

Facility Name & ID Number DANVILLE CARE CENTER

0032862 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	118	Skilled (SNF)	118	43,070	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	82	Intermediate/DD	82	29,930	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	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	1,538		4,470	6,008	8
9	SNF/PED					9
10	ICF	28,785	3,817	1,241	33,843	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,323	3,817	5,711	39,851	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.59%

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 10/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/01/87 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 24 and days of care provided 4,470

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **DANVILLE CARE CENTER** # **0032862** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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	193,501	18,413	10,862	222,776		222,776	0	222,776		1
2	Food Purchase		203,878		203,878	0	203,878	(571)	203,307		2
3	Housekeeping	145,524	34,858	0	180,382		180,382	0	180,382		3
4	Laundry	81,350	30,600	1,135	113,085	0	113,085	0	113,085		4
5	Heat and Other Utilities			156,703	156,703		156,703	1,319	158,022		5
6	Maintenance	69,934	36,905	27,380	134,219		134,219	1,293	135,512		6
7	Other (specify):*			8,653	8,653		8,653	0	8,653		7
8	TOTAL General Services	490,309	324,654	204,733	1,019,696	0	1,019,696	2,041	1,021,737		8
	B. Health Care and Programs										
9	Medical Director	0		5,250	5,250		5,250	0	5,250		9
10	Nursing and Medical Records	1,304,944	158,740	217,132	1,680,816		1,680,816	24,507	1,705,323		10
10a	Therapy	0	1,200	1,424	2,624		2,624	0	2,624		10a
11	Activities	52,659	1,682	1,349	55,690		55,690	0	55,690		11
12	Social Services	99,830		3,193	103,023		103,023	0	103,023		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	1,457,433	161,622	228,348	1,847,403	0	1,847,403	24,507	1,871,910		16
	C. General Administration										
17	Administrative	108,015		78,033	186,048		186,048	(19,131)	166,917		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			75,412	75,412		75,412	(45,082)	30,330		19
20	Dues, Fees, Subscriptions & Promotions			44,737	44,737		44,737	(8,836)	35,901		20
21	Clerical & General Office Expenses	98,527	31,842	243,893	374,262		374,262	(101,664)	272,598		21
22	Employee Benefits & Payroll Taxes			468,021	468,021	0	468,021	16,879	484,900		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			3,076	3,076		3,076	5,903	8,979		24
25	Other Admin. Staff Transportation			12,430	12,430		12,430	9,450	21,880		25
26	Insurance-Prop.Liab.Malpractice			86,048	86,048		86,048	18,929	104,977		26
27	Other (specify):* Marketing			0	0		0	0	0		27
28	TOTAL General Administration	206,542	31,842	1,011,650	1,250,034	0	1,250,034	(123,552)	1,126,482		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,154,284	518,118	1,444,731	4,117,133	0	4,117,133	(97,004)	4,020,129		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	10,862
	REPAIRS & MAINTENANCE	0
		0
		10,862
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,135
		0
		1,135
5	HEAT & OTHER UTILITIES	
	GAS HEAT	23,149
	ELECTRICITY	81,526
	WATER	50,729
	CABLE TV - LOBBY	1,299
		0
		156,703
6	MAINTENANCE	
	GROUNDS MAINTENANCE	10,555
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	1,522
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	10,979
	FIRE SERVICE	4,324
		0
		0
		0
		0
		27,380
7	OTHER	
	SCAVENGER	8,653
	SECURITY SERVICE	0
		0
		0
		8,653
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	5,250
		5,250

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	202,781
	LABORATORY & XRAY EXPENSE	1,308
	PURCHASED SERVICES	8,501
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	729
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,413
	PHARMACY CONSULTANT XVIII B 39-2	2,400
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		217,132
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	83
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	1,341
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		1,424
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,349
		0
		1,349
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,193
		0
		3,193
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	78,033
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	9,203
	ADMINISTRATIVE CONSULTANTS XIX C	45,606
	PROFESSIONAL FEES XIX C	20,603
		0
		75,412
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	5,903
	EMPLOYEE WANT ADS XIX F	30,504
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	0
	LICENSES & PERMITS XIX F	5,397
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	2,933
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		44,737
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	270
	OUTSIDE CLERICAL SERVICES	193,299
	PENALTIES / OVERDRAFT CHARGES VI 18	30,259
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	56
	TELEPHONE	16,554
	MESSENGER SERVICE	3,455
		0
		243,893

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	162,791
	UNEMPLOYMENT COMPENSATION XIX D	87,054
	WORKERS COMPENSATION INSURANC XIX D	137,887
	HOSPITALIZATION INSURANCE XIX D	78,360
	EMPLOYEE BENEFITS - OTHER XIX D	826
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	1,103
	CHICAGO HEAD TAX XIX D	0
		0
		468,021
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	858
	TRAVEL XIX G	2,218
		3,076
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	12,430
		12,430
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	86,048
		86,048
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,444,731

DANVILLE CARE CENTER
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	203,878	PATIENT MEALS	119553
LESS SALES TAX	(571)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	203,307	TOTAL MEALS/YEAR	119553
TOTAL PATIENT CENSUS	39,851	NET FOOD	203307
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	119553

TOTAL PATIENT MEALS	119553	COST PER MEAL	1.7
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number **DANVILLE CARE CENTER**

#0032862

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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			58,493	58,493		58,493	191,464	249,957			30
31	Amortization of Pre-Op. & Org.			0	0		0	26,667	26,667			31
32	Interest			118,834	118,834		118,834	506,416	625,250			32
33	Real Estate Taxes			68,033	68,033		68,033	0	68,033			33
34	Rent-Facility & Grounds			629,263	629,263		629,263	(622,663)	6,600			34
35	Rent-Equipment & Vehicles			22,180	22,180		22,180	0	22,180			35
36	Other (specify):*			0	0		0	0	0			36
37	TOTAL Ownership			896,803	896,803	0	896,803	101,884	998,687			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		153,002	345,317	498,319		498,319	0	498,319			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			109,500	109,500		109,500	0	109,500			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	153,002	454,817	607,819	0	607,819	0	607,819			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,154,284	671,120	2,796,351	5,621,755	0	5,621,755	4,880	5,626,635			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	35,092	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	(571)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(30,259)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(5,903)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,933)	20		28
29	Other-Attach Schedule	(3,984)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (8,558)		\$ 0	30

BHF USE ONLY					
48	49	50	51	52	

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

		1	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)	13,438		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 13,438		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 4,880		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

DANVILLE CARE CENTER

ID# 0032862

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 0	6 1
2	LEGAL FEES	(3,984)	19 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	(3,984)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DANVILLE CARE CENTER# 0032862 Report Period Beginning:

01/01/2006

Ending: 12/31/2006

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	(571)	0	0	0	0	0	0	0	0	0	0	(571)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,319	0	0	0	0	0	0	0	0	1,319	5
6	Maintenance	0	0	1,293	0	0	0	0	0	0	0	0	1,293	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(571)	0	2,612	0	2,041	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	24,507	0	0	0	0	0	0	0	0	24,507	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	24,507	0	24,507	16							
	C. General Administration													
17	Administrative	0	(78,033)	58,902	0	0	0	0	0	0	0	0	(19,131)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,984)	(45,606)	4,508	0	0	0	0	0	0	0	0	(45,082)	19
20	Fees, Subscriptions & Promotions	(8,836)	0	0	0	0	0	0	0	0	0	0	(8,836)	20
21	Clerical & General Office Expenses	(30,259)	(193,049)	121,644	0	0	0	0	0	0	0	0	(101,664)	21
22	Employee Benefits & Payroll Taxes	0	0	16,879	0	0	0	0	0	0	0	0	16,879	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	5,903	0	0	0	0	0	0	0	0	5,903	24
25	Other Admin. Staff Transportation	0	0	9,450	0	0	0	0	0	0	0	0	9,450	25
26	Insurance-Prop.Liab.Malpractice	0	0	18,929	0	0	0	0	0	0	0	0	18,929	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(43,079)	(316,688)	236,215	0	(123,552)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(43,650)	(316,688)	263,334	0	(97,004)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DANVILLE CARE CENTER

0032862

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	35,092	152,672	3,700	0	0	0	0	0	0	0	0	191,464	30
31	Amortization of Pre-Op. & Org.	0	26,667	0	0	0	0	0	0	0	0	0	26,667	31
32	Interest	0	506,416	0	0	0	0	0	0	0	0	0	506,416	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(629,263)	6,600	0	0	0	0	0	0	0	0	(622,663)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	35,092	56,492	10,300	0	101,884	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)	(8,558)	(260,196)	273,634	0	4,880	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
BRADLEY ALTER	23.00	SEE ATTACHED SCHEDULE		CERTIFIED HEALTH MANAGEMENT	SKOKIE	BKKPG/MGMT
RITA L GELLER	38.00					
JOSEPH C CHOW	39.00			DANVILLE CARE 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	17 MANAGEMENT FEES	\$ 78,033	CERTIFIED HEALTH MANAGEMENT		\$	\$ (78,033)	1
2	V	21 BOOKKEEPING	193,299				(193,299)	2
3	V	19 ADMIN CONSULTING FEES	45,606				(45,606)	3
4	V							4
5	V							5
6	V							6
7	V	34 RENT	629,263	DANVILLE CARE CENTER LLC			(629,263)	7
8	V	21 OFFICE EXPENSE				250	250	8
9	V	30 DEPRECIATION				152,672	152,672	9
10	V	31 AMORTIZATION				26,667	26,667	10
11	V	32 INTEREST				506,416	506,416	11
12	V							12
13	V							13
14	Total		\$ 946,201			\$ 686,005	\$ * (260,196)	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	3 HOUSEKEEPING	\$	CERTIFIED HEALTH MANAGEMENT		\$ 0	\$	15	
16	V	5 ELECTRIC/GAS		" " "		1,319		16	
17	V	6 MAINTENANCE		" " "		1,293		17	
18	V	10 NURSING/MEDICAL RECORDS		" " "		24,507		18	
19	V	17 ADMIN SALARIES		" " "		58,902		19	
20	V	19 PROFESSIONAL FEES		" " "		4,508		20	
21	V	20 FEES, SUBSCRIPTIONS		" " "		0		21	
22	V	21 OFFICE EXP		" " "		121,644		22	
23	V	22 EMPLOYEE BENEFITS		" " "		16,879		23	
24	V	24 TRAVEL/SEMINAR		" " "		5,903		24	
25	V	25 TRANSPORTATION		" " "		9,450		25	
26	V	26 INSURANCE		" " "		18,929		26	
27	V	30 DEPRECIATION		" " "		3,700		27	
28	V	32 INTEREST		" " "		0		28	
29	V	34 OFFICE RENT		" " "		6,600		29	
30	V	36 EQUIPMENT RENTAL		" " "		0		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		\$			\$ 273,634	\$ *	273,634	39

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

Facility Name & ID Number

DANVILLE CARE CENTER

#

0032862

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	BRADLEY ALTER		ADMINISTRATION		SEE ATTACHED SCHEDULE			SALARY	\$ 44,770	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 44,770		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 **DANVILLE CARE CENTER**

0032862 Report Period Beginning: **01/01/2006**

Ending: **2/31/2006**

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 CERTIFIED HEALTH MANAGEMENT
 Street Address 3865 OAKTON SUITE 200
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 674-4700
 Fax Number (847) 674-4733

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	3	HOUSEKEEPING	PER PATIENT DAY	8	\$ 0	\$	39,851	\$ 0	1
2	5	ELECTRIC/GAS	" " "	8	6,594		39,851	1,319	2
3	6	MAINTENANCE	" " "	8	6,467		39,851	1,293	3
4	10	NURSING/MEDICAL RECORDS	" " "	8	122,529	122,529	39,851	24,507	4
5	17	ADMIN SALARIES	" " "	8	294,492	294,492	39,851	58,902	5
6	19	PROFESSIONAL FEES	" " "	8	22,540		39,851	4,508	6
7	20	FEES, SUBSCRIPTIONS	" " "	8			39,851	0	7
8	21	OFFICE EXP	" " "	8	608,185	545,133	39,851	121,644	8
9	22	EMPLOYEE BENEFITS	" " "	8	84,392		39,851	16,879	9
10	24	TRAVEL/SEMINAR	" " "	8	29,513		39,851	5,903	10
11	25	TRANSPORTATION	" " "	8	47,249		39,851	9,450	11
12	26	INSURANCE	" " "	8	94,640		39,851	18,929	12
13	30	DEPRECIATION	" " "	8	18,500		39,851	3,700	13
14	32	INTEREST	" " "	8	0		39,851	0	14
15	34	OFFICE RENT	" " "	8	33,000		39,851	6,600	15
16	36	EQUIPMENT RENTAL	" " "	8	0		39,851	0	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,368,101	\$ 962,154		\$ 273,634	25

Facility Name & ID Number DANVILLE CARE CENTER

0032862 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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 DANVILLE CARE CENTER LLC
 Street Address 3856 OAKTON SUITE 200
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 674-4700
 Fax Number (847) 674-4733

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	30	DEPRECIATION	DIRECT COSTS	1	1	\$ 152,672	\$ 1	\$ 152,672	1
2	31	AMORTIZATION		1	1	26,667	1	26,667	2
3	32	INTEREST		1	1	506,416	1	506,416	3
4	21	OFFICE EXPENSE		1	1	250	1	250	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 686,005	\$	\$ 686,005	25

Facility Name & ID Number

DANVILLE CARE CENTER

0032862

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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							\$	\$			\$	1						
2												2						
3												3						
4												4						
5	INS FINANCING		X									2,317	5					
Working Capital																		
6	BANK FINANCIAL		X	WORKING CAPITAL				992,736		PRIME+		77,959	6					
7	BANK FINANCIAL		X	WORKING CAPITAL				100,000		PRIME+		26,891	7					
8	SHAREHOLDER LOAN	X		WORKING CAPITAL				175,000		PRIME+		11,667	8					
9	TOTAL Facility Related						\$ 0	\$ 1,267,736				\$ 118,834	9					
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES									10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$ 0	\$ 0				\$ 0	14					
15	TOTALS (line 9+line14)						\$ 0	\$ 1,267,736				\$ 118,834	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 2005 report.	\$	66,374	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.)	\$	66,537	2
3. Under or (over) accrual (line 2 minus line 1).	\$	163	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	67,870	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.	\$	68,033	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	59,372	8
	2002	60,866	9
	2003	60,485	10
	2004	65,072	11
	2005	66,537	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	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 2005 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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DANVILLE CARE CENTER COUNTY VERMILLION

FACILITY IDPH LICENSE NUMBER 0032862

CONTACT PERSON REGARDING THIS REPORT DON FIETS

TELEPHONE (847) 674-4700 X40 FAX #: (847) 674-4733

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>18-34-100-005-0060</u>	<u>NURSING HOME</u>	\$ <u>26,563.00</u>	\$ <u>26,563.00</u>
2. <u>18-33-200-016-0060</u>	<u>NURSING HOME</u>	\$ <u>39,974.46</u>	\$ <u>39,974.46</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>66,537.46</u>	\$ <u>66,537.46</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number DANVILLE CARE CENTER

0032862

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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).

N/A

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				\$	1
2					2
3	TOTALS			\$ 0	3

Facility Name & ID Number DANVILLE CARE CENTER

0032862

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	200	1998		\$ 2,954,225	\$ 152,666		\$ 152,666	\$	\$ 1,374,000	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	LEASEHOLD IMPROVEMENTS		1989	34,167	1,085	30	1,139	54	19,067	9
10	LEASEHOLD IMPROVEMENTS		1990	17,344	551	30	578	27	9,334	10
11	LEASEHOLD IMPROVEMENTS		1991	45,376	1,441	30	1,513	72	22,983	11
12	LEASEHOLD IMPROVEMENTS		1992	12,043	382	30	401	19	5,710	12
13	LEASEHOLD IMPROVEMENTS		1993	9,213	236	30	307	71	3,835	13
14	LEASEHOLD IMPROVEMENTS		1994	8,304	213	39	213	(0)	2,672	14
15	NURSING STATION		1995	14,331	367	39	367	0	4,145	15
16	DOOR/LIGHT FIXTURES		1995	17,592	451	39	451	0	5,092	16
17	FIRE ALARM & ELECTRICAL WORK		1995	2,420	62	39	62	0	700	17
18	SHOWER/BATH CONST.		1995	4,704	121	39	121	(0)	1,366	18
19	NURSECALL REPAIR		1996	1,655	42	39	42	0	466	19
20	SMOKE DETECTORS/LIGHT FIXTURES/DOOR		1996	5,894	151	39	151	0	1,627	20
21	RESURFACE PARKING AREA		1996	12,910	861	15	861	(0)	9,030	21
22	ROOF REPAIR		1966	12,742	327	39	327	(0)	3,311	22
23	WARDROBE UNITS		1996	8,361	214	39	214	0	2,149	23
24	FLOORING		1996	2,444	63	39	63	(0)	632	24
25	CARPET/WALLPAPER/BUMPER GUARDS/COVE BASE		1997	19,014	488	39	488	(0)	4,674	25
26	PARKING LOT REPAIR		1997	1,500	100	15	100		950	26
27	PAVILION CONST.		1997	8,297	213	39	213	(0)	2,057	27
28	THERAPY ROOM ADDITION		1998	320,230	8,211	39	8,211	0	66,031	28
29	NORTH WING RENOVATION		1998	65,143	1,670	39	1,670	0	13,430	29
30	BUMPER GUARDS		1998	9,285	238	39	238	0	2,133	30
31	CEILING REPAIR/DRYWALL/TILE		1999	17,083	438	39	438	0	3,108	31
32	NURSE CALL/FIRE ALARM SYSTEM		1999	5,616	144	39	144		1,088	32
33	ROOF REPAIR/AIR EXHAUSTS		1999	7,095	182	39	182	(0)	1,378	33
34	LANDSCAPING		1999	12,535	836	15	836	(0)	6,269	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 DANVILLE CARE CENTER

0032862

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	AIR CONDITIONER	2000	\$ 3,436	\$ 140	7	\$ 491	\$ 351	\$ 2,723	37
38	CARPET/COVE BASE/WALLPAPER	2000	9,734	395	7	1,391	996	7,685	38
39	BATHROOM REPAIR/REMODEL	2000	11,104	404	27.5	404	(0)	2,734	39
40	HOT TUB ROOM REPAIR/REMODEL	2000	6,700	244	27.5	244	(0)	1,646	40
41	ALARMA SYSTEM/DOORS/CAMERAS	2000	15,171	552	27.5	552	(0)	3,730	41
42	NORTH WING RENOVATION	2000	4,809	175	27.5	175	(0)	1,178	42
43	WATER HEATER VALVE	2000	1,026	37	27.5	37	0	254	43
44	SECURITY DOOR	2001	693	25	27.5	25	0	137	44
45	WATER HEATER	2001	684	25	27.5	25	(0)	136	45
46	ROOF REPAIRS	2002	10,000	364	27.5	364	(0)	1,501	46
47	CONCRETE REPAIRS	2002	1,592	58	27.5	58	(0)	240	47
48	ROOF	2003	23,000	836	27.5	836	0	2,891	48
49	BEDROOM CEILING/WALLS	2003	3,300	120	27.5	120		415	49
50	BLINDS	2003	3,118	359	5	624	265	2,496	50
51	VENT TO ROOF	2003	5,700	207	27.5	207	0	716	51
52	INSTALL PULL STATIONS	2003	1,033	38	27.5	38	(0)	131	52
53	ELECTRIC DOOR HOLDER/CLOSER	2003	852	31	27.5	31	(0)	107	53
54	GAS/ELECT ROOF TOP UNIT	2003	6,542	238	27.5	238	(0)	823	54
55	WATER HEATER REPAIR	2003	1,971	72	27.5	72	(0)	249	55
56	REPLACE DOORS/EXIT DEVICES	2003	13,040	474	27.5	474	0	1,639	56
57	NURSE CALL SYSTEM	2003	9,000	327	27.5	327	0	1,131	57
58	HEAT/COOL ROOF TOP UNIT	2003	5,287	192	27.5	192	0	664	58
59	DURO LAST ROOFING SYSTEM	2003	41,750	1,518	27.5	1,518	0	5,250	59
60	REPAIR CEILING/DOORS	2003	8,000	291	27.5	291	(0)	1,006	60
61	NURSE CALL SYSTEM/PULL STATIONS	2004	7,368	268	27.5	268	(0)	670	61
62	CEILING PANEL REPLACEMENT	2004	999	36	27.5	36	0	90	62
63	HANDRAILS	2004	1,406	51	27.5	51	0	128	63
64	SKYLITE	2004	2,400	87	27.5	87	0	218	64
65	WALL A/C UNITS	2004	10,249	373	27.5	373	(0)	932	65
66	ALARM SYSTEM	2004	1,995	73	27.5	73	(0)	182	66
67	WALLPAPER/PAINTING/COVE REPLACEMENT	2004	26,302	956	27.5	956	0	2,390	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,867,784	\$ 180,719		\$ 182,572	\$ 1,853	\$ 1,611,327	70

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

Facility Name & ID Number DANVILLE CARE CENTER

0032862

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,867,784	\$ 180,719		\$ 182,572	\$ 1,853	\$ 1,611,327	1
2	WALL AC UNITS/WALLPAPERING	2005	27,054	8,657	5	5,411	(3,246)	8,116	2
3	SHEET VINYL BATHROOM/ROTUNDA	2005	5,456	198	27.5	198	0	297	3
4	ROOF REPLACEMENT-PARTIAL	2005	29,083	1,058	27.5	1,058	(0)	1,587	4
5	HANDRAILS IN HALLWAYS	2005	15,871	577	27.5	577	0	866	5
6	REMOVE OLD/INSTALL NEW CERAMIC TILE	2005	9,460	344	27.5	344		516	6
7	BACKFLOW PREVENTER	2005	9,410	342	27.5	342	0	513	7
8	SIDEWALKS	2006	6,658	222	15	222	(0)		8
9	DOOR REPLACEMENT	2006	12,000	200	27.5	218	18		9
10	ROOF REPAIRS	2006	5,000	83	27.5	91	8		10
11	CONCRETE REPLACEMENT NORTH BLDG	2006	1,900	32	27.5	35	3		11
12	HANDRAILS IN HALLWAYS	2006	6,103	102	27.5	111	9		12
13	THRU WALL AC UNITS	2006	1,631	27	27.5	30	3		13
14	GENERATOR REPAIR/UPGRADE	2006	2,550	43	27.5	46	3		14
15	ROOFTOP A/C UNIT	2006	6,908	115	27.5	126	11		15
16	HOT/COLD WATER LINE/MIXING VALVE	2006	10,702	178	27.5	195	17		16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,017,570	\$ 192,897		\$ 191,575	\$ (1,322)	\$ 1,623,222	34

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

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	
1		\$ 4,017,570	\$ 192,897		\$ 191,575	\$ (1,322)	\$ 1,623,222	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		\$ 4,017,570	\$ 192,897		\$ 191,575	\$ (1,322)	\$ 1,623,222	34

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

Facility Name & ID Number **DANVILLE CARE CENTER**

0032862

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	\$ 366,381	\$ 17,465	\$ 54,279	\$ 36,814	5-7	\$ 313,214	71
72	Current Year Purchases	4,000	800	400	(400)	5	400	72
73	Fully Depreciated Assets	267,843			0		267,843	73
74			3,703	3,703	0			74
75	TOTALS	\$ 638,224	\$ 21,968	\$ 58,382	\$ 36,414		\$ 581,457	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	MAINT DEPT	1995 DODGE VAN	1994	\$ 19,595	\$ 0	\$ 0	\$ 0	5	\$ 15,535	76
77	PATIENT TRANSP	1996 FORD WAGON	2000	21,907	0	0	0	5	21,907	77
78							0			78
79							0			79
80	TOTALS			\$ 41,502	\$ 0	\$ 0	\$ 0		\$ 37,442	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)	\$ 4,697,296	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 214,865	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 249,957	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 35,092	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,242,121	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: _____

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: \$ **22,180** 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			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	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. _____/2007 \$ _____

13. _____/2008 \$ _____

14. _____/2009 \$ _____

* 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		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

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	\$		\$ 170,771	\$		\$ 170,771	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			17,152			17,152	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			157,394			157,394	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				148,503		148,503	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): lab/xrays						4,499		4,499	13
14	TOTAL			\$		\$ 345,317	\$ 153,002		\$ 498,319	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 DANVILLE CARE CENTER

0032862

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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>21,005</u>)	1,116,264		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,244		6
7	Other Prepaid Expenses	160,757		7
8	Accounts Receivable (owners or related parties)	(293,015)		8
9	Other(specify): <u>real estate tax deposit</u>	140,046		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,171,296	\$ 0	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	1,063,346		15
16	Equipment, at Historical Cost	647,028		16
17	Accumulated Depreciation (book methods)	(871,650)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 838,724	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,010,020	\$ 0	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 535,475	\$	26
27	Officer's Accounts Payable	832,090		27
28	Accounts Payable-Patient Deposits	33,050		28
29	Short-Term Notes Payable	1,092,736		29
30	Accrued Salaries Payable	115,263		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,558		31
32	Accrued Real Estate Taxes(Sch.IX-B)	67,870		32
33	Accrued Interest Payable	14,134		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)	\$ 2,711,176	\$ 0	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)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,711,176	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ (701,156)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,010,020	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (403,418)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (403,418)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(297,738)	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)	\$ (297,738)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (701,156)	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	\$ 4,881,743	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,881,743	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	420,504	6
7	Oxygen	21,751	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 442,255	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)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 19	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)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,324,017	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,019,696	31
32	Health Care	1,847,403	32
33	General Administration	1,250,034	33
	B. Capital Expense		
34	Ownership	896,803	34
	C. Ancillary Expense		
35	Special Cost Centers	498,319	35
36	Provider Participation Fee	109,500	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,621,755	40
41	Income before Income Taxes (line 30 minus line 40)**	(297,738)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (297,738)	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 DANVILLE CARE CENTER

0032862

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	839	839	\$ 23,831	\$ 28.40	1
2	Assistant Director of Nursing	240	240	6,286	26.19	2
3	Registered Nurses	9,799	10,143	253,836	25.03	3
4	Licensed Practical Nurses	15,575	16,409	356,560	21.73	4
5	CNAs & Orderlies	67,873	70,239	657,179	9.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,768	2,080	19,800	9.52	9
10	Activity Assistants	4,326	4,610	32,859	7.13	10
11	Social Service Workers	6,881	7,332	99,830	13.62	11
12	Dietician					12
13	Food Service Supervisor	2,769	2,897	35,757	12.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,352	10,926	91,362	8.36	15
16	Dishwashers	9,194	9,226	66,382	7.20	16
17	Maintenance Workers	6,781	7,040	69,934	9.93	17
18	Housekeepers	16,688	17,703	145,524	8.22	18
19	Laundry	10,709	11,613	81,350	7.01	19
20	Administrator	2,040	2,080	62,861	30.22	20
21	Assistant Administrator	1,896	2,080	45,154	21.71	21
22	Other Administrative					22
23	Office Manager	3,878	4,098	51,365	12.53	23
24	Clerical	5,405	5,614	47,162	8.40	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 C: <u>Care Plan Coord</u>	387	387	7,252	18.74	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,400	185,556	\$ 2,154,284 *	\$ 11.61	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	\$ 10,862	1-3	35
36	Medical Director	O	5,250	9-3	36
37	Medical Records Consultant	N	1,413	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,400	10-3	39
40	Physical Therapy Consultant	L	83	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		1,341	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,349	11-3	44
45	Social Service Consultant	E	3,193	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 25,891		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,621	\$ 79,253	10-3	50
51	Licensed Practical Nurses	3,149	123,135	10-3	51
52	Certified Nurse Assistants/Aides	16	393	10-3	52
53	TOTAL (lines 50 - 52)	4,786	\$ 202,781		53

Facility Name & ID Number DANVILLE CARE CENTER

0032862

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? _____
- (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? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ 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. \$ 109,500
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? 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