

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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>0046334</u></p> <p>Facility Name: <u>MOSAIC LIVING CENTER</u></p> <p>Address: <u>7464 NORTH SHERIDAN ROAD</u> <u>CHICAGO</u> <u>60626</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(773) 338-0200</u> Fax # <u>(773) 338-6812</u></p> <p>HFS ID Number: <u>01-0759894001</u></p> <p>Date of Initial License for Current Owners: <u>04/01/03</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 type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" 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 type="checkbox"/> "Sub-S" Corp.			<input checked="" 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>01/01/2006</u> to <u>12/31/2006</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="3" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>BENJAMIN KLEIN</u></td> </tr> <tr> <td>(Title) <u>MANAGER</u></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>BENJAMIN KLEIN</u>	(Title) <u>MANAGER</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number MOSAIC LIVING CENTER

0046334 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		Skilled (SNF)			1
2	150	Skilled Pediatric (SNF/PED)	150	54,750	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	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			893	893	8
9	SNF/PED	31,241			31,241	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,241		893	32,134	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.69%

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 04/04/2003

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/2003 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

ACCRUAL 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 **MOSAIC LIVING CENTER** # **0046334** 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	190,430	14,657	10,200	215,287		215,287	0	215,287		1
2	Food Purchase		249,857		249,857	0	249,857	(12,932)	236,925		2
3	Housekeeping	105,774	21,197	0	126,971		126,971	0	126,971		3
4	Laundry	69,295	16,490	0	85,785	0	85,785	0	85,785		4
5	Heat and Other Utilities			148,154	148,154		148,154	3,599	151,753		5
6	Maintenance	36,820	68,603	2,776	108,199		108,199	3,757	111,956		6
7	Other (specify):*			10,637	10,637		10,637	0	10,637		7
8	TOTAL General Services	402,319	370,804	171,767	944,890	0	944,890	(5,576)	939,314		8
	B. Health Care and Programs										
9	Medical Director	0		41,000	41,000		41,000	0	41,000		9
10	Nursing and Medical Records	2,414,647	222,503	21,186	2,658,336		2,658,336	0	2,658,336		10
10a	Therapy	156,938		131,123	288,061		288,061	0	288,061		10a
11	Activities	124,940	13,003	0	137,943		137,943	0	137,943		11
12	Social Services	181,650		26,515	208,165		208,165	0	208,165		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			13,825	13,825		13,825	0	13,825		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	2,878,175	235,506	233,649	3,347,330	0	3,347,330	0	3,347,330		16
	C. General Administration										
17	Administrative	101,059		0	101,059		101,059	24,540	125,599		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			72,309	72,309		72,309	1,456	73,765		19
20	Dues, Fees, Subscriptions & Promotions			51,637	51,637		51,637	(24,856)	26,781		20
21	Clerical & General Office Expenses	158,344	27,331	198,101	383,776		383,776	(168,872)	214,904		21
22	Employee Benefits & Payroll Taxes			593,264	593,264	0	593,264	0	593,264		22
23	Inservice Training & Education			4,932	4,932		4,932	0	4,932		23
24	Travel and Seminar			0	0		0	78	78		24
25	Other Admin. Staff Transportation			14,070	14,070		14,070	(2,890)	11,180		25
26	Insurance-Prop.Liab.Malpractice			17,576	17,576		17,576	589	18,165		26
27	Other (specify):*			28,838	28,838		28,838	(12,322)	16,516		27
28	TOTAL General Administration	259,403	27,331	980,727	1,267,461	0	1,267,461	(182,277)	1,085,184		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,539,897	633,641	1,386,143	5,559,681	0	5,559,681	(187,853)	5,371,828		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	10,200
	REPAIRS & MAINTENANCE	0
		0
		10,200
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	67,357
	ELECTRICITY	69,460
	WATER	11,337
	CABLE TV - LOBBY	0
		0
		148,154
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,776
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	0
	FIRE SERVICE	0
		0
		0
		0
		2,776
7	OTHER	
	SCAVENGER	10,637
	SECURITY SERVICE	0
		0
		0
		10,637
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	41,000
		41,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	312
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,224
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	16,650
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		21,186
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	106,171
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	21,000
	SPEECH THERAPY CONSULTANT XVIII B 43-2	3,952
		131,123
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	26,515
		0
		26,515
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	13,825
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	9,616
	ADMINISTRATIVE CONSULTANTS XIX C	
	PROFESSIONAL FEES XIX C	62,693
		0
		72,309
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	18,535
	EMPLOYEE WANT ADS XIX F	14,800
	CONTRIBUTIONS VI 20 XIX F	372
	DUES & SUBSCRIPTIONS XIX F	6,656
	LICENSES & PERMITS XIX F	1,550
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,373
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	4,956
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	3,395
	PATIENT BACKGROUND CHECKS XIX F	0
		51,637
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	4,967
	EQUIPMENT REPAIR & MAINTENANCE	5,356
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	21,326
	HOME OFFICE EXPENSE	132,000
	THEFT & DAMAGE LOSS	3,155
	TELEPHONE	31,297
	MESSENGER SERVICE	0
		0
		198,101

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	273,386
	UNEMPLOYMENT COMPENSATION XIX D	72,928
	WORKERS COMPENSATION INSURANCE XIX D	104,334
	HOSPITALIZATION INSURANCE XIX D	126,808
	EMPLOYEE BENEFITS - OTHER XIX D	15,808
	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
		0
		593,264
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	4,932
		4,932
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	14,070
		14,070
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	17,576
		17,576
27	OTHER	
	BAD DEBTS VI 24	28,838
		28,838

GRAND TOTAL COLUMN 3 OTHER

1,386,143

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

TOTAL FOOD PURCHASE	249,857	PATIENT MEALS	96402
LESS SALES TAX	(12,932)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	236,925	TOTAL MEALS/YEAR	96402
TOTAL PATIENT CENSUS	32,134	NET FOOD	236925
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	96402

TOTAL PATIENT MEALS	96402	COST PER MEAL	2.46
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number **MOSAIC LIVING CENTER**

#0046334

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			15,202	15,202		15,202	2,967	18,169		30
31	Amortization of Pre-Op. & Org.			21,378	21,378		21,378	173	21,551		31
32	Interest			118,311	118,311		118,311	4,523	122,834		32
33	Real Estate Taxes			111,766	111,766		111,766	2,450	114,216		33
34	Rent-Facility & Grounds			612,505	612,505		612,505	5,755	618,260		34
35	Rent-Equipment & Vehicles			227,321	227,321		227,321	0	227,321		35
36	Other (specify):*				0		0	0	0		36
37	TOTAL Ownership			1,106,483	1,106,483	0	1,106,483	15,868	1,122,351		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation				0		0	0	0		38
39	Ancillary Service Centers		0	0	0		0	0	0		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			406,994	406,994		406,994	0	406,994		42
43	Other (specify):*				0		0	0	0		43
44	TOTAL Special Cost Centers	0	0	406,994	406,994	0	406,994	0	406,994		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,539,897	633,641	2,899,620	7,073,158	0	7,073,158	(171,985)	6,901,173		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 **MOSAIC LIVING CENTER**

0046334

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	(1,388)	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	(12,932)	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	(21,326)	21		18
19	Entertainment		20		19
20	Contributions	(5,328)	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	(28,838)	27		24
25	Fund Raising, Advertising and Promotional	(18,535)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,373)	20		28
29	Other-Attach Schedule	(65,638)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (155,358)		\$ 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)	(16,627)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (16,627)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (171,985)		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

MOSAIC LIVING CENTER

ID# 0046334

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0		1
2	NON ALLOWABLE TRAVEL	(3,888)	25	2
3	MARKETING SALARY	(61,750)	21	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	(65,638)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MOSAIC LIVING CENTER# 0046334

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	(12,932)	0	0	0	0	0	0	0	0	0	0	(12,932)	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	3,599	0	0	0	0	0	0	0	0	3,599	5
6	Maintenance	0	0	3,757	0	0	0	0	0	0	0	0	3,757	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(12,932)	0	7,356	0	(5,576)	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	24,540	0	0	0	0	0	0	0	0	24,540	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	1,456	0	0	0	0	0	0	0	0	1,456	19
20	Fees, Subscriptions & Promotions	(25,236)	0	380	0	0	0	0	0	0	0	0	(24,856)	20
21	Clerical & General Office Expenses	(83,076)	0	(85,796)	0	0	0	0	0	0	0	0	(168,872)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	78	0	0	0	0	0	0	0	0	78	24
25	Other Admin. Staff Transportation	(3,888)	0	998	0	0	0	0	0	0	0	0	(2,890)	25
26	Insurance-Prop.Liab.Malpractice	0	0	589	0	0	0	0	0	0	0	0	589	26
27	Other (specify):*	(28,838)	0	16,516	0	0	0	0	0	0	0	0	(12,322)	27
28	TOTAL General Administration	(141,038)	0	(41,239)	0	(182,277)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(153,970)	0	(33,883)	0	(187,853)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MOSAIC LIVING CENTER# 0046334

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(1,388)	3,849	506	0	0	0	0	0	0	0	0	2,967	30
31	Amortization of Pre-Op. & Org.	0	173	0	0	0	0	0	0	0	0	0	173	31
32	Interest	0	4,523	0	0	0	0	0	0	0	0	0	4,523	32
33	Real Estate Taxes	0	2,450	0	0	0	0	0	0	0	0	0	2,450	33
34	Rent-Facility & Grounds	0	0	5,755	0	0	0	0	0	0	0	0	5,755	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	(1,388)	10,995	6,261	0	15,868	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)	(155,358)	10,995	(27,622)	0	(171,985)	45							

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	21 HOME OFFICE EXPENSE	\$ 132,000	PLATINUM HEALTH CARE LLC	100.00%	\$	\$ (132,000)
16	V	5 UTILITIES				3,599	3,599
17	V	6 REPAIRS & MAINTENANCE				3,757	3,757
18	V	17 ADMINISTRATIVE SALARY				24,540	24,540
19	V	19 PROFESSIONAL FEES				1,456	1,456
20	V	20 FEES & SUBSCRIPTIONS				380	380
21	V	21 OFFICE EXPENSES				46,204	46,204
22	V	24 EDUCATION & SEMINARS				78	78
23	V	25 TRAVEL				998	998
24	V	27 EMPLOYEE BENEFITS				16,516	16,516
25	V	26 INSURANCE				589	589
26	V	30 DEPRECIATION				506	506
27	V	34 OFFICE RENT				5,755	5,755
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 132,000			\$ 104,378	\$ * (27,622)

* 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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
15	V		\$			\$	\$	15	
16	V							16	
17	V							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		\$			\$	0	\$ *	39

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

Facility Name & ID Number

MOSAIC LIVING CENTER

#

0046334

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	BEN KLEIN	ADMINISTRATIVE			SEE ATTACHED			SALARY	\$ 8,874	17-7	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	\$ 8,874		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 MOSAIC LIVING CENTER

0046334 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 PLATINUM HEALTH CARE LLC
 Street Address 7444 LONG AVENUE
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847)329-4100
 Fax Number (847)329-4900

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	UTILITIES	TOTAL PATIENT DAYS	369,267	8	\$ 41,358	\$ 32,134	\$ 3,599	1
2	6	REPAIRS & MAINTENANCE	TOTAL PATIENT DAYS	369,267	8	43,174	32,134	3,757	2
3	17	ADMINISTRATIVE SALARY	TOTAL PATIENT DAYS	369,267	8	282,000	32,134	24,540	3
4	19	PROFESSIONAL FEES	TOTAL PATIENT DAYS	369,267	8	16,736	32,134	1,456	4
5	20	FEES & SUBSCRIPTIONS	TOTAL PATIENT DAYS	369,267	8	4,372	32,134	380	5
6	21	OFFICE EXPENSES	TOTAL PATIENT DAYS	369,267	8	530,949	32,134	46,204	6
7	24	EDUCATION & SEMINARS	TOTAL PATIENT DAYS	369,267	8	895	32,134	78	7
8	25	TRAVEL	TOTAL PATIENT DAYS	369,267	8	11,467	32,134	998	8
9	27	EMPLOYEE BENEFITS	TOTAL PATIENT DAYS	369,267	8	189,793	32,134	16,516	9
10	26	INSURANCE	TOTAL PATIENT DAYS	369,267	8	6,774	32,134	589	10
11	30	DEPRECIATION	TOTAL PATIENT DAYS	369,267	8	5,811	32,134	506	11
12	34	OFFICE RENT	TOTAL PATIENT DAYS	369,267	8	66,129	32,134	5,755	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					\$ 1,199,458	\$ 711,429	\$ 104,378	25

Facility Name & ID Number

MOSAIC LIVING CENTER

0046334

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												5						
	Working Capital																	
6	DR TOM KLEIN		X									18,000	6					
7	MB FINANCIAL		X	LINE OF CREDIT		4/01/2003	1,500,000	1,500,000	04/05/2004	4.5000		100,311	7					
8	RELATED PARTY											4,523	8					
9	TOTAL Facility Related						\$ 1,500,000	\$ 1,500,000			\$	122,834	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)						\$ 1,500,000	\$ 1,500,000			\$	122,834	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.

\$ **108,000** 1

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$ **111,766** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **3,766** 3

4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **108,000** 4

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$ 5

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$ 6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ **111,766** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001		8
	2002	73,978	9
	2003	179,731	10
	2004	110,639	11
	2005	111,766	12

FOR BHF USE ONLY

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

13 FROM R. E. TAX STATEMENT FOR 2005 \$ 13

14 PLUS APPEAL COST FROM LINE 5 \$ 14

15 LESS REFUND FROM LINE 6 \$ 15

THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.

16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 MOSAIC LIVING CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0046334

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 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>11-29-307-019-0000</u>	<u>NURSING HOME</u>	\$ <u>25,561.30</u>	\$ <u>25,561.30</u>
2. <u>11-29-307-020-0000</u>	<u>NURSING HOME</u>	\$ <u>24,737.24</u>	\$ <u>24,737.24</u>
3. <u>11-29-307-022-0000</u>	<u>NURSING HOME</u>	\$ <u>61,467.34</u>	\$ <u>61,467.34</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>111,765.88</u>	\$ <u>111,765.88</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 MOSAIC LIVING CENTER

0046334

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,316 B. General Construction Type: Exterior BRICK 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: 106,890 2. Number of Years Over Which it is Being Amortized: 5
 3. Current Period Amortization: 21,378 4. Dates Incurred: 04/01/03

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				\$	1
2					2
3	TOTALS			\$ 0	3

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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8		RELATED PARTY ALLOCATION				1,127		1,127			8
		Improvement Type**									
9		SEWER DRAIN WORK		2003	7,400	269	27.5	269		929	9
10		COMPRESSOR		2003	2,565	93	27.5	93		323	10
11		BOILER & AC		2003	876	32	27.5	32		111	11
12		CARPETING, SHADES & WALLPAPER		2003	10,463	603	5	603		9,559	12
13		DUMBWAITER REPAIR		2003	4,347	158	27.5	158		546	13
14		INSTALLED VERTICAL BLINDS		2004	4,489	163	27.5	163		401	14
15		INSTALLED SPRINKLER HEADS		2004	5,033	183	27.5	183		450	15
16		ELECTRICAL WORK		2004	4,607	168	27.5	168		413	16
17		REMODEL RESIDENTS ROOMS, BATHROOM & SHOWER ROOM		2004	18,950	690	27.5	690		1,700	17
18		ALARM SYSTEM		2004	7,115	259	27.5	259		638	18
19		REMODEL OFFICES, LOBBY AND BATHROOMS		2004	31,125	1,132	27.5	1,132		2,791	19
20		ROOF AND LAUNDRY ROOM RENOVATION		2004	7,900	286	27.5	286		690	20
21		REPL FIRE PUMP		2005	9,995	364	27.5	364		530	21
22		REPIPE KITCHEN SINK		2005	5,550	202	27.5	202		293	22
23		DOOR ALARM		2005	2,247	81	27.5	81		118	23
24		CARPETING		2005	1,265	46	5	46		299	24
25		INFARED SAFETY EDGE		2005	1,850	67	27.5	67		99	25
26		FIRE ALARM		2006	13,248	220	27.5	220		220	26
27		REPAIR FIRE PUMP SYSTEM		2006	4,945	83	27.5	83		83	27
28		ROUGH-IN PLUMBING,SHOWER DRAIN, SINK REPAIR		2006	5,200	86	27.5	86		86	28
29		REPLACE TILES IN 1ST AND 2ND FLOOR SHOWER AREA		2006	1,480	25	27.5	25		25	29
30		REPLACE RADIATOR AND PUMP		2006	4,061	68	27.5	68		68	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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)		\$ 154,711	\$ 6,405		\$ 6,405	\$ 0	\$ 20,372	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	\$ 58,948	\$ 7,194	\$ 8,992	\$ 1,798	5-10	\$ 30,951	71
72	Current Year Purchases	13,650	2,730	682	(2,048)	10	682	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY ALLOC		3,228	2,090	(1,138)			74
75	TOTALS	\$ 72,598	\$ 13,152	\$ 11,764	\$ (1,388)		\$ 31,633	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 227,309	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 19,557	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 18,169	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,388)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 52,005	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: **CDS, LLC**

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:	150		\$ 612,505			3
4	Additions						4
5							5
6							6
7	TOTAL	150		\$ 612,505			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: \$ **223,574** 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	FACILITY	2003 FORD WINDSTAR	\$ 358.00	\$ 3,347	17
18	FACILITY	2005 TOYOTA 4 RANN.	400.00	400	18
19					19
20					20
21	TOTAL		\$ 758.00	\$ 3,747	21

10. Effective dates of current rental agreement:

Beginning 4/1/03

Ending 4/1/18

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

Fiscal Year Ending Annual Rent

12. 4/1/2007 \$ 615,522

13. _____ \$ _____

14. _____ \$ _____

* 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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts			N/A				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			\$		\$ 0	\$ 0		\$ 0	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 MOSAIC LIVING CENTER

0046334

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)	2,428,934		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,786		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Real Estate Tax escrow</u>	101,595		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,568,315	\$ 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	154,712		15
16	Equipment, at Historical Cost	72,599		16
17	Accumulated Depreciation (book methods)	(73,547)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	106,890		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(80,168)		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)	\$ 180,486	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,748,801	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,774,123	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,876,000		29
30	Accrued Salaries Payable	115,482		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	108,000		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)	\$ 3,873,605	\$ 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)	\$ 3,873,605	\$ 0	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,124,804)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,748,801	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (861,311)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (861,311)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(263,493)	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)	\$ (263,493)	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)	\$ (1,124,804)	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	\$ 6,809,665	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,809,665	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	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***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 0	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)	\$ 6,809,665	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	944,890	31
32	Health Care	3,347,330	32
33	General Administration	1,267,461	33
	B. Capital Expense		
34	Ownership	1,106,483	34
	C. Ancillary Expense		
35	Special Cost Centers	0	35
36	Provider Participation Fee	406,994	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,073,158	40
41	Income before Income Taxes (line 30 minus line 40)**	(263,493)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (263,493)	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 **MOSAIC LIVING CENTER**

0046334

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	2,193	2,050	\$ 84,696	\$ 41.32	1
2	Assistant Director of Nursing					2
3	Registered Nurses	36,662	27,999	806,274	28.80	3
4	Licensed Practical Nurses	13,195	9,249	225,322	24.36	4
5	CNAs & Orderlies	78,190	67,853	718,399	10.59	5
6	CNA Trainees					6
7	Licensed Therapist	2,060	1,928	60,296	31.27	7
8	Rehab/Therapy Aides	7,716	6,700	96,642	14.42	8
9	Activity Director	1,800	1,720	26,236	15.25	9
10	Activity Assistants	9,618	9,090	98,704	10.86	10
11	Social Service Workers	8,708	8,222	181,650	22.09	11
12	Dietician					12
13	Food Service Supervisor	2,080	1,936	51,977	26.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,790	13,591	138,453	10.19	15
16	Dishwashers					16
17	Maintenance Workers	2,157	2,071	36,820	17.78	17
18	Housekeepers	12,295	11,342	105,774	9.33	18
19	Laundry	7,972	7,446	69,295	9.31	19
20	Administrator	3,018	2,618	101,059	38.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,957	10,384	158,344	15.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,304	1,545	24,418	15.80	31
32	Other Health Care(specify)					32
33	Other(specify) RESPIRATORY	31,236	21,401	555,538	25.96	33
34	TOTAL (lines 1 - 33)	245,951	207,145	\$ 3,539,897 *	\$ 17.09	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	\$ 10,200	1-3	35
36	Medical Director	O	41,000	9-3	36
37	Medical Records Consultant	N	4,224	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	106,171	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant	Monthly	21,000	10a-3	42
43	Speech Therapy Consultant	76	3,952	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	442	26,515	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	518	\$ 213,062		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses	8	312	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	8	\$ 312		53

Facility Name & ID Number MOSAIC LIVING CENTER

0046334

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG CARE \$4914
- (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. \$ _____ 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? _____
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. \$ 406,994
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