

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE

0035642 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	55	Skilled (SNF)	55	20,075	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	55	TOTALS	55	20,075	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	1,278	100	967	2,345	8
9	SNF/PED					9
10	ICF	9,991	1,240		11,231	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,269	1,340	967	13,576	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.63%

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 07/01/89

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/01/89 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 55 and days of care provided 967

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 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	108,610	4,199	4,070	116,879		116,879	0	116,879		1
2	Food Purchase		58,516		58,516	(1,533)	56,983	(126)	56,857		2
3	Housekeeping	45,182	5,213	0	50,395		50,395	0	50,395		3
4	Laundry	26,348	2,725	2,487	31,560	0	31,560	0	31,560		4
5	Heat and Other Utilities			54,693	54,693		54,693	583	55,276		5
6	Maintenance	25,059	2,492	14,493	42,044		42,044	4,418	46,462		6
7	Other (specify):*			4,110	4,110		4,110	0	4,110		7
8	TOTAL General Services	205,199	73,145	79,853	358,197	(1,533)	356,664	4,875	361,539		8
	B. Health Care and Programs										
9	Medical Director	0		5,325	5,325		5,325	0	5,325		9
10	Nursing and Medical Records	583,366	37,428	3,973	624,767		624,767	0	624,767		10
10a	Therapy	0		0	0		0	0	0		10a
11	Activities	34,867	559	0	35,426		35,426	0	35,426		11
12	Social Services	19,840		1,010	20,850		20,850	0	20,850		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			25	25		25	0	25		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	638,073	37,987	10,333	686,393	0	686,393	0	686,393		16
	C. General Administration										
17	Administrative	64,830		0	64,830		64,830	37,628	102,458		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			45,933	45,933		45,933	(4,495)	41,438		19
20	Dues, Fees, Subscriptions & Promotions			10,875	10,875		10,875	(5,492)	5,383		20
21	Clerical & General Office Expenses	51,962	4,256	25,938	82,156		82,156	(19,167)	62,989		21
22	Employee Benefits & Payroll Taxes			158,485	158,485	1,533	160,018	0	160,018		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			1,909	1,909		1,909	304	2,213		24
25	Other Admin. Staff Transportation			14,766	14,766		14,766	(8,867)	5,899		25
26	Insurance-Prop.Liab.Malpractice			38,022	38,022		38,022	1,117	39,139		26
27	Other (specify):*			8,897	8,897		8,897	207	9,104		27
28	TOTAL General Administration	116,792	4,256	304,825	425,873	1,533	427,406	1,235	428,641		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	960,064	115,388	395,011	1,470,463	0	1,470,463	6,110	1,476,573		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	4,070
	REPAIRS & MAINTENANCE	0
		0
		4,070
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	2,487
		0
		2,487
5	HEAT & OTHER UTILITIES	
	GAS HEAT	18,700
	ELECTRICITY	15,183
	WATER	16,755
	CABLE TV - LOBBY	4,055
		0
		54,693
6	MAINTENANCE	
	GROUNDS MAINTENANCE	969
	PAINTING & DECORATING	950
	BUILDING REPAIRS	5,010
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	3,571
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	998
	FIRE SERVICE	2,995
		0
		0
		0
		0
		14,493
7	OTHER	
	SCAVENGER	4,110
	SECURITY SERVICE	0
		0
		0
		4,110
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	5,325
		5,325

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	3,373
	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	0
	PHARMACY CONSULTANT XVIII B 39-2	600
	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
		3,973
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	100
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	910
	SOCIAL WORKER XVIII B 45-2	0
		0
		1,010
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	25
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	16,119
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	29,814
		0
		45,933
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	4,200
	EMPLOYEE WANT ADS XIX F	2,087
	CONTRIBUTIONS VI 20 XIX F	51
	DUES & SUBSCRIPTIONS XIX F	1,204
	LICENSES & PERMITS XIX F	213
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,392
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,728
	PATIENT BACKGROUND CHECKS XIX F	0
		10,875
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	4,936
	EQUIPMENT REPAIR & MAINTENANCE	20
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	380
	HOME OFFICE EXPENSE	12,000
	THEFT & DAMAGE LOSS	0
	TELEPHONE	8,602
	MESSENGER SERVICE	0
		0
		25,938

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	73,445
	UNEMPLOYMENT COMPENSATION XIX D	33,453
	WORKERS COMPENSATION INSURANC XIX D	40,387
	HOSPITALIZATION INSURANCE XIX D	6,103
	EMPLOYEE BENEFITS - OTHER XIX D	4,446
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	651
	CHICAGO HEAD TAX XIX D	0
		0
		158,485
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,909
	TRAVEL XIX G	0
		1,909
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	14,766
		14,766
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	38,022
		38,022
27	OTHER	
	BAD DEBTS VI 24	8,897
		8,897

GRAND TOTAL COLUMN 3 OTHER

395,011

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

TOTAL FOOD PURCHASE	58,516	PATIENT MEALS	40728
LESS SALES TAX	(126)	ADD EMPLOYEE MEALS	1095
	-----		-----
NET FOOD	58,390	TOTAL MEALS/YEAR	41823
TOTAL PATIENT CENSUS	13,576	NET FOOD	58390
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	41823

TOTAL PATIENT MEALS	40728	COST PER MEAL	1.4
		TIME EMPLOYEE MEALS	1095

ADD # EMPLOYEE MEALS/DAY	3	EMPLOYEE MEAL RECLASSIFICATION	1533
TIME # DAYS	365		=====

TOTAL EMPLOYEE MEALS	1095		

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE

#0035642

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			16,360	16,360		16,360	23,317	39,677			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			29,923	29,923		29,923	117,234	147,157			32
33	Real Estate Taxes			16,627	16,627		16,627	372	16,999			33
34	Rent-Facility & Grounds			133,169	133,169		133,169	(133,169)	0			34
35	Rent-Equipment & Vehicles			5,439	5,439		5,439	0	5,439			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			201,518	201,518	0	201,518	7,754	209,272			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		37,186	71,117	108,303		108,303	0	108,303			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			30,191	30,191		30,191	0	30,191			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	37,186	101,308	138,494	0	138,494	0	138,494			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	960,064	152,574	697,837	1,810,475	0	1,810,475	13,864	1,824,339			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	(2,917)	30		9
10	Interest and Other Investment Income	(932)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(126)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(380)	21		18
19	Entertainment	0	20		19
20	Contributions	(51)	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	(8,897)	27		24
25	Fund Raising, Advertising and Promotional	(4,200)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,392)	20		28
29	Other-Attach Schedule	(32,147)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (51,042)		\$ 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)	64,906		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 64,906		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 13,864		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

NEW BEGINNINGS CARE CENTRE

ID# 0035642

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1,277	6	1
2	MARKETING SALARY	(12,868)	21	2
3	BANK CHARGES	(4,936)	21	3
4	STAFF TRANSPORTAION - MARKETING	(9,620)	25	4
5	HEALTHCARE HORIZONS	(6,000)	19	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	(32,147)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE# 0035642

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	(126)	0	0	0	0	0	0	0	0	0	0	(126)	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	583	0	0	0	0	0	0	0	0	0	583	5
6	Maintenance	1,277	3,141	0	0	0	0	0	0	0	0	0	4,418	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	1,151	3,724	0	4,875	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	37,628	0	0	0	0	0	0	0	0	0	37,628	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,000)	1,505	0	0	0	0	0	0	0	0	0	(4,495)	19
20	Fees, Subscriptions & Promotions	(5,643)	151	0	0	0	0	0	0	0	0	0	(5,492)	20
21	Clerical & General Office Expenses	(18,184)	(983)	0	0	0	0	0	0	0	0	0	(19,167)	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	304	0	0	0	0	0	0	0	0	0	304	24
25	Other Admin. Staff Transportation	(9,620)	753	0	0	0	0	0	0	0	0	0	(8,867)	25
26	Insurance-Prop.Liab.Malpractice	0	1,117	0	0	0	0	0	0	0	0	0	1,117	26
27	Other (specify):*	(8,897)	9,104	0	0	0	0	0	0	0	0	0	207	27
28	TOTAL General Administration	(48,344)	49,579	0	1,235	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(47,193)	53,303	0	6,110	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE

0035642

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	(2,917)	0	580	25,654	0	0	0	0	0	0	0	23,317	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(932)	0	1,530	116,636	0	0	0	0	0	0	0	117,234	32
33	Real Estate Taxes	0	0	372	0	0	0	0	0	0	0	0	372	33
34	Rent-Facility & Grounds	0	0	0	(133,169)	0	0	0	0	0	0	0	(133,169)	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	(3,849)	0	2,482	9,121	0	7,754	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)	(51,042)	53,303	2,482	9,121	0	13,864	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
<u>WILLIAM IRVINE</u>	<u>50</u>			<u>HI CARE</u>		
				<u>MANAGEMENT</u>	<u>SPRINGFIELD</u>	<u>MANAGEMENT</u>
<u>ROBERT HEDGES</u>	<u>50</u>	<u>SEE ATTACHED SCHEDULE</u>				
				<u>H.I. PROPERTIES</u>	<u>SPRINGFIELD</u>	<u>REAL ESTATE</u>

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)	
<u>1</u>	<u>V</u>	<u>17</u>		<u>HI CARE MANAGEMENT</u>				<u>1</u>
<u>2</u>	<u>V</u>	<u>21</u>	<u>12,000</u>				<u>(12,000)</u>	<u>2</u>
<u>3</u>	<u>V</u>	<u>5</u>				<u>583</u>	<u>583</u>	<u>3</u>
<u>4</u>	<u>V</u>	<u>6</u>				<u>3,141</u>	<u>3,141</u>	<u>4</u>
<u>5</u>	<u>V</u>	<u>17</u>				<u>37,628</u>	<u>37,628</u>	<u>5</u>
<u>6</u>	<u>V</u>	<u>19</u>				<u>1,505</u>	<u>1,505</u>	<u>6</u>
<u>7</u>	<u>V</u>	<u>20</u>				<u>151</u>	<u>151</u>	<u>7</u>
<u>8</u>	<u>V</u>	<u>21</u>				<u>11,017</u>	<u>11,017</u>	<u>8</u>
<u>9</u>	<u>V</u>	<u>24</u>				<u>304</u>	<u>304</u>	<u>9</u>
<u>10</u>	<u>V</u>	<u>25</u>				<u>753</u>	<u>753</u>	<u>10</u>
<u>11</u>	<u>V</u>	<u>26</u>				<u>1,117</u>	<u>1,117</u>	<u>11</u>
<u>12</u>	<u>V</u>	<u>27</u>				<u>9,104</u>	<u>9,104</u>	<u>12</u>
<u>13</u>	<u>V</u>							<u>13</u>
<u>14</u>	Total		\$ 12,000			\$ 65,303	\$ * 53,303	<u>14</u>

* 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	30 DEPRECIATION	\$	H & I PROPERTIES (HOME OFFICE)		\$ 580	\$ 580	15
16	V	32 INTEREST				1,530	1,530	16
17	V	33 REAL ESTATE TAXES				372	372	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		\$			\$ 2,482	\$ * 2,482	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34 RENT	\$ 133,169	H & I PROPERTIES (FACILITY)		\$	(133,169)	15
16	V	30 DEPRECIATION				25,654	25,654	16
17	V	32 INTEREST				116,636	116,636	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		\$ 133,169			\$ 142,290	\$ * 9,121	39

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

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 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	ROBERT HEDGES	PRESIDENT	OFFICE MGMT.	50.00				SALARY	\$ 12,482	17-7	1
2	TOTAL ALLOWABLE SALARY RECEIVED FROM HI CARE \$170,000										2
3											3
4	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT.	50.00				SALARY	12,481	17-7	4
5	TOTAL ALLOWABLE SALARY RECEIVED FROM HI CARE \$170,000										5
6											6
7	MARTHA IRVINE	BOOKKEEPING						SALARY	633	21-7	7
8	TOTAL SALARY RECEIVED FROM HI CARE \$8,615										8
9											9
10	DEREK HEDGES	SPECIAL PROJECTS MNGR						SALARY	1,982	17-7	10
11	TOTAL SALARY RECEIVED FROM HI CARE \$27,000										11
12											12
13								TOTAL	\$ 27,578		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 NEW BEGINNINGS CARE CENTRE

0035642

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 HI CARE MANAGEMENT
 Street Address 1625 SOUTH 6TH STREET
 City / State / Zip Code SPRINGFIELD, IL. 62703
 Phone Number (217)528-0044
 Fax Number (217)528-0412

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	PER RESIDENT DAY	184,904	7	\$ 7,946	\$ 13,576	\$ 583	1	
2	6	MAINTENANCE	PER RESIDENT DAY	184,904	7	42,775	36,113	13,576	3,141	2
3	17	OFFICER SALARY	PER RESIDENT DAY	184,904	7	340,000	340,000	13,576	24,963	3
4	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	184,904	7	68,050	68,050	13,576	4,996	4
5	17	DIRECTOR OF FINANCE	PER RESIDENT DAY	184,904	7	77,460	77,460	13,576	5,687	5
6	17	SPECIAL PROJECTS MNGR	PER RESIDENT DAY	184,904	7	27,000	27,000	13,576	1,982	6
7	19	PROFESSIONAL FEES	PER RESIDENT DAY	184,904	7	20,492		13,576	1,505	7
8	20	DUES & SUBSCRIPTION	PER RESIDENT DAY	184,904	7	2,057		13,576	151	8
9	21	OFFICE EXPENSE	PER RESIDENT DAY	184,904	7	150,049	112,536	13,576	11,017	9
10	24	TRAVEL & SEMINARS	PER RESIDENT DAY	184,904	7	4,140		13,576	304	10
11	25	TRANSPORTATION	PER RESIDENT DAY	184,904	7	10,252		13,576	753	11
12	26	INSURANCE	PER RESIDENT DAY	184,904	7	15,218		13,576	1,117	12
13	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	184,904	7	123,996		13,576	9,104	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					\$ 889,435	\$ 661,159	\$ 65,303		25

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE

0035642

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 H & I PROPERTIES-HOME OFFICE
 Street Address 1625 S SIXTH STREET
 City / State / Zip Code SPRINGFIELD IL 62703
 Phone Number (217)528-0044
 Fax Number (217)528-0412

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	639	7	\$ 6,741	\$ 0	55	\$ 580	1
2	32	INTEREST	639	7	17,780	0	55	1,530	2
3	33	REAL ESTATE	639	7	4,317	0	55	372	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 28,838	\$		\$ 2,482	25

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE

0035642 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 H & I PROPERTIE - FACILITY
 Street Address 1625 S SIXTH STREET
 City / State / Zip Code SPRINGFIELD IL 62703
 Phone Number (217)528-0044
 Fax Number (217)528-0412

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	1	1	\$ 25,654	\$ 0	1	\$ 25,654	1
2	32	INTEREST	DIRECT	1	1	116,636	0	1	116,636	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 142,290	\$		\$ 142,290	25

Facility Name & ID Number

NEW BEGINNINGS CARE CENTRE

0035642

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	COLE TAYLOR (HI PROP)		X	MORTGAGE (facility)	\$10,935.59	8/03/05	\$ 1,410,500	\$ 1,367,239	08/01/10	0.0700	\$ 116,636	1								
2	US BANK (HI PROP)		X	MORTGAGE (office)		6/29/05			6/29/12	0.0635	1,530	2								
3												3								
4												4								
5												5								
Working Capital																				
6	ILLINI BANK		X	LINE OF CREDIT	INTEREST	REVOLV		252,234	REVOLV		29,358	6								
7	ILLINI BANK		X	DEBT CONSOLIDATION	\$495.47	5/10/02	23,776	2,425	5/10/07		495	7								
8	ILLINI BANK		X	POWER LIFTER SCALE	\$140.00	9/01/02	4,291	0	7/01/06		70	8								
9	TOTAL Facility Related				\$11,571.06		\$ 1,438,567	\$ 1,621,898			\$ 148,089	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)						\$ 1,438,567	\$ 1,621,898			\$ 148,089	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.		\$	15,527	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.)		\$	16,077	2
3. Under or (over) accrual (line 2 minus line 1).		\$	550	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	16,077	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.		\$	16,627	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	14,671	8
	2002	14,834	9
	2003	14,924	10
	2004	15,527	11
	2005	16,077	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 ~ 100 % 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 NEW BEGINNINGS CARE CENTRE COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0035642

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>11-27-401-002</u>	<u>NURSING HOME</u>	\$ <u>16,077.18</u>	\$ <u>16,077.18</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>16,077.18</u>	\$ <u>16,077.18</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 NEW BEGINNINGS CARE CENTRE

0035642

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 1

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	<u>NURSING HOME</u>	<u>67,000</u>	<u>1998</u>	<u>\$ 83,295</u>	<u>1</u>
2	<u>OFFICE BUILDING</u>		<u>2005</u>	<u>4,992</u>	<u>2</u>
3	TOTALS	67,000		\$ 88,287	3

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE

0035642

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	55	1998		\$ 698,118	\$ 17,900	39	\$ 17,900	\$	\$ 132,032	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	PARKING LOT IMPROVEMENTS		1992	17,677	561	31.5	561		8,129	9
10	CURTAIN TRACKS		1993	5,650	179	31.5	179		2,499	10
11	REWIRING WORK		1996	6,043	155	39	155		1,647	11
12	ROOF		1997	66,564	1,707	39	1,707		15,861	12
13	OUTDOOR FLOODLIGHTS		1997	2,856	73	39	73		660	13
14	HANDRAILS& WALL GUARDS		1999	2,524	65	39	65		490	14
15	STORAGE BARN		1999	2,100	54	39	54		407	15
16	BACKFLOW PREVENTER		2000	1,696	62	27.5	62		405	16
17	ROOF		2000	2,680	97	27.5	97		635	17
18	NEW WATER HEATER		2001	3,096	113	27.5	113		626	18
19	ALARM SYSTEM		2001	5,013	182	27.5	182		1,009	19
20	OVERBED LIGHT		2001	3,687	134	27.5	134		743	20
21	CARPET		2001	1,730	100	5		(100)	1,730	21
22	WATER HEATER TANK		2002	1,678	61	27.5	61		277	22
23	ALARM SYSTEM		2002	4,991	182	27.5	182		827	23
24	WATER HEATER		2003	2,846	103	27.5	103		365	24
25	WATER HEATER		2004	5,299	193	27.5	193		539	25
26	WINDOWS		2005	35,827	1,303	27.5	1,303		1,303	26
27	SMOKE DETECTORS		2005	1,754	64	27.5	64		99	27
28	STEEL FIRE DOOR		2005	1,974	72	27.5	72		111	28
29	FIRE SYSTEM		2005	1,769	64	27.5	64		98	29
30	CARPETING & TILING		2006	13,437	386	27.5	386		386	30
31	WATER SOFTENER		2006	3,425	99	27.5	99		99	31
32	GENERATOR		2006	49,050	372	27.5	372		372	32
33										33
34										34
35										35
36	H & I PROPERTIES - OFFICE BUILDING		2005	22,626	580	39	580		1,030	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.

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)	\$	\$		\$	\$	\$	70
			964,110		24,861	24,761	(100)	172,379

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

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE

0035642

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	\$ 72,548	\$ 8,877	\$ 6,886	\$ (1,991)	10 YRS	\$ 38,866	71
72	Current Year Purchases	5,511	1,102	276	(826)	10 YRS	276	72
73	Fully Depreciated Assets	24,969			0	10 YRS	24,969	73
74	REL PARTY SL (facility)	77,542	7,754	7,754	0		65,909	74
75	TOTALS	\$ 180,570	\$ 17,733	\$ 14,916	\$ (2,817)		\$ 130,020	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		95 BUICK CENTRY	2000	\$ 6,181	\$ 0	\$ 0	\$ 0	3	\$ 6,181	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 6,181	\$ 0	\$ 0	\$ 0		\$ 6,181	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)	\$ 1,239,148	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 42,594	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 39,677	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,917)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 308,580	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:				\$ <u>133,169</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>133,169</u>			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: \$ 5,439 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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
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	\$		\$ 19,043	\$		\$ 19,043	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			52,074			52,074	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				37,186		37,186	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			\$		\$ 71,117	\$ 37,186		\$ 108,303	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 NEW BEGINNINGS CARE CENTRE

0035642

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	\$ 27,582	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (25,000))	292,037		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,235		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 353,854	\$ 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	241,636		15
16	Equipment, at Historical Cost	117,514		16
17	Accumulated Depreciation (book methods)	(140,516)		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)	\$ 218,634	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 572,488	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 293,920	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	261,530		29
30	Accrued Salaries Payable	30,984		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,619		31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,077		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	INTERCOMPANY PAYABLES	100,000		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 719,130	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	977,482		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)	\$ 977,482	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,696,612	\$ 0	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,124,124)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 572,488	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (943,891)	1
2	Restatements (describe):		2
3	ROUNDING	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (943,892)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(180,232)	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)	\$ (180,232)	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)	\$ (1,124,124)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,629,311	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,629,311	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	0	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***	932	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 932	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)	\$ 1,630,243	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	358,197	31
32	Health Care	686,393	32
33	General Administration	425,873	33
	B. Capital Expense		
34	Ownership	201,518	34
	C. Ancillary Expense		
35	Special Cost Centers	108,303	35
36	Provider Participation Fee	30,191	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,810,475	40
41	Income before Income Taxes (line 30 minus line 40)**	(180,232)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (180,232)	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 NEW BEGINNINGS CARE CENTRE

0035642

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	1,923	2,159	\$ 52,576	\$ 24.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,263	3,505	79,724	22.75	3
4	Licensed Practical Nurses	7,536	8,548	152,832	17.88	4
5	CNAs & Orderlies	28,421	31,267	266,502	8.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,391	1,629	20,293	12.46	9
10	Activity Assistants	1,818	2,127	14,574	6.85	10
11	Social Service Workers	1,324	1,739	19,840	11.41	11
12	Dietician					12
13	Food Service Supervisor	1,806	2,160	23,394	10.83	13
14	Head Cook	5,235	5,952	43,230	7.26	14
15	Cook Helpers/Assistants	4,671	5,210	41,986	8.06	15
16	Dishwashers					16
17	Maintenance Workers	1,911	2,212	25,059	11.33	17
18	Housekeepers	6,072	6,731	45,182	6.71	18
19	Laundry	3,751	3,999	26,348	6.59	19
20	Administrator	2,039	2,353	64,830	27.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,962	4,434	51,962	11.72	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>MDS</u>	1,383	1,597	31,732	19.87	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	76,506	85,622	\$ 960,064 *	\$ 11.21	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 4,070	1-3	35
36	Medical Director	O	5,325	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	600	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	910	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 10,905		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			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	07/99	\$ 3,379	3 YRS	\$ 564															
2	PAINT/DECORATING	07/00	1,889	3 YRS		315	630	630	314											
3	PAINT/DECORATING	07/04	1,943	3 YRS			325	647	647	324										
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$ 7,211		\$ 564	\$ 315	\$ 955	\$ 1,277	\$ 961	\$ 324										

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE# 0035642Report Period Beginning: 01/01/2006Ending: 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? 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. \$ 4,887 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. \$ 30,191
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. \$ 1,533 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