

		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>0032961</u></p> <p>Facility Name: <u>SPRINGFIELD TERRACE</u></p> <p>Address: <u>525 SO MARTIN LUTHER KING DR</u> <u>SPRINGFIELD</u> <u>62703</u> Number City Zip Code</p> <p>County: <u>SANGAMON</u></p> <p>Telephone Number: <u>(217) 789-1680</u> Fax # <u>(217) 789-0842</u></p> <p>IDPA ID Number: <u>37-1223350001</u></p> <p>Date of Initial License for Current Owners: <u>11/06/87</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>MELVIN SIEGEL</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) (SEE ATTACHED ACCOUNTANTS' REPORT) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</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>MELVIN SIEGEL</u> (Date) _____		(Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</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 SPRINGFIELD TERRACE

0032961 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,725	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,725	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	18,458	459		18,917
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	18,458	459		18,917

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.73%

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 11/06/87

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/06/87 NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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 **SPRINGFIELD TERRACE** # **0032961** 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	48,782	5,434	4,459	58,675		58,675		58,675		1
2	Food Purchase		71,184		71,184		71,184	(272)	70,912		2
3	Housekeeping	33,077	4,851		37,928		37,928		37,928		3
4	Laundry	25,987	3,287		29,274		29,274		29,274		4
5	Heat and Other Utilities			44,587	44,587		44,587	1,530	46,117		5
6	Maintenance	21,677		30,857	52,534		52,534	(3,369)	49,165		6
7	Other (specify):*			3,981	3,981		3,981	211	4,192		7
8	TOTAL General Services	129,523	84,756	83,884	298,163		298,163	(1,900)	296,263		8
	B. Health Care and Programs										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	493,455	25,491	15,688	534,634		534,634	6,589	541,223		10
10a	Therapy			5,101	5,101		5,101		5,101		10a
11	Activities	25,696	1,390	3,240	30,326		30,326	(3,240)	27,086		11
12	Social Services	52,428	720		53,148		53,148		53,148		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	571,579	27,601	34,829	634,009		634,009	3,349	637,358		16
	C. General Administration										
17	Administrative	60,536		3,000	63,536		63,536	1,960	65,496		17
18	Directors Fees										18
19	Professional Services			102,453	102,453		102,453	(76,347)	26,106		19
20	Dues, Fees, Subscriptions & Promotions			8,464	8,464		8,464	(1,862)	6,602		20
21	Clerical & General Office Expenses	28,408	9,256	21,941	59,605		59,605	21,936	81,541		21
22	Employee Benefits & Payroll Taxes			146,724	146,724		146,724		146,724		22
23	Inservice Training & Education			530	530		530	196	726		23
24	Travel and Seminar			3,023	3,023		3,023	5,935	8,958		24
25	Other Admin. Staff Transportation			10,345	10,345		10,345	3,755	14,100		25
26	Insurance-Prop.Liab.Malpractice			55,100	55,100		55,100	1,137	56,237		26
27	Other (specify):*			466	466		466	18,384	18,850		27
28	TOTAL General Administration	88,944	9,256	352,046	450,246		450,246	(24,906)	425,340		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	790,046	121,613	470,759	1,382,418		1,382,418	(23,457)	1,358,961		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	4,459
	REPAIRS & MAINTENANCE		0
			0
			4,459
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		10,199
	ELECTRICITY		18,845
	WATER		14,982
	CABLE TV - LOBBY		561
			0
			44,587
6	MAINTENANCE		
	GROUNDS MAINTENANCE		0
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		18,507
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		905
	FIRE SERVICE		1,461
	MAINTENANCE CONSULTANT		9,984
			0
			0
			30,857
7	OTHER		
	SCAVENGER		3,337
	SECURITY SERVICE		644
			3,981
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	10,800
			10,800

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	8,481
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B 47-2	5,240
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	767
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
	GERIATRIC CONSULTANT	XVIII B 48-2	1,200
			0
			15,688
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		3,569
	SPEECH THERAPY SERVICES		83
	OCCUPATIONAL THERAPY SERVICES		1,449
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			5,101
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,240
			0
			3,240
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	0
			0
			0
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	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	3,000
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	8,073
	ADMINISTRATIVE CONSULTANTS XIX C	6,480
	PROFESSIONAL FEES XIX C	17,739
	BOOKKEEPING/ADMINIST SERVICE XIX C	70,161
20	FEES,SUBSCRIPTIONS,PROMOTIONS	102,453
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	1,628
	EMPLOYEE WANT ADS XIX F	2,088
	CONTRIBUTIONS VI 20 XIX F	180
	DUES & SUBSCRIPTIONS XIX F	3,763
	LICENSES & PERMITS XIX F	300
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	245
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	260
21	CLERICAL & GENERAL OFFICE EXPENSES	8,464
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	669
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	13,075
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	8,136
	MESSENGER SERVICE	61
		0
		21,941

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	60,389
	UNEMPLOYMENT COMPENSATION XIX D	51,300
	WORKERS COMPENSATION INSURANCI XIX D	31,800
	HOSPITALIZATION INSURANCE XIX D	
	EMPLOYEE BENEFITS - OTHER XIX D	3,235
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		146,724
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	530
		530
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	3,023
		0
		0
		3,023
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	10,345
		10,345
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	55,100
		55,100
27	OTHER	
	BAD DEBTS VI 24	466
		466

GRAND TOTAL COLUMN 3 OTHER 470,759

SPRINGFIELD TERRACE
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2005

TOTAL FOOD PURCHASE	71,184	PATIENT MEALS	56751
LESS SALES TAX	(272)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	70,912	TOTAL MEALS/YEAR	56751
TOTAL PATIENT CENSUS	18,917	NET FOOD	70912
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	56751

TOTAL PATIENT MEALS	56751	COST PER MEAL	1.25
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number

SPRINGFIELD TERRACE

#0032961

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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			3,300	3,300		3,300	21,556	24,856			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,546	11,546		11,546	65,130	76,676			32
33	Real Estate Taxes			15,058	15,058		15,058		15,058			33
34	Rent-Facility & Grounds			76,750	76,750		76,750	(70,031)	6,719			34
35	Rent-Equipment & Vehicles			6,685	6,685		6,685	3,682	10,367			35
36	Other (specify):*											36
37	TOTAL Ownership			113,339	113,339		113,339	20,337	133,676			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			35,588	35,588		35,588		35,588			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			35,588	35,588		35,588		35,588			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	790,046	121,613	619,686	1,531,345		1,531,345	(3,120)	1,528,225			45

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

Facility Name & ID Number **SPRINGFIELD TERRACE**

0032961

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	2,540	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	(272)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(13,075)	21		18
19	Entertainment		20		19
20	Contributions	(425)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(466)	27		24
25	Fund Raising, Advertising and Promotional	(1,628)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (14,326)		\$	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)	11,206		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 11,206		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,120)		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

SPRINGFIELD TERRACE

ID# 0032961

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$	6
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SPRINGFIELD TERRACE# 0032961

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(272)	0	0	0	0	0	0	0	0	0	0	(272)	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	1,530	0	0	0	0	0	0	0	0	0	1,530	5
6	Maintenance	0	(3,369)	0	0	0	0	0	0	0	0	0	(3,369)	6
7	Other (specify):*	0	211	0	0	0	0	0	0	0	0	0	211	7
8	TOTAL General Services	(272)	(1,628)	0	0	0	0	0	0	0	0	0	(1,900)	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	6,589	0	0	0	0	0	0	0	0	0	6,589	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	(3,240)	0	0	0	0	0	0	0	0	0	(3,240)	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	3,349	0	0	0	0	0	0	0	0	0	3,349	16
	C. General Administration													
17	Administrative	0	1,960	0	0	0	0	0	0	0	0	0	1,960	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,000)	(75,347)	0	0	0	0	0	0	0	0	0	(76,347)	19
20	Fees, Subscriptions & Promotions	(2,053)	0	191	0	0	0	0	0	0	0	0	(1,862)	20
21	Clerical & General Office Expenses	(13,075)	0	35,011	0	0	0	0	0	0	0	0	21,936	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	196	0	0	0	0	0	0	0	0	196	23
24	Travel and Seminar	0	0	5,935	0	0	0	0	0	0	0	0	5,935	24
25	Other Admin. Staff Transportation	0	0	3,755	0	0	0	0	0	0	0	0	3,755	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,137	0	0	0	0	0	0	0	0	1,137	26
27	Other (specify):*	(466)	0	18,850	0	0	0	0	0	0	0	0	18,384	27
28	TOTAL General Administration	(16,594)	(73,387)	65,075	0	(24,906)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16,866)	(71,666)	65,075	0	(23,457)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SPRINGFIELD TERRACE# 0032961

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	2,540	0	307	18,709	0	0	0	0	0	0	0	21,556	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	888	64,242	0	0	0	0	0	0	0	65,130	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	6,719	(76,750)	0	0	0	0	0	0	0	(70,031)	34
35	Rent-Equipment & Vehicles	0	0	3,682	0	0	0	0	0	0	0	0	3,682	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	2,540	0	11,596	6,201	0	20,337	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(14,326)	(71,666)	76,671	6,201	0	(3,120)	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
		ARC OF JACKSONVILLE	JACKSONVILLE	MAVIN	SKOKIE, IL	COUNSULTING,
		LITCHFIELD TERRACE	LITCHFIELD	ENTERPRISES, LTD.		BOOKKEEPING
		RIVER VIEW MANOR	LOVES PARK			
SEE ATTACHED SCHEDULE		PARKVIEW TERRACE	EAST MOLINE	IDEA ASSOCIATES	SKOKIE, IL	REAL ESTATE
		GOLDEN MOMENTS	JACKSONVILLE			
		VANDALIA TERRACE	VANDALIA			

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	6 MAINTENANCE CONSULTANT	\$ 9,984	MAVIN ENTERPRISES, LTD		\$	\$ (9,984)	1
2	V	10 PSYCHO-SOCIAL CONSULTANT	3,240				(3,240)	2
3	V	11 ACTIVITIES CONSULTANT	3,240				(3,240)	3
4	V	19 ADMIN. /BKPP. FEES	69,351				(69,351)	4
5	V	19 ADMIN. /CONSULT. FEES	6,480				(6,480)	5
6	V							6
7	V	5 ELECTRICITY/GAS				1,530	1,530	7
8	V	6 MAINTENANCE SALARIES				6,598	6,598	8
9	V	6 MAINTENANCE & REPAIR				17	17	9
10	V	7 SCAVENGER				211	211	10
11	V	10 PSYCHO-SOCIAL & NURSING CONSULT				9,829	9,829	11
12	V	17 ADMINISTRATIVE SALARIES				1,960	1,960	12
13	V	19 PROFESSIONAL FEES				484	484	13
14	Total		\$ 92,295			\$ 20,629	\$ * (71,666)	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	20 ADVERTISING	\$	MAVIN ENTERPRISES, LTD.		\$ 191	\$	191	15
16	V	21 TOTAL OFFICE				35,011		35,011	16
17	V	23 SEMINARS				196		196	17
18	V	24 TRAVEL				5,935		5,935	18
19	V	25 TRANSPORTATION				3,755		3,755	19
20	V	26 INSURANCE				1,137		1,137	20
21	V	27 EMPLOYEE BENEFITS				18,850		18,850	21
22	V	30 DEPRECIATION (SL)				307		307	22
23	V	32 INTEREST				888		888	23
24	V	34 OFFICE RENT				6,719		6,719	24
25	V	35 EQUIPMENT RENT				3,682		3,682	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 76,671	\$ *	76,671	39

* 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	34 RENT	\$ 76,750	IDEA ASSOCIATES		\$	(76,750)	15
16	V	30 DEPRECIATION				18,709	18,709	16
17	V	32 INTEREST				64,242	64,242	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 76,750			\$ 82,951	\$ * 6,201	39

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

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 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									\$		1	
2											2	
3											3	
4											4	
5											5	
6											6	
7			SEE ATTACHED LIST									7
8											8	
9											9	
10											10	
11											11	
12											12	
13								TOTAL	\$		13	

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

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

Facility Name & ID Number **SPRINGFIELD TERRACE**

0032961

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

Name of Related Organization MAVIN ENTERPRISES, LTD.
 Street Address 3845 OAKTON
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-0100
 Fax Number (847) 679-0647

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	5	ELECTRICITY/GAS	PATIENT DAYS	143,350	7	\$ 11,595	\$ 18,917	\$ 1,530	1
2	6	MAINTENANCE SALARIES	PATIENT DAYS	143,350	7	50,000	18,917	6,598	2
3	6	MAINTENANCE & REPAIR	PATIENT DAYS	143,350	7	128	18,917	17	3
4	7	SCAVENGER	PATIENT DAYS	143,350	7	1,602	18,917	211	4
5	10	PSYCHO-SOCIAL & NURSING	PATIENT DAYS	143,350	7	74,480	18,917	9,829	5
6	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	143,350	7	14,850	18,917	1,960	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	143,350	7	3,665	18,917	484	7
8	20	ADVERTISING	PATIENT DAYS	143,350	7	1,451	18,917	191	8
9	21	TOTAL OFFICE	PATIENT DAYS	143,350	7	265,310	18,917	35,011	9
10	23	SEMINARS	PATIENT DAYS	143,350	7	1,485	18,917	196	10
11	24	TRAVEL	PATIENT DAYS	143,350	7	44,974	18,917	5,935	11
12	25	TRANSPORTATION	PATIENT DAYS	143,350	7	28,456	18,917	3,755	12
13	26	INSURANCE	PATIENT DAYS	143,350	7	8,617	18,917	1,137	13
14	27	EMPLOYEE BENEFITS	PATIENT DAYS	143,350	7	142,843	18,917	18,850	14
15	30	DEPRECIATION (SL)	PATIENT DAYS	143,350	7	2,332	18,917	307	15
16	32	INTEREST	PATIENT DAYS	143,350	7	6,726	18,917	888	16
17	34	OFFICE RENT	PATIENT DAYS	143,350	7	50,915	18,917	6,719	17
18	35	EQUIPMENT RENT	PATIENT DAYS	143,350	7	27,901	18,917	3,682	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 737,330	\$ 283,523	\$ 97,300	25

Facility Name & ID Number

SPRINGFIELD TERRACE

0032961

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	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	RELATED PARTY					\$	\$			\$	1									
2	IDEA ASSOCIATES										2									
3	BANK FINANCIAL	X	MORTGAGE	\$6,755.00	01/04	874,500	824,112		6.5000	64,242	3									
4											4									
5	MGMT ALLOCATION									888	5									
Working Capital																				
6	SUCCESS BANK	X	LINE OF CREDIT	DEMAND	11/97	150,000	142,636		PRIME +	11,546	6									
7											7									
8											8									
9	TOTAL Facility Related			\$6,755.00		\$ 1,024,500	\$ 966,748			\$ 76,676	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 1,024,500	\$ 966,748			\$ 76,676	15									

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2004 report.		\$	13,829	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.)		\$	14,372	2
3. Under or (over) accrual (line 2 minus line 1).		\$	543	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	14,515	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.		\$	15,058	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	13,073	8
	2001	13,434	9
	2002	13,676	10
	2003	13,692	11
	2004	14,372	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

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.

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 SPRINGFIELD TERRACE COUNTY SANGAMON

FACILITY IDPH LICENSE NUMBER 0032961

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>14-35-0-157-019</u>	<u>NURSING HOME</u>	\$ <u>14,371.64</u>	\$ <u>14,371.64</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>14,371.64</u>	\$ <u>14,371.64</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 SPRINGFIELD TERRACE

0032961

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY		1987	\$ 22,340	1
2					2
3	TOTALS			\$ 22,340	3

Facility Name & ID Number **SPRINGFIELD TERRACE**# **0032961**

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	65	1897		\$ 589,342	\$ 18,709	31.5	\$ 18,709	\$	\$ 284,254	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	VARIOUS		1991	3,905	124	20	196	72	2,720	9
10	VARIOUS		1992	8,184	260	20	409	149	5,159	10
11	VARIOUS		1993	750	19	20	38	19	421	11
12	VARIOUS		1994	540	13	20	27	14	311	12
13	DOOR		1997	1,086	27	20	54	27	455	13
14	SPRINKLER		1997	3,790	97	20	189	92	1,591	14
15	DECORATING		1997	2,281	58	20	114	56	969	15
16	EXHAUST SYTEM		1997	1,250	32	20	62	30	543	16
17	TILE		1997	1,944	49	20	97	48	873	17
18	TILE		1997	638	16	20	32	16	267	18
19	DOORS		1997	1,327	35	20	66	31	539	19
20	SPRINKLER		1997	705	18	20	35	17	289	20
21	SPRINKLER		1997	1,532	40	20	77	37	633	21
22	REWIRE & REPLACE SECURITY		1997	3,000	77	20	150	73	1,213	22
23	SPRINKLER		1998	2,138	56	20	107	51	802	23
24	DOORS		1998	1,896	49	20	95	46	712	24
25	SECURITY SYSTEM		1998	1,149	30	20	57	27	456	25
26	FLOOR TILE, LIGHTS		1999	1,468	38	20	73	35	511	26
27	SHINGLE ROOF		2000	26,800	974	27.5	974		5,666	27
28	NEW AIR CONDITIONERS		2000	2,255	82	27.5	82		477	28
29	FRONT DOOR WITH LOCK		2000	1,245	46	27.5	46		267	29
30	REPLACE 3 TON CONDENSING UNIT FOR LUNCH ROOM		2001	3,494	127	27.5	127		572	30
31	GUTTERS AND DOWNSPOUTS		2001	2,654	97	27.5	97		436	31
32										32
33										33
34										34
35										35
36										36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number **SPRINGFIELD TERRACE**

0032961

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	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)		\$ 663,373	\$ 21,073		\$ 21,913	\$ 840	\$ 310,136	70

**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	\$ 24,830	\$ 935	\$ 2,636	\$ 1,701	5-10 YRS	\$ 18,076	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	48,223					48,223	73
74	MGMT ALLOCATION		307	307				74
75	TOTALS	\$ 73,053	\$ 1,242	\$ 2,943	\$ 1,701		\$ 66,299	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	1998 CHEVROLET VAN	1999	\$ 5,429	\$ 1	\$	\$ (1)	5 YRS	\$ 5,429	76
77										77
78										78
79										79
80	TOTALS			\$ 5,429	\$ 1	\$	\$ (1)		\$ 5,429	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)	\$ 764,195	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,316	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 24,856	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,540	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 381,864	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: \$ 6,685 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>N/A</u>	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>0</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.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

* 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		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			N/A				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.

Facility Name & ID Number **SPRINGFIELD TERRACE**# **0032961**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	\$ 1,494	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	397,941		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,482		6
7	Other Prepaid Expenses	14,631		7
8	Accounts Receivable (owners or related parties)	172,221		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 627,769	\$	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	74,031		15
16	Equipment, at Historical Cost	78,481		16
17	Accumulated Depreciation (book methods)	(96,984)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,350		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 56,878	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 684,647	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 363,000	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,850		28
29	Short-Term Notes Payable	1,064,206		29
30	Accrued Salaries Payable	21,848		30
31	Accrued Taxes Payable (excluding real estate taxes)	160,676		31
32	Accrued Real Estate Taxes(Sch.IX-B)	14,515		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)	\$ 1,648,095	\$	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,648,095	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (963,448)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 684,647	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (813,756)	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	(1,996)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (815,752)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(147,696)	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)	\$ (147,696)	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)	\$ (963,448)	24 *

* This must agree with page 17, line 47.

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	\$ 1,375,921	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,375,921	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,728	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,728	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			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)	\$ 1,383,649	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	298,163	31
32	Health Care	634,009	32
33	General Administration	450,246	33
	B. Capital Expense		
34	Ownership	113,339	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	35,588	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,531,345	40
41	Income before Income Taxes (line 30 minus line 40)**	(147,696)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (147,696)	43

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

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

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

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

Facility Name & ID Number **SPRINGFIELD TERRACE**

0032961

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	1,946	2,109	\$ 48,271	\$ 22.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,123	1,145	22,681	19.81	3
4	Licensed Practical Nurses	8,392	8,915	155,990	17.50	4
5	CNAs & Orderlies	22,752	24,694	212,446	8.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,648	2,850	25,696	9.02	10
11	Social Service Workers	3,459	3,662	52,428	14.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	6,930	7,163	48,782	6.81	15
16	Dishwashers					16
17	Maintenance Workers	1,853	2,058	21,677	10.53	17
18	Housekeepers	4,642	4,753	33,077	6.96	18
19	Laundry	3,437	3,676	25,987	7.07	19
20	Administrator	2,048	2,088	60,536	28.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,738	4,844	28,408	5.86	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>SEE ATTACHED</u>	3,249	3,534	54,067	15.30	33
34	TOTAL (lines 1 - 33)	67,217	71,491	\$ 790,046 *	\$ 11.05	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	\$ 4,459	1-3	35
36	Medical Director	O	10,800	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	767	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,240	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47	<u>PSYCHO-SOCIAL CONSULTANT</u>		5,240	10-3	47
48	<u>GERIATRIC CONSULTANT</u>		1,200	10-3	48
49	TOTAL (lines 35 - 48)		\$ 25,706		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses	231	8,481	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	231	\$ 8,481		53

Facility Name & ID Number **SPRINGFIELD TERRACE**

0032961

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

Ending: **12/31/2005**

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		
SHELLEY REISS	ADMIN	0	\$ 59,382	Workers' Compensation Insurance	\$ 31,800	IDPH License Fee	\$		
MARSHA JACOBS	ADMIN	0	1,154	Unemployment Compensation Insurance	51,300	Advertising: Employee Recruitment	2,088		
				FICA Taxes	60,389	Health Care Worker Background Check	260		
				Employee Health Insurance	0	(Indicate # of checks performed <u>19</u>)			
				Employee Meals	0	MARKETING/ADV/PROMO	1,628		
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	425		
				EMPLOYEE BENEFITS - OTHER	3,235	LICENSES & PERMITS	300		
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	3,763		
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOCATION	191		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(425)		
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)		
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(1,628)		
						Yellow page advertising	(0)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 60,536	TOTAL (agree to Schedule V, line 22, col.8)		\$ 146,724	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 6,602
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	
MELVIN SIEGEL	MANAGEMENT FEE		\$ 3,000				Out-of-State Travel	\$	
							In-State Travel		
								3,023	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 3,000				MGMT CO ALLOCATION	5,935	
C. Professional Services							Seminar Expense		
Vendor/Payee	Type		Amount					Amount	
NURSING CARE SYSTEMS	DATA PROCESSING		\$ 3,720						
ALPHA DATA SERVICE	DATA PROCESSING		2,580					0	
LTC SOLUTIONS	DATA PROCESSING		1,320				Entertainment Expense	()	
BKD TECHNOLOGIES	DATA PROCESSING		454				(agree to Sch. V, line 24, col. 8)		
MAVIN ENTERPRISES LTD	ADMIN. CONSULTANT		6,480				TOTAL	\$ 8,958	
KRUPNICK,BOKOR,KAGDA	ACCOUNTING FEES		10,250						
GARY A. WEINTRAUB, P.C.	LEGAL FEES		3,612						
EDDIE CARPENTER	LEGAL FEES		375						
PERSONNEL PLANNERS	UC CONSULTANT		2,501						
MAVIN ENTERPRISES LTD	BOOKKEEPING/ADMIN		69,351						
SAK MANAGEMENT SERVICES	BOOKKEEPING/ADMIN		810						
GENSON & GILLESPIE	LEGAL FEES		1,000						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 102,453	TOTAL			\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SPRINGFIELD TERRACE# 0032961Report Period Beginning: 01/01/2005Ending: 12/31/2005**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE \$3,258
- (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. \$ 35,588
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. \$ 0 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 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