

		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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.

<p>I. IDPH Facility ID Number: <u>0042671</u></p> <p>Facility Name: <u>PRAIRIE VILLAGE HEALTHCARE CENTER INC</u></p> <p>Address: <u>1024 WEST WALNUT</u> <u>JACKSONVILLE</u> <u>62650</u> Number City Zip Code</p> <p>County: <u>MORGAN</u></p> <p>Telephone Number: <u>(847) 329-1555</u> Fax # <u>(847) 329-9555</u></p> <p>IDPA ID Number: <u>36-4149930</u></p> <p>Date of Initial License for Current Owners: <u>05/01/97</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2005</u> to <u>12/31/2005</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>SHERWIN I. RAY</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>PRESIDENT</u></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> <tr> <td colspan="2"> 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 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>SHERWIN I. RAY</u> (Date) _____		(Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	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	
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Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER INC

0042671 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	74	Skilled (SNF)	74	27,010	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	18,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	126	TOTALS	126	45,990	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	825		3,103	3,928	8
9	SNF/PED					9
10	ICF	25,244	2,949		28,193	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,069	2,949	3,103	32,121	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.84%

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)

NONE

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

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

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 05/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES Date 05/01/97 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 18 and days of care provided 3,103

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number **PRAIRIE VILLAGE HEALTHCARE CENT** # **0042671** Report Period Beginning: **01/01/2005** Ending: **12/31/2005**

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	108,320	13,068	7,893	129,281		129,281		129,281		1
2	Food Purchase		109,002		109,002	(11,060)	97,942	(377)	97,565		2
3	Housekeeping	88,950	19,401		108,351		108,351		108,351		3
4	Laundry	34,865	12,202	655	47,722		47,722		47,722		4
5	Heat and Other Utilities			98,828	98,828		98,828	33	98,861		5
6	Maintenance	37,131	28,024	7,178	72,333		72,333	4,300	76,633		6
7	Other (specify):*			10,026	10,026		10,026	26	10,052		7
8	TOTAL General Services	269,266	181,697	124,580	575,543	(11,060)	564,483	3,982	568,465		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	835,900	66,720	108,779	1,011,399		1,011,399	(79,803)	931,596		10
10a	Therapy	108,596	31,758	95,070	235,424		235,424	(1,477)	233,947		10a
11	Activities	38,719	1,602	971	41,292		41,292		41,292		11
12	Social Services	16,697		1,140	17,837		17,837		17,837		12
13	CNA Training										13
14	Program Transportation			885	885		885		885		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	999,912	100,080	212,845	1,312,837		1,312,837	(81,280)	1,231,557		16
	C. General Administration										
17	Administrative	104,066			104,066		104,066	63,312	167,378		17
18	Directors Fees										18
19	Professional Services			258,988	258,988		258,988	(189,384)	69,604		19
20	Dues, Fees, Subscriptions & Promotions			26,253	26,253		26,253	(17,238)	9,015		20
21	Clerical & General Office Expenses	99,751	10,677	192,107	302,535		302,535	(156,343)	146,192		21
22	Employee Benefits & Payroll Taxes			208,341	208,341	11,060	219,401		219,401		22
23	Inservice Training & Education			5,396	5,396		5,396	874	6,270		23
24	Travel and Seminar			306	306		306	170	476		24
25	Other Admin. Staff Transportation			2,214	2,214		2,214	1,937	4,151		25
26	Insurance-Prop.Liab.Malpractice			90,222	90,222		90,222	983	91,205		26
27	Other (specify):*							38,041	38,041		27
28	TOTAL General Administration	203,817	10,677	783,827	998,321	11,060	1,009,381	(257,648)	751,733		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,472,995	292,454	1,121,252	2,886,701		2,886,701	(334,946)	2,551,755		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	7,893
	REPAIRS & MAINTENANCE	0
		0
		7,893
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	655
		0
		655
5	HEAT & OTHER UTILITIES	
	GAS HEAT	40,798
	ELECTRICITY	37,067
	WATER	15,175
	CABLE TV - LOBBY	5,788
		0
		98,828
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,035
	PAINTING & DECORATING	401
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	2,733
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	900
	FIRE SERVICE	1,109
		0
		0
		0
		7,178
7	OTHER	
	SCAVENGER	10,026
	SECURITY SERVICE	0
		10,026
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	776
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	2,610
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	714
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B 47-2	4,679
	RN CONSULTANT XVIII B 38-2	0
	DENTAL SERVICES	0
	MEDICARE & PUBLIC AID CONSULTAN' XVIII B 48-2	100,000
		108,779
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	3,139
	SPEECH THERAPY SERVICES	3,415
	OCCUPATIONAL THERAPY SERVICES	1,386
	THERAPY CONTRACT SERVICES	76,330
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	5,400
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	5,400
	RESPIRATORY THERAPY CONSULTAN' XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		95,070
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	971
		0
		971
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN' XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,140
		0
		1,140
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	885
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	23,825
	ADMINISTRATIVE CONSULTANTS XIX C	188,000
	PROFESSIONAL FEES XIX C	47,163
		0
		258,988
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	18,992
	EMPLOYEE WANT ADS XIX F	3,732
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	156
	LICENSES & PERMITS XIX F	2,363
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	250
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	500
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	260
		26,253
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	61
	EQUIPMENT REPAIR & MAINTENANCE	2,956
	OUTSIDE CLERICAL SERVICES	76,146
	PENALTIES / OVERDRAFT CHARGES VI 18	23,008
	HOME OFFICE EXPENSE	82,389
	THEFT & DAMAGE LOSS	0
	TELEPHONE	7,547
	MESSENGER SERVICE	0
		0
		192,107

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	110,057
	UNEMPLOYMENT COMPENSATION XIX D	31,165
	WORKERS COMPENSATION INSURANCE XIX D	52,241
	HOSPITALIZATION INSURANCE XIX D	12,789
	EMPLOYEE BENEFITS - OTHER XIX D	797
	EMPLOYEE PHYSICAL EXAMS XIX D	1,292
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		208,341
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	5,396
		5,396
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	306
		0
		0
		306
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	2,214
		2,214
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	89,293
	SELF-CAP INSURANCE EXPENSE	929
		90,222
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,121,252

PRAIRIE VILLAGE HEALTHCARE CENTER INC
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2005

TOTAL FOOD PURCHASE	109,002	PATIENT MEALS	96363
LESS SALES TAX	(377)	ADD EMPLOYEE MEALS	10950
-----		-----	
NET FOOD	108,625	TOTAL MEALS/YEAR	107313
TOTAL PATIENT CENSUS	32,121	NET FOOD	108625
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	107313
-----		-----	
TOTAL PATIENT MEALS	96363	COST PER MEAL	1.01
		TIME EMPLOYEE MEALS	10950
ADD # EMPLOYEE MEALS/DAY	30	EMPLOYEE MEAL RECLASSIFICATION	11060
TIME # DAYS	365	=====	
-----		-----	
TOTAL EMPLOYEE MEALS	10950		

PRAIRIE VILLAGE HEALTHCARE CENTER TRANSPORTATION - STAFF 12/31/05										
G/L #18370										
DATE	ALISSA FOSTER	LISA DAVIS	RUSTY SAXER	DIANNA BLACKKETTER	PAM BROWN	LORENA KNIGHT	TERRI SOLOMON	RICHARD NOLTING	PAM STEGE	TOTAL
JAN				141.21						141.21
FEB				91.66						91.66
MAR				310.11						310.11
APR				116.41						116.41
MAY				31.60						31.60
JUN	12.90			12.90						25.80
JUL				130.00						130.00
AUG		71.10	104.70	129.82	54.00	78.35	26.70	59.10		523.77
SEP			30.00			48.67				78.67
OCT			52.80	174.05		181.71			58.70	467.26
NOV			32.40							32.40
DEC			31.20	85.05		162.10				278.35

TOTAL	12.90	71.10	251.10	1,209.91	54.00	470.83	26.70	59.10	58.70	2,214.34
=====										
GASOLINE FOR FACILITY BANKING, MAINTENANCE, PURCHASING, AND ACTIVITIES										

PRAIRIE VILLAGE HEALTHCARE CENTER EDUCATION & SEMINAR 12/31/05						
DATE	INV	SPONSOR OF SEMINAR	PURPOSE OF SEMINAR	PERSONNEL ATTENDING	LOC	COST OF SEMINAR
1.05	X	LINCOLN LAND COMMUNITY COLLEGE	CNA TEXT BOOKS	FRELANDRA WOMACK BARBARA CATHERS SANDRA DELONG DAVID SCRIBNER	IL	225.24
	X	LINCOLN LAND COMMUNITY	CHARTING TO STAY OUT OF COURT	DIANNA BLACKKETTER ALLYSON L KUCKER PAMELA BROWN	IL	270.00
	X	MORGAN COUNTY HEALTH	FOOD SERVICE SANITATION MANAGERS CERTIFICATION	SHARONA NOLTING	IL	85.00
	X	LINCOLN LAND COMMUNITY	BASIC NURSE ASST TRAINING	FRELANDRA WOMACK	IL	354.00
	X	MORGAN COUNTY HEALTH	FOOD SERVICE SANITATION MANAGERS CERTIFICATION	STEVE ROBINSON	IL	85.00
	X	MORGAN COUNTY HEALTH	FOOD SERVICE SANITATION MANAGERS CERTIFICATION	ANGELA SULLIVAN	IL	85.00
2.05	X	AUBURN UNIVERSITY	INDEPENDENT STUDY PROGRAM-DIETARY MGT	SHAWNA NOLTING	IL	615.00
	X	ALZHEIMER'S ASSOC	IL DEMENTIA CARE TRAINING: TRAIN-THE-TRAINER PROG	LISA DAVIS ALLYSA FOSTER	IL	120.00
	X	FRED C BOCH BCD	36 HOUR ACTIVITY WORKSHOP	LISA DAVIS	IL	450.00
	X	FRED C BOCH BCD	ACTIVITY WORKSHOP	LISA DAVIS	IL	119.00
	X	BRIAN NOLTING	CPR BOOKS		IL	40.00
	X	LIPPINCOTT WILLIAMS & WILK	PROFESSIONAL GUIDE TO PATHOPHYS		IL	53.70
	X	LINCOLN LAND COMMUNITY COLLEGE	BASIC NURSE ASST TRAINING	BARBARA CATHERS	IL	354.00
	X	LINCOLN LAND COMMUNITY COLLEGE	BASIS NURSE ASST TRAINING	DAVID SCRIBNER	IL	354.00
	X	IL HEALTH CARE ASSOC	ESSENTIALS OF THE MDS	DIANNA BLACKKETTER SHERI GOODALL HEATHER TAPSCOTT	IL	285.00
3.05	X	LINCOLN LAND COMMUNITY COLLEGE	BASIC NURSE ASST TRAINING	SANDRA A DELONG	IL	321.00
	X	INTEGRA HEALTHCARE EDUC	FALLS MGMT - BEYOND ALARMS & LOW BEDS	DIANNA BLACKKETTER PAM BROWN	IL	298.00
	X	BRIAN NOLTING	CPR CLASS- CPR CARDS	11 PEOPLE		22.00
	X	ICLTC	NEW CM REQUIREMENTS FOR PRESSURE ULCERS	PAM BROWN	IL	290.00
	X	IL HEALTH CARE ASSOC	MDS MANAGEMENT REPORTS	DIANNA BLACKKETTER	IL	190.00
8.05	X	LINCOLN LAND COMMUNITY COLLEGE	BASIC NURSE ASST TRAIN, INTRO TO PSYCH	KERI HAMEL	IL	354.00
	X	INSTITUTE FOR NATURAL RESOURCES	THE ADDICTED BRAIN	PAM BROWN	IL	79.00
	X	INSTITUTE FOR NATURAL RESOURCES	THE ADDICTED BRAIN	DIANNA BLACKKETTER	IL	79.00
9.05	X	IL HEALTH CARE ASSOC	MEDICARE PART D - PART II	DIANNA BLACKKETTER PAM BROWN	IL	170.00
10.05	X	BIOMED HOME STUDY COURSES	GERMS & VIRUSES	PAM BROWN	IL	59.00
	X	BIOMED HOME STUDY COURSES	TRANQUILITY TIME	DIANNA BLACKKETTER	IL	39.00

						5,395.94
						=====

PRAIRIE VILLAGE HEALTHCARE CENTER EQUIPMENT RENTAL 12/31/2005		
VENDOR	DESCRIPTION	AMOUNT
UNIVERSAL HOSPITAL SERVICES	NURSING EQUIPMENT	344
KCI USA	NURSING EQUIPMENT	1,171
RCS MANAGEMENT	NURSING EQUIPMENT	962
FLYNN SALES & SERV	LAUNDRY EQUIPMENT	7,500
QUALITY WATER SERVICE FINANCE	PLANT EQUIPMENT	851
CDS OFFICE TECHNOLOGY	COPIER	1,613
GE CAPITAL	COPIER	1,213
GE CAPITAL	COPIER	3,810
CAREPLUS REHAB	EQUIPMENT/FURNITURE/COMPUTERS	56,811
TOTAL:		74,275

PRAIRIE VILLAGE HEALTHCARE CENTER PROFESSIONAL FEES 12/31/2005		
VENDOR	DESCRIPTION	AMOUNT
CARE PLUS	DATA PROCESSING	\$ 12,000
ACHIEVE HEALTHCARE	DATA PROCESSING	3,472
NATIONAL DATA CARE	DATA PROCESSING	2,262
E-HEALTH DATA SOLUTION	DATA PROCESSING	2,118
AMERICAN DATA	DATA PROCESSING	3,973
CARE PLUS	ADMINISTRATIVE CONSULT	188,000
KRUPNICK, BOKOR, KAGDA LTD	ACCOUNTING	33,550
MEYER MAGECE	LEGAL	4,500
SACHNOFF & WEAVER	LEGAL	810
EDDIE CARPENTER ATTNY	LEGAL	534
RICHARD PEELO	MEDICARE CONSULTANT	4,800
PERSONNEL PLANNER	UC CONSULTANT	2,969
TOTAL:		258,988

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			4,161	4,161		4,161	82,477	86,638			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,886	1,886		1,886	149,404	151,290			32
33	Real Estate Taxes			25,955	25,955		25,955		25,955			33
34	Rent-Facility & Grounds			264,870	264,870		264,870	(284,267)	(19,397)			34
35	Rent-Equipment & Vehicles			81,641	81,641		81,641	(52,283)	29,358			35
36	Other (specify):*											36
37	TOTAL Ownership			378,513	378,513		378,513	(104,669)	273,844			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		126,466	122,604	249,070		249,070	(12,495)	236,575			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			68,985	68,985		68,985		68,985			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		126,466	191,589	318,055		318,055	(12,495)	305,560			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,472,995	418,920	1,691,354	3,583,269		3,583,269	(452,110)	3,131,159			45

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

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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	12,046	30		9
10	Interest and Other Investment Income	(57,357)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(377)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(250)	20		17
18	Fines and Penalties	(23,008)	21		18
19	Entertainment				19
20	Contributions	(500)	20		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	(18,992)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(28,380)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (116,818)		\$	30

OHF USE ONLY					
48		49		50	
				51	
					52

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

		1	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)	(335,292)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (335,292)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (452,110)		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		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

ID# 0042671

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARY	\$ (28,380)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(28,380)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER INC

0042671

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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)	
1	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(377)	0	0	0	0	0	0	0	0	0	0	(377)	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	33	0	0	0	0	0	0	0	0	0	33	5
6	Maintenance	0	4,300	0	0	0	0	0	0	0	0	0	4,300	6
7	Other (specify):*	0	26	0	0	0	0	0	0	0	0	0	26	7
8	TOTAL General Services	(377)	4,359	0	0	0	0	0	0	0	0	0	3,982	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	(79,803)	0	0	0	0	0	0	0	0	0	(79,803)	10
10a	Therapy	0	1,933	(3,410)	0	0	0	0	0	0	0	0	(1,477)	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	(77,870)	(3,410)	0	(81,280)	16							
	C. General Administration													
17	Administrative	0	0	63,312	0	0	0	0	0	0	0	0	63,312	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(200,000)	10,616	0	0	0	0	0	0	0	0	(189,384)	19
20	Fees, Subscriptions & Promotions	(19,742)	0	2,504	0	0	0	0	0	0	0	0	(17,238)	20
21	Clerical & General Office Expenses	(51,388)	(157,989)	53,034	0	0	0	0	0	0	0	0	(156,343)	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	874	0	0	0	0	0	0	0	0	874	23
24	Travel and Seminar	0	0	170	0	0	0	0	0	0	0	0	170	24
25	Other Admin. Staff Transportation	0	0	1,937	0	0	0	0	0	0	0	0	1,937	25
26	Insurance-Prop.Liab.Malpractice	0	0	983	0	0	0	0	0	0	0	0	983	26
27	Other (specify):*	0	0	38,041	0	0	0	0	0	0	0	0	38,041	27
28	TOTAL General Administration	(71,130)	(357,989)	171,471	0	(257,648)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(71,507)	(431,500)	168,061	0	(334,946)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER INC# 0042671

Report Period Beginning:

01/01/2005 Ending:12/31/2005

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	12,046	0	70,431	0	0	0	0	0	0	0	0	82,477	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(57,357)	0	206,761	0	0	0	0	0	0	0	0	149,404	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(284,267)	0	0	0	0	0	0	0	0	(284,267)	34
35	Rent-Equipment & Vehicles	0	0	(52,283)	0	0	0	0	0	0	0	0	(52,283)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(45,311)	0	(59,358)	0	(104,669)	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	(12,495)	0	0	0	0	0	0	0	0	(12,495)	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	(12,495)	0	(12,495)	44							
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(116,818)	(431,500)	96,208	0	(452,110)	45							

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
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					SKOKIE	THERAPY
				PRAIRIE VILLAGE HEALTHCARE CENTER LLC		
					SKOKIE	REAL ESTATE

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$	CAREPLUS MGMT INC		\$	\$	1
2	V	19 ADMIN. CONSULTANT FEES	188,000	" "			(188,000)	2
3	V	19 DATA PROCESSING FEES	12,000	" "			(12,000)	3
4	V	21 CLERICAL FEES	75,600	" "			(75,600)	4
5	V	21 REIMBURSED HOME OFFICE EXP	82,389	" "			(82,389)	5
6	V	10 M/C,PA,PSYCH FEES	100,000	" "			(100,000)	6
7	V			" "				7
8	V	5 ELECTRICITY		" "		33	33	8
9	V	6 REPAIRS		" "		1,600	1,600	9
10	V	6 MAINTENANCE SALARIES		" "		2,700	2,700	10
11	V	7 SECURITY		" "		26	26	11
12	V	10 NURSING		" "		20,197	20,197	12
13	V	10a THERAPY SALARIES		" "		1,933	1,933	13
14	Total		\$ 457,989			\$ 26,489	\$ * (431,500)	14

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

VII. RELATED PARTIES (continued)

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:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 ADMIN SALARIES	\$	CAREPLUS MGMT INC		\$ 63,312	\$	63,312	15
16	V	19 PROFESSIONAL FEES		" "		3,366		3,366	16
17	V	20 DUES/LICENSES/WANT ADS		" "		2,504		2,504	17
18	V	21 OFFICE EXPENSES		" "		19,794		19,794	18
19	V	21 CLERICAL SALARIES		" "		33,240		33,240	19
20	V	23 SEMINARS		" "		874		874	20
21	V	24 TRAVEL		" "		170		170	21
22	V	25 TRANSPORTATION		" "		1,937		1,937	22
23	V	26 INSURANCE		" "		983		983	23
24	V	27 EMPLOYEE BENEFITS		" "		38,041		38,041	24
25	V	30 SL DEPRECIATION		" "		6,906		6,906	25
26	V	32 INTEREST		" "		32,456		32,456	26
27	V	35 EQUIP RENT/AUTO LEASE		" "		4,528		4,528	27
28	V								28
29	V	10a THERAPY SERVICES	94,432	CAREPLUS REHABILITATIVE SERVICES		91,022		(3,410)	29
30	V	39 ANCILLARY THERAPY	123,240	" "		110,745		(12,495)	30
31	V	35 EQUIPMENT RENT EXPENSE	56,811	" "				(56,811)	31
32	V	30 SL DEPRECIATION		" "		8,385		8,385	32
33	V	32 INTEREST		" "		3,718		3,718	33
34	V								34
35	V	34 RENT	284,267	PRAIRIE VILLAGE HEALTHCARE CENTER LLC				(284,267)	35
36	V	30 SL DEPRECIATION		" "		55,140		55,140	36
37	V	32 INTEREST		" "		170,587		170,587	37
38	V	19 ACCOUNTING FEES		" "		7,250		7,250	38
39	Total		\$ 558,750			\$ 654,958	\$ *	96,208	39

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

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CEN # 0042671 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	CAREPLUS MGMT ALLOCATIONS:								\$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	32.02	SEE ATTACHED	3.5	5.80	SALARY	11,601	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	32.02	SCHEDULES	3.5	5.80	" "	11,601	17-7	3
4	JAMEE O'BRIEN	REGIONAL DIR.	ADMIN	1.70	" "	3.5	5.80	" "	7,396	17-7	4
5	JOE ZIMMERMAN	CFO	CLERICAL	1.70	" "	3.5	5.80	" "	7,489	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 38,087		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 PRAIRIE VILLAGE HEALTHCARE CENTER INC # 0042671 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

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

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

Name of Related Organization CAREPLUS MANAGEMENT INC
 Street Address 5940 W TOUHY
 City / State / Zip Code NILES 60714
 Phone Number (847) 647-1717
 Fax Number (847) 647-0222

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		CENSUS DAYS			\$	\$		\$	1
2	5	ELECTRICITY	553,765	13 FACILITIES	574		32,121	33	2
3	6	REPAIRS	553,765	13 FACILITIES	27,588		32,121	1,600	3
4	6	MAINTENANCE SALARIES	553,765	13 FACILITIES	46,540	46,540	32,121	2,700	4
5	7	SECURITY	553,765	13 FACILITIES	444		32,121	26	5
6	10	NURSING	553,765	13 FACILITIES	348,203	348,203	32,121	20,197	6
7	10a	THERAPY SALARIES	553,765	13 FACILITIES	33,317	33,317	32,121	1,933	7
8	17	ADMIN SALARIES	553,765	13 FACILITIES	1,091,504	1,091,504	32,121	63,312	8
9	19	PROFESSIONAL FEES	553,765	13 FACILITIES	58,031		32,121	3,366	9
10	20	DUES/LICENSES/WANT ADS	553,765	13 FACILITIES	43,163		32,121	2,504	10
11	21	OFFICE EXPENSES	553,765	13 FACILITIES	341,243		32,121	19,794	11
12	21	CLERICAL SALARIES	553,765	13 FACILITIES	573,059	573,059	32,121	33,240	12
13	23	SEMINARS	553,765	13 FACILITIES	15,061		32,121	874	13
14	24	TRAVEL	553,765	13 FACILITIES	2,923		32,121	170	14
15	25	TRANSPORTATION	553,765	13 FACILITIES	33,401		32,121	1,937	15
16	26	INSURANCE	553,765	13 FACILITIES	16,951		32,121	983	16
17	27	EMPLOYEE BENEFITS	553,765	13 FACILITIES	655,825		32,121	38,041	17
18	30	SL DEPRECIATION	553,765	13 FACILITIES	119,076		32,121	6,906	18
19	32	INTEREST	553,765	13 FACILITIES	559,538		32,121	32,456	19
20	35	EQUIP RENT/AUTO LEASE	553,765	13 FACILITIES	78,057		32,121	4,528	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 4,044,498	\$ 2,092,623		\$ 234,600	25

Facility Name & ID Number **PRAIRIE VILLAGE HEALTHCARE CENT**

0042671

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	RELATED PARTY: PRAIRIE VILLAGE HEALTHCARE CENTER LLC						\$	\$			\$	1						
2	CAMBRIDGE/HEARTLAND		X	MORTGAGE	\$16,072.41	11/03	2,830,700	2,752,285	10/33			152,401	2					
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN	11/03	76,676	71,245				2,556	3					
4	MIP INSURANCE		X	MORTGAGE INSURANCE								13,871	4					
5	CAREPLUS MGMT - CIB BK	X		CAPITAL IMPROVEMENT	\$882.75	01/04	37,157	20,653	01/09	PRIME+		1,759	5					
	Working Capital																	
6	INSURANCE FINANCING		X	INSUR. FINANCE								1,886	6					
7	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC											32,456	7					
8	CAREPLUS REHAB ALLOCATION: EQUIP LOAN											3,718	8					
9	TOTAL Facility Related				\$16,955.16		\$ 2,944,533	\$ 2,844,183			\$ 208,647	9						
	B. Non-Facility Related*																	
10													10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 2,944,533	\$ 2,844,183			\$ 208,647	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 13,871 Line # 32-7

* 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 2004 report.	\$	23,920	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.)	\$	24,815	2
3. Under or (over) accrual (line 2 minus line 1).	\$	895	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	25,060	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	25,955	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	22,702	8
	2001	23,337	9
	2002	23,390	10
	2003	23,687	11
	2004	24,815	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

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.

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 VILLAGE HEALTHCARE CENTER INC COUNTY MORGAN

FACILITY IDPH LICENSE NUMBER 0042671

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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>09-17-100-012</u>	<u>NURSING HOME</u>	\$ <u>24,814.86</u>	\$ <u>24,814.86</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>24,814.86</u>	\$ <u>24,814.86</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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,028 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1 + BASEMENT

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	RELATED PARTY:PRAIRIE VILLAGE HEALTHCARE CENTER LLC				1
2	NURSING HOME: ACRES	8.686	1997	170,000	2
3	TOTALS			\$ 170,000	3

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER INC

0042671

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	RELATED PARTY: PRAIRIE VILLAGE HEALTHCARE CENTER LLC:			\$	\$		\$	\$	
5	126	1997		1,114,539	28,577	39	28,577		241,735
6									
7									
8									
	Improvement Type**								
9	ELECTRIC PANEL IN BOILER ROOM	1997		1,192	31	39	31		265
10	NURSE CALL SYSTEM	1997		17,863	458	39	458		3,854
11	40 TON A/C AND GAS LINE	1997		114,953	2,947	39	2,947		24,437
12	NEW ROOF	1997		35,981	923	39	923		7,576
13	CUBICLE TRACK / PAINTING / HAND & BUMPER RAILS	1997		18,875	484	39	484		3,973
14	CEILING TILE / LIGHT FIXTURES / CUBICLE TRACK	1997		44,010	1,128	39	1,128		9,165
15	MECHANICAL, PLUMBING, HVAC & ELECTRICAL OVERHAUL	1997		165,706	4,249	39	4,249		34,524
16	FLOOR TILE	1997		35,928	921	39	921		7,406
17	REMODELLING / PAINTING / WALLCOVERINGS / BUMPER RAIL	1997		52,605	1,349	39	1,349		10,848
18	REMODELLING / WALLCOVERINGS / RAILS / WINDOW TREATM	1998		58,466	1,500	39	1,500		11,612
19	TILING / FLOORING / DOORS	1998		36,939	948	39	948		7,269
20	ELECTRICAL / ELEVATOR / PLUMBING REPAIRS	1998		69,378	1,778	39	1,778		13,555
21	GENERATOR	1998		21,049	540	39	540		4,073
22	JFK CONTEMPORARY DESIGNS	1999		3,549	91	39	91		550
23	CANOPY/BARRIERS/CORNER GUARDS/KICKPLATES	2000		9,164	333	27.5	333		1,769
24	SHAYMAN,SALK ARENSON SETTLEMENT / PUMP	2001		54,531	1,983	27.5	1,983		9,469
25	CONCRETE WORK / DRYWALL / DOORS	2002		4,490	163	27.5	163		513
26	DOOR INSTALLATIONS / 6 VENTILATOR RECEPTACLES	2003		9,733	353	27.5	354	1	887
27	CONCRETE SLABS OUTSIDE EXIT DOORS	2003		3,350	223	15	223		558
28	OUTLET INSTALLATION AND REWIRING	2004		5,343	194	27.5	194		380
29	SHOWER REMODEL	2005		4,475	149	15	149		149
30									
31									
32									
33									
34	RELATED PARTY ALLOCATION - CAREPLUS MGMT								
35	BUILDING-TAG-18 PROPERTIES	2004		36,308	931	39	931		
36	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES	2004		14,264	549	39	549		

*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

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		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
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58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70	TOTAL (lines 4 thru 69)	\$ 1,932,691	\$ 50,802		\$ 50,803	\$ 1	\$ 394,567

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

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	\$ 197,462	\$ 2,259	\$ 14,837	\$ 12,578	8-15 YRS	\$ 116,689	71
72	Current Year Purchases	5,736	820	287	(533)		287	72
73	Fully Depreciated Assets							73
74	**REL'D PARTY-SL DEPN:CAREPL MGT, 5426 /CP REHAB, 8,385/PRAIRIE VILL LLC, 6,900		20,711	20,711				74
75	TOTALS	\$ 203,198	\$ 23,790	\$ 35,835	\$ 12,045		\$ 116,976	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,305,889	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 74,592	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 86,638	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,046	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 511,543	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A -- RELATED PARTY

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

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: \$ 74,275 Description: SEE SCHEDULE ATTACHED

(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>FACILITY VAN</u>	<u>'02 FORD CLB WAGON</u>	\$ <u>668.94</u>	\$ <u>7,366</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>668.94</u>	\$ <u>7,366</u>	21

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. _____/2006 \$ _____

13. _____/2007 \$ _____

14. _____/2008 \$ _____

* 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>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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.

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	39-3	hrs	\$		\$ 46,276	\$		\$ 46,276	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			17,705			17,705	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			49,961			49,961	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				103,392		103,392	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2				8,662	9,413		18,075	12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					13,661		13,661	13
14	TOTAL			\$		\$ 122,604	\$ 126,466		\$ 249,070	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 PRAIRIE VILLAGE HEALTHCARE CENTER INC

0042671

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>50,000</u>)	676,403		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments	491,309		5
6	Prepaid Insurance	41,320		6
7	Other Prepaid Expenses	242,967		7
8	Accounts Receivable (owners or related parties)	62,603		8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,514,602	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	29,952		15
16	Equipment, at Historical Cost	200,638		16
17	Accumulated Depreciation (book methods)	(197,009)		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): <u>SECURITY DEPOSITS</u>	4,137		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 37,718	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,552,320	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 517,566	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	100,543		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,986		31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,060		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	_____			36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 653,155	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>DUE TO LLC</u>	138,428		43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 138,428	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 791,583	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 760,737	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,552,320	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 618,563	1
2	Restatements (describe):		2
3	POST-CLOSING FURNISHINGS/DEPRECIATION ADJ	(3,566)	3
4	BAD DEBTS	(43,403)	4
5	ROUNDING	3	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 571,597	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	189,140	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)	\$ 189,140	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)	\$ 760,737	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER IN # 0042671 Report Period Beginning: 01/01/2005Ending: 12/31/2005**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,716,741	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,716,741	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***	55,668	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 55,668	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,772,409	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	575,543	31
32	Health Care	1,312,837	32
33	General Administration	998,321	33
	B. Capital Expense		
34	Ownership	378,513	34
	C. Ancillary Expense		
35	Special Cost Centers	249,070	35
36	Provider Participation Fee	68,985	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,583,269	40
41	Income before Income Taxes (line 30 minus line 40)**	189,140	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 189,140	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.

TAX RETURN PREPARED ON CASH BASIS

*** 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 **PRAIRIE VILLAGE HEALTHCARE CENTER INC**

0042671

Report Period Beginning: **01/01/2005**

Ending:

12/31/2005

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,418	1,653	\$ 37,516	\$ 22.70	1
2	Assistant Director of Nursing	156	160	3,329	20.81	2
3	Registered Nurses	6,458	6,738	126,127	18.72	3
4	Licensed Practical Nurses	16,143	16,921	273,778	16.18	4
5	CNAs & Orderlies	40,817	41,492	376,744	9.08	5
6	CNA Trainees					6
7	Licensed Therapist	3,472	3,640	69,673	19.14	7
8	Rehab/Therapy Aides	3,555	3,753	38,923	10.37	8
9	Activity Director	2,064	2,199	21,259	9.67	9
10	Activity Assistants	2,568	2,686	17,460	6.50	10
11	Social Service Workers	1,841	1,841	16,697	9.07	11
12	Dietician					12
13	Food Service Supervisor	2,156	2,297	18,282	7.96	13
14	Head Cook	5,013	5,269	38,095	7.23	14
15	Cook Helpers/Assistants	7,718	7,930	51,943	6.55	15
16	Dishwashers					16
17	Maintenance Workers	3,917	4,037	37,131	9.20	17
18	Housekeepers	12,666	13,002	88,950	6.84	18
19	Laundry	4,750	5,075	34,865	6.87	19
20	Administrator	2,023	2,192	59,041	26.93	20
21	Assistant Administrator	1,866	2,021	45,025	22.28	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,333	4,656	71,371	15.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,900	2,096	18,406	8.78	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MARKETING</u>	1,453	1,490	28,380	19.05	33
34	TOTAL (lines 1 - 33)	126,287	131,148	\$ 1,472,995 *	\$ 11.23	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	M	\$ 7,893	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	714	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	971	11-3	44
45	Social Service Consultant	E	1,140	12-3	45
46	Other(specify)	S			46
47	<u>PSYCHIATRIC</u>		4,679	10-3	47
48	<u>M/C & PA CONSULTING</u>		100,000	10-3	48
49	TOTAL (lines 35 - 48)		\$ 132,197		49

C. CONTRACT NURSES

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

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER INC

0042671

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 68,985
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 11,060 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees