	0	0	0	0	0	0	0	0	0	11,363	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	11,363	0	11,363	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):*	(16,998)	0	0	0	0	0	0	0	0	0	0	(16,998)	43
44	TOTAL Special Cost Centers	(16,998)	0	(16,998)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(5,635)	0	(5,635)	45									

Facility Name & ID Number Prairie City Health Care Center

0045377

Report Period Beginning:

01/01/05

Ending:

12/31/05

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
Eddie Franciskovich	50					
Carolyn Petersen	50					

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	NA	\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	Eddie Franciskovich	Administrator	Administrator	50.00		40	100.00	Salary	\$ 49,634	L.17C.1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 49,634		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center

0045377

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 NA
 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	NA				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	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	Bank of Farmington		X	Van	\$997.00	12/18/01	\$ 59,816	\$ 11,523	1/17/07	0.0690	\$ 1,202	1								
2	Ipava State Bank		X	Long-term working capital	\$2,561.00	9/11/03	250,000	203,401	09/10/13	0.0425	9,849	2								
3	James Petersen	X		Long-term working capital	NA	7/31/02	487,211	481,182	Various	Prime		3								
4												4								
5												5								
Working Capital																				
6	Ipava State Bank		X	Working Capital	NA	12/21/05	30,000	30,000	3/21/06	0.0775		6								
7	Ipava State Bank		X	Working Capital	NA	06/10/05	30,000		9/10/05	0.0675	405	7								
8	Ipava State Bank		X	Working Capital	NA	10/03/05	30,000		12/03/05	0.0700	328	8								
9	TOTAL Facility Related				\$3,558.00		\$ 887,027	\$ 726,106			\$ 11,784	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 887,027	\$ 726,106			\$ 11,784	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 2004 report.	\$	4,115	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.)	\$	4,144	2
3. Under or (over) accrual (line 2 minus line 1).	\$	29	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	4,350	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.	\$	4,379	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	3,673	8
	2001	3,806	9
	2002	3,874	10
	2003	3,994	11
	2004	4,144	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie City Health Care Center COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0045377

CONTACT PERSON REGARDING THIS REPORT Eddie Franciskovich

TELEPHONE (309) 775-3313 FAX #: (309) 775-3311

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(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>15-000-002-05</u>	<u>Facility - gounds</u>	\$ <u>4,144.00</u>	\$ <u>4,144.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>4,144.00</u>	\$ <u>4,144.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Prairie City Health Care Center

0045377 Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,500 B. General Construction Type: Exterior Brick Frame Cinderblock Number of Stories 1 floor

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).

None

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: 6,825 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 1,365 4. Dates Incurred: 2001

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>Land</u>	<u>216,058</u>	<u>2001</u>	<u>\$ 9,000</u>	1
2					2
3	TOTALS	216,058		\$ 9,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Prairie City Health Care Center**

0045377

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	48		2001	1970	\$ 53,000	\$ 1,359	39	\$ 1,359		\$ 6,115	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Sewer hook up		2001	2,894	75	39	75		334	9
10		Architectural design and consultation		2001	2,903	74	39	74		297	10
11		Roofing materials		2002	878	23	39	23		82	11
12		2 new bathrooms		2002	13,854	355	39	355		1,272	12
13		Install new grease trap		2002	1,318	34	39	34		122	13
14		Floor tiles and carpeting		2002	7,578	194	39	194		679	14
15		Sprinkler heads		2002	2,649	68	39	68		238	15
16		Architectural design and consultation		2002	10,792	277	39	277		969	16
17		upgrade bathroom and shower facilities		2002	3,370	86	39	86		294	17
18		Architectural design and consultation		2002	500	13	39	13		42	18
19		Lighting fixtures and wallpaper		2002	4,097	105	39	105		333	19
20		Ceiling tiles		2002	2,152	55	39	55		197	20
21		Hardwood items		2002	1,771	45	39	45		162	21
22		Building materials		2002	728	19	39	19		64	22
23		Upgrade drainage system		2002	1,067	27	39	27		93	23
24		Painting		2003	4,320	288	15	288		816	24
25		Heater Repair		2003	2,300	153	15	153		434	25
26		Fire wall installation		2005	24,119	26	39	52	26	52	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Prairie City Health Care Center**

0045377

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	140,290	\$	3,276	\$	26	\$	12,595	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	\$ 82,954	\$ 7,250	\$ 12,573	\$ 5,323	5,7	\$ 53,016	71
72	Current Year Purchases	2,224	245	132	(113)	5,7	132	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 85,178	\$ 7,495	\$ 12,705	\$ 5,210		\$ 53,148	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	Facility	2001 Chevy Van	2001	\$ 50,473	\$ 3,968	\$ 10,095	\$ 6,127	5	\$ 45,427	76
77										77
78										78
79										79
80	TOTALS			\$ 50,473	\$ 3,968	\$ 10,095	\$ 6,127		\$ 45,427	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)	\$ 284,941	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,739	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 26,102	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,363	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 111,170	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	2001 truck	\$ 28,915	\$ 1,509	\$ 11,730	86
87	Beauty shopequipment	920	115	633	87
88					88
89					89
90					90
91	TOTALS	\$ 29,835	\$ 1,624	\$ 12,363	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center

0045377

Report Period Beginning: 01/01/05

Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning NA

Ending _____

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

Fiscal Year Ending Annual Rent

12.	<u>/2006</u>	\$ <u>NA</u>
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

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

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

NA

NA

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

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: \$ 1,091 Description: Therapy Equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>NA</u>		\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>6.5</u></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	\$	\$ 456	\$	\$ 456
2	Books and Supplies		56		56
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	\$	\$ 512	\$	\$ 512
10	SUM OF line 9, col. 1 and 2 (e)	\$	512		

C. CONTRACTUAL INCOME

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

\$ NA

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center# 0045377Report Period Beginning: 01/01/05

Ending:

12/31/05**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/05

(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	\$ 91,958	\$ 91,958	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	127,482	127,482	3
4	Supply Inventory (priced at)	5,567	5,567	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 225,007	\$ 225,007	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,000	9,000	13
14	Buildings, at Historical Cost	140,290	140,290	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	165,486	165,486	16
17	Accumulated Depreciation (book methods)	(139,590)	(139,590)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,826	6,826	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,257)	(6,257)	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)	\$ 175,755	\$ 175,755	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 400,762	\$ 400,762	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 112,679	\$ 112,679	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	63,141	63,141	29
30	Accrued Salaries Payable	23,835	23,835	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,350	4,350	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other accrued expenses</u>	3,499	3,499	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 207,504	\$ 207,504	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	662,965	662,965	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)	\$ 662,965	\$ 662,965	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 870,469	\$ 870,469	46
47	TOTAL EQUITY(page 18, line 24)	\$ (469,707)	\$ (469,707)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 400,762	\$ 400,762	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (477,889)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (477,889)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	8,182	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)	\$ 8,182	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)	\$ (469,707)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center

0045377

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	\$ 1,274,763	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,274,763	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending machines and employee meals	1,032	28
28a	Meals on Wheels	13	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,045	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,275,816	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	323,607	31
32	Health Care	583,371	32
33	General Administration	315,140	33
B. Capital Expense			
34	Ownership	45,516	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,267,634	40
41	Income before Income Taxes (line 30 minus line 40)**	8,182	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 8,182	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Prairie City Health Care Center

0045377

Report Period Beginning: 01/01/05

Ending:

12/31/05

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	2,000	2,080	\$ 40,231	\$ 19.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,026	6,237	96,950	15.54	3
4	Licensed Practical Nurses	2,728	2,857	38,281	13.40	4
5	CNAs & Orderlies	25,787	27,201	198,227	7.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	2,080	19,358	9.31	9
10	Activity Assistants	1,616	1,890	13,139	6.95	10
11	Social Service Workers	2,000	2,080	22,325	10.73	11
12	Dietician					12
13	Food Service Supervisor	2,096	2,096	19,142	9.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,192	9,629	63,315	6.58	15
16	Dishwashers					16
17	Maintenance Workers	1,152	1,216	10,349	8.51	17
18	Housekeepers	8,949	9,485	62,610	6.60	18
19	Laundry	1,687	1,980	14,535	7.34	19
20	Administrator	2,000	2,080	49,634	23.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,000	2,080	23,782	11.43	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>Care Plan Coord.</u>	2,000	2,080	30,292	14.56	33
34	TOTAL (lines 1 - 33)	71,233	75,071	\$ 702,170 *	\$ 9.35	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	\$ 4,558	L1,C3	35
36	Medical Director				36
37	Medical Records Consultant	23	347	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	45	1,800	L10,C3	39
40	Physical Therapy Consultant	814	85,433	L10A,C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	18	1,168	L11,C3	44
45	Social Service Consultant	18	1,167	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,014	\$ 94,473		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center

0045377

Report Period Beginning: 01/01/05

Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Eddie Franciskovich	Administrator	50	\$ 49,634	Workers' Compensation Insurance	\$ 28,962	IDPH License Fee	\$ 175		
Carolyn Petersen	NA	50	0	Unemployment Compensation Insurance	16,665	Advertising: Employee Recruitment	4,158		
				FICA Taxes	53,543	Health Care Worker Background Check	352		
				Employee Health Insurance	37,980	(Indicate # of checks performed <u>22</u>)			
				Employee Meals		IL Nursing Home Admin. Assoc	100		
				Illinois Municipal Retirement Fund (IMRF)*		Social Service Prof. of IL	59		
				Employee relations	3,797				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 49,634						
(List each licensed administrator separately.)									
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$				Out-of-State Travel	\$	
							None		
							In-State Travel		
							Mileage	2,039	
							Lodging		
							Seminar Expense	1,895	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 140,947	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type	Amount							
Ginoli & Company	Accounting	\$ 3,511		NA					
Claudon, Barnhart, and Beal	Legal	1,543							
FR&R Healthcare	Accounting	415							
IDPA (eliminated in col 5)	Provider Assesments	23,835							
Administar Federal	Computer Services	25							
Ivans	Computer Services	259							
Infobahn Outfitters	Computer Services	264							
ADP	Computer Services	7,922							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 37,774	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)								\$ 3,934	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1	NA		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie City Health Care Center
0045377
12/31/05

Reclassification Entries

To Reclassify CNA Training

PG3, Line 24 Travel and Seminars		\$	512
PG3, Line 23 Inservice Training and Education	\$	512	

To Reclassify Interest

PG3, Line 27 Other		\$	733
PG4, Line 32 Interest	\$	733	

To Reclassify Dues

PG3, Line 24 Travel and Seminars		\$	-
PG3, Line 20 Dues, Fees, Subscriptions, and Promotions	\$	-	

To Reclassify Equipment Rental

PG3, Line 10 Nursing and Medical Records - Other		\$	1,091
PG4, Line 35 Equipment Rental	\$	1,091	

To Reclassify Provider Participation Fees

PG3, Line 19 Professional Services - Other		\$	23,835
PG4, Line 42 Provider Participation Fees	\$	23,835	

To Reclassify Property and Auto Insurance

PG4, Line 36 Other		\$	12,358
PG3, Line 26 Insurance - Property, Liability, Malpractice	\$	12,358	

To Reclassify Nonallowable Expenses

	Amount	Line
Beauty Shops	\$ 115	30
Other		
Bad Debts	5,723	27
Nonpatient food	997	1
Resident Flowers	497	12
Pet Expense	42	27
Contributions	608	27
Advertising	2,839	20
Special Events	239	1
Special Events	-	27
Cable TV	3,733	5
Penalties and fines	27	27
Sales tax	217	1
Other non allowable	452	27
NonCare Auto (Depreciation)	1,509	30
Nonallowable	<u>\$ 16,998</u>	<u>43</u>

SEE ACCOUNTANT'S COMPILATION REPORT

Prairie City Health Care Center
0045377
12/31/05
Detail Schedules

Part V, Schedule C, Line 27

General Administration - Other

Charitable contributions	\$ 608
Special events	-
Pet expense	42
Penalties and fines	27
Bad debts	5,723
Interest	733
Vendor service charge	228
Other non-allowable	<u>452</u>
Total per general ledger	\$ 7,813
Less interest expense reclassified	(733)
Less unallowable costs reclassified	
Charitable contributions	(608)
Special events	-
Pet expense	(42)
Penalties and fines	(27)
Bad debts	(5,723)
Other non-allowable	<u>(452)</u>
Total after reclassifications	<u>\$ 228</u>

Part VI, Schedule C, Line 45

	Amount	Line
Nonpatient food	\$ 997	1
Resident flowers	497	12
Charitable contributions	608	27
Promotional advertising	2,839	20
Special events	239	27
Special events	-	1
Bad Debts	5,723	27
Non-care auto depreciation	1,509	30
In-room cable TV	3,733	5
Penalties and fines	27	27
Sales tax	217	1
Other non-allowable	452	27
Pet Expense	42	27
	<u>\$ 16,883</u>	

Part V, Schedule C, Line 36

Capital Expense - Other

General insurance	\$ 9,962
Auto insurance	<u>2,396</u>
Total per general ledger	\$ 12,358
Less insurance reclassified	<u>(12,358)</u>
Total after reclassifications	<u>\$ -</u>

SEE ACCOUNTANT'S COMPILATION REPORT

Prairie City Health Care Center
0045377
12/31/05

Detail Schedules, Cont.

Part V, Schedule C, Line 24

Travel and Seminar

Seminar

Attendee, Title	Dates	Location	Seminar	Sponsor	
Amy Brooks, Social Services Director	04/06/05	Springfield, IL	Quality - Spelled with U	Social Service Prof of IL	75
Eddie Franciskovich, Administrator	10/14/05	Galesburg, IL	Illinois Dementia Care Training	Alzheimer's Assoc	60
Eddie Franciskovich and Amy Brooks	10/26/05	Moline, IL	Medicare Prescription Drug Training	Western IL Area Agency on Aging	
Eddie Franciskovich and Amy Brooks	10/18/05	Springfield, IL	The New IDPH IDR Process and Fingerprinting Everyone	IL Council on LTC	290
Russel Brand, Annie Mitchell, Care Plan Coord. Amy Brooks	05/02/05	Prairie City, IL	MDS Training	LSN Foundation	285
Eddie Franciskovich, Russel Brand, Anni Mitchell	11/9-11/10/2005	East Peoria, IL	INNAA Conference	INNAA	285
Eddie Franciskovich	11/22/2005	Deerfield, IL	Catching up with Medicare.	FR&R Healthcare	100
Rex Fidler	1/3/2005	Galesburg, IL	Misc. Healthcare Seminar	Carl Sandburg College	77
All Staff	05/25/05	Prairie City, IL	Fire Equipment Training	J&L Fire	83
Melody Fowler, LPN	Spring Semester	Canton, IL	Tuition, Books, and Fees to obtain RN	Spoon River College	640
Total Seminar Expense					1,895
Travel					
Employee travel vouchers, less than \$250 each					2,039
Total Travel and Seminar Expense					<u><u>3,934</u></u>

Part V, Schedule C, Line 25

Other Admin Staff Transportation

Fuel					223
Auto Repairs and Maintenance					755
Total Other Admin Staff Transportation					<u><u>978</u></u>

SEE ACCOUNTANT'S COMPILATION REPORT

Prairie City Health Care Center
0045377
12/31/2005

Reconciliation to Taxable Income

Income (Loss) per Books	\$ 8,182
Expenses recorded on books not deducted on return	
Charitable Contributions	608
Penalties and fines	27
Deduction on return not deducted on books	
Depreciation	(1,144)
NOL deduction	(7,673)
Taxable Income, per Federal Tax Return	<u>\$ -</u>

SEE ACCOUNTANT'S COMPILATION REPORT