



Facility Name & ID Number PARKVIEW TERRACE

# 0045294 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	<u>24</u>	Skilled (SNF)	<u>24</u>	<u>8,760</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>96</u>	Intermediate (ICF)	<u>96</u>	<u>35,040</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</u>	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			<u>3,480</u>	<u>3,480</u>	8
9	SNF/PED					9
10	ICF	<u>25,615</u>	<u>3,467</u>	<u>1,048</u>	<u>30,130</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>25,615</u>	<u>3,467</u>	<u>4,528</u>	<u>33,610</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.74%

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 02/01/01

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/01/01 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 24 and days of care provided 3,480

Medicare Intermediary ADMINISTAR

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 **PARKVIEW TERRACE** # **0045294** 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
	<b>A. General Services</b>										
1	Dietary	131,774	10,760	6,090	148,624		148,624	0	148,624		1
2	Food Purchase		135,319		135,319	0	135,319	(739)	134,580		2
3	Housekeeping	93,918	15,034	0	108,952		108,952	0	108,952		3
4	Laundry	43,240	10,351	0	53,591	0	53,591	0	53,591		4
5	Heat and Other Utilities			98,586	98,586		98,586	2,454	101,040		5
6	Maintenance	47,620		29,250	76,870		76,870	13,984	90,854		6
7	Other (specify):*			4,418	4,418		4,418	119	4,537		7
8	<b>TOTAL General Services</b>	<b>316,552</b>	<b>171,464</b>	<b>138,344</b>	<b>626,360</b>	<b>0</b>	<b>626,360</b>	<b>15,818</b>	<b>642,178</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		12,000	12,000		12,000	0	12,000		9
10	Nursing and Medical Records	1,088,951	87,871	8,370	1,185,192		1,185,192	15,830	1,201,022		10
10a	Therapy	21,733	4,599	1,164	27,496		27,496	0	27,496		10a
11	Activities	48,414	1,517	4,620	54,551		54,551	(4,620)	49,931		11
12	Social Services	50,936		0	50,936		50,936	0	50,936		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,210,034</b>	<b>93,987</b>	<b>26,154</b>	<b>1,330,175</b>	<b>0</b>	<b>1,330,175</b>	<b>11,210</b>	<b>1,341,385</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	126,067		156,000	282,067		282,067	8,499	290,566		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			173,841	173,841		173,841	(127,734)	46,107		19
20	Dues, Fees, Subscriptions & Promotions			14,417	14,417		14,417	(1,355)	13,062		20
21	Clerical & General Office Expenses	47,648	9,317	60,228	117,193		117,193	68,213	185,406		21
22	Employee Benefits & Payroll Taxes			257,809	257,809	0	257,809	0	257,809		22
23	Inservice Training & Education			0	0		0	351	351		23
24	Travel and Seminar			3,794	3,794		3,794	16,236	20,030		24
25	Other Admin. Staff Transportation			2,964	2,964		2,964	7,493	10,457		25
26	Insurance-Prop.Liab.Malpractice			82,580	82,580		82,580	319	82,899		26
27	Other (specify):*			25,008	25,008		25,008	2,335	27,343		27
28	<b>TOTAL General Administration</b>	<b>173,715</b>	<b>9,317</b>	<b>776,641</b>	<b>959,673</b>	<b>0</b>	<b>959,673</b>	<b>(25,643)</b>	<b>934,030</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,700,301</b>	<b>274,768</b>	<b>941,139</b>	<b>2,916,208</b>	<b>0</b>	<b>2,916,208</b>	<b>1,385</b>	<b>2,917,593</b>		<b>29</b>

\*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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	6,090
	REPAIRS & MAINTENANCE	0
		0
		6,090
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	39,741
	ELECTRICITY	24,739
	WATER	33,400
	CABLE TV - LOBBY	706
		0
		98,586
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	2,252
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	23,547
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	594
	FIRE SERVICE	2,857
		0
		0
		0
		0
		29,250
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	4,339
	SECURITY SERVICE	79
		0
		0
		4,418
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,000
		12,000

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	7,770
	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
		8,370
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	1,113
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	51
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		1,164
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	4,620
		0
		4,620
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	156,000
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	14,791
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	27,047
	BOOKKEEPING/ADMINISTRATIVE SERVICE	132,003
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	173,841
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	891
	EMPLOYEE WANT ADS XIX F	2,502
	CONTRIBUTIONS VI 20 XIX F	580
	DUES & SUBSCRIPTIONS XIX F	6,988
	LICENSES & PERMITS XIX F	2,496
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	420
	PATIENT BACKGROUND CHECKS XIX F	540
		14,417
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	37,632
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	4,592
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	17,124
	MESSENGER SERVICE	880
		0
		60,228

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	142,839
	UNEMPLOYMENT COMPENSATION XIX D	53,432
	WORKERS COMPENSATION INSURANC XIX D	32,500
	HOSPITALIZATION INSURANCE XIX D	25,635
	EMPLOYEE BENEFITS - OTHER XIX D	3,403
	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
		257,809
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	2,980
	TRAVEL XIX G	814
		3,794
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	2,964
		2,964
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	82,580
		82,580
27	<b>OTHER</b>	
	BAD DEBTS VI 24	25,008
		25,008

GRAND TOTAL COLUMN 3 OTHER

941,139

PARKVIEW TERRACE  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2006

TOTAL FOOD PURCHASE	135,319	PATIENT MEALS	100830
LESS SALES TAX	(739)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	134,580	TOTAL MEALS/YEAR	100830
TOTAL PATIENT CENSUS	33,610	NET FOOD	134580
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	100830
	-----		
TOTAL PATIENT MEALS	100830	COST PER MEAL	1.33
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name &amp; ID Number

PARKVIEW TERRACE

#0045294

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	
	<b>D. Ownership</b>											
30	Depreciation			7,589	7,589		7,589	195,523	203,112			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			60,097	60,097		60,097	244,851	304,948			32
33	Real Estate Taxes			80,931	80,931		80,931	0	80,931			33
34	Rent-Facility & Grounds			428,265	428,265		428,265	(410,359)	17,906			34
35	Rent-Equipment & Vehicles			33,653	33,653		33,653	4,806	38,459			35
36	Other (specify):*				0		0	0	0			36
37	<b>TOTAL Ownership</b>			610,535	610,535	0	610,535	34,821	645,356			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		159,163	265,937	425,100		425,100	0	425,100			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			65,700	65,700		65,700	0	65,700			42
43	Other (specify):*				0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	159,163	331,637	490,800	0	490,800	0	490,800			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,700,301	433,931	1,883,311	4,017,543	0	4,017,543	36,206	4,053,749			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 **PARKVIEW TERRACE**

# **0045294**

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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	12,567	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	(739)	2		13
14	Non-Care Related Interest	(11)	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	(4,592)	21		18
19	Entertainment	0	20		19
20	Contributions	(580)	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	(25,008)	27		24
25	Fund Raising, Advertising and Promotional	(891)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	0			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (19,254)		\$ 0	30

<b>BHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
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)	55,460		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 55,460		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 36,206		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

PARKVIEW TERRACE

ID# 0045294

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number PARKVIEW TERRACE# 0045294

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	(739)	0	0	0	0	0	0	0	0	0	0	(739)	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	2,454	0	0	0	0	0	0	0	0	0	2,454	5
6	Maintenance	0	13,984	0	0	0	0	0	0	0	0	0	13,984	6
7	Other (specify):*	0	119	0	0	0	0	0	0	0	0	0	119	7
8	<b>TOTAL General Services</b>	<b>(739)</b>	<b>16,557</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>15,818</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	15,830	0	0	0	0	0	0	0	0	0	15,830	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	(4,620)	0	0	0	0	0	0	0	0	0	(4,620)	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>11,210</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>11,210</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	8,499	0	0	0	0	0	0	0	0	0	8,499	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(127,734)	0	0	0	0	0	0	0	0	0	(127,734)	19
20	Fees, Subscriptions & Promotions	(1,471)	116	0	0	0	0	0	0	0	0	0	(1,355)	20
21	Clerical & General Office Expenses	(4,592)	0	72,805	0	0	0	0	0	0	0	0	68,213	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	351	0	0	0	0	0	0	0	0	351	23
24	Travel and Seminar	0	0	16,236	0	0	0	0	0	0	0	0	16,236	24
25	Other Admin. Staff Transportation	0	0	7,493	0	0	0	0	0	0	0	0	7,493	25
26	Insurance-Prop.Liab.Malpractice	0	0	319	0	0	0	0	0	0	0	0	319	26
27	Other (specify):*	(25,008)	0	27,343	0	0	0	0	0	0	0	0	2,335	27
28	<b>TOTAL General Administration</b>	<b>(31,071)</b>	<b>(119,119)</b>	<b>124,547</b>	<b>0</b>	<b>(25,643)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(31,810)</b>	<b>(91,352)</b>	<b>124,547</b>	<b>0</b>	<b>1,385</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number PARKVIEW TERRACE# 0045294

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	12,567	0	595	182,361	0	0	0	0	0	0	0	195,523	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11)	0	3,167	241,695	0	0	0	0	0	0	0	244,851	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	17,906	(428,265)	0	0	0	0	0	0	0	(410,359)	34
35	Rent-Equipment & Vehicles	0	0	4,806	0	0	0	0	0	0	0	0	4,806	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>12,556</b>	<b>0</b>	<b>26,474</b>	<b>(4,209)</b>	<b>0</b>	<b>34,821</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(19,254)</b>	<b>(91,352)</b>	<b>151,021</b>	<b>(4,209)</b>	<b>0</b>	<b>36,206</b>	<b>45</b>						

Facility Name & ID Number

**PARKVIEW TERRACE**

# **0045294**

Report Period Beginning:

**01/01/2006**

Ending:

**12/31/2006**

**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
SUZANNE KOENIG	51.00	LITCHFIELD TERRACE	LITCHFIELD	MAVIN		BOOKKEEPING
MELVIN SIEGEL	49.00	ARC OF JACKSONVILLE	JACKSONVILLE	ENTERPRISES LTD	SKOKIE, IL	CONSULTING,
		SPRINGFIELD TERRACE	SPRINGFIELD			
		VANDALIA TERRACE	VANDALIA	PARKVIEW TERRACE		REAL ESTATE
		GOLDEN MOMENTS	JACKSONVILLE	PROPERTIES, LLC	SKOKIE, IL	

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10 PSYCH-SOCIAL CONSULTANT	\$ 4,620	MAVIN ENTERPRISES LTD		\$	\$ (4,620)	1
2	V	11 ACTIVITY CONSULTANT	4,620				(4,620)	2
3	V	19 ADMIN/BKPP. FEES	132,003				(132,003)	3
4	V							4
5	V							5
6	V	5 ELECTRICITY/GAS				2,454	2,454	6
7	V	6 MAINTENANCE SALARIES				13,305	13,305	7
8	V	6 MAINTENANCE & REPAIR				679	679	8
9	V	7 SCAVENGER				119	119	9
10	V	10 PSYCH-SOCIAL & NURSING CONSULT				20,450	20,450	10
11	V	17 ADMINISTRATIVE SALARIES				8,499	8,499	11
12	V	19 PROFESSIONAL FEES				4,269	4,269	12
13	V	20 ADVERTISING				116	116	13
14	Total		\$ 141,243			\$ 49,891	\$ * (91,352)	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	21 TOTAL OFFICE	\$	MAVIN ENTERPRISES LTD		\$ 72,805	\$	72,805	15
16	V	23 SEMINAR				351		351	16
17	V	24 TRAVEL				16,236		16,236	17
18	V	25 TRANSPORTATION				7,493		7,493	18
19	V	26 INSURANCE				319		319	19
20	V	27 EMPLOYEE BENEFITS				27,343		27,343	20
21	V	30 DEPRECIATION (SL)				595		595	21
22	V	32 INTEREST				3,167		3,167	22
23	V	34 OFFICE RENT				17,906		17,906	23
24	V	35 EQUIPMENT RENT				4,806		4,806	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		\$			\$ 151,021	\$ *	151,021	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	\$ 428,265	PARKVIEW TERRACE PROPERTIES, LLC		\$	\$ (428,265)
16	V	30 DEPRECIATION				182,361	182,361
17	V	32 INTEREST				241,695	241,695
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 428,265			\$ 424,056	\$ * (4,209)

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

Facility Name &amp; ID Number

PARKVIEW TERRACE

#

0045294

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									\$		1
2											2
3											3
4											4
5			SEE ATTACHED SCHEDULE								5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number **PARKVIEW TERRACE**

# **0045294**

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	ELECTRICITY/GAS	PATIENT DAYS	126,554	6	\$ 9,240	\$ 33,610	\$ 2,454	1
2	6	MAINTENANCE SALARIES	PATIENT DAYS	126,554	6	50,100	50,100	13,305	2
3	6	MAINTENANCE & REPAIR	PATIENT DAYS	126,554	6	2,556	33,610	679	3
4	7	SCAVENGER	PATIENT DAYS	126,554	6	448	33,610	119	4
5	10	PSYCH-SOCIAL & NURSING C	PATIENT DAYS	126,554	6	77,000	33,610	20,450	5
6	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	126,554	6	32,000	32,000	8,499	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	126,554	6	16,074	33,610	4,269	7
8	20	ADVERTISING	PATIENT DAYS	126,554	6	438	33,610	116	8
9	21	TOTAL OFFICE	PATIENT DAYS	126,554	6	274,137	224,827	72,805	9
10	23	SEMINAR	PATIENT DAYS	126,554	6	1,320	33,610	351	10
11	24	TRAVEL	PATIENT DAYS	126,554	6	61,135	33,610	16,236	11
12	25	TRANSPORTATION	PATIENT DAYS	126,554	6	28,213	33,610	7,493	12
13	26	INSURANCE	PATIENT DAYS	126,554	6	1,200	33,610	319	13
14	27	EMPLOYEE BENEFITS	PATIENT DAYS	126,554	6	102,955	33,610	27,343	14
15	30	DEPRECIATION (SL)	PATIENT DAYS	126,554	6	2,239	33,610	595	15
16	32	INTEREST	PATIENT DAYS	126,554	6	11,923	33,610	3,167	16
17	34	OFFICE RENT	PATIENT DAYS	126,554	6	67,423	33,610	17,906	17
18	35	EQUIPMENT RENT	PATIENT DAYS	126,554	6	18,096	33,610	4,806	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 756,497	\$ 306,927	\$ 200,912	25

Facility Name &amp; ID Number

PARKVIEW TERRACE

# 0045294

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			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1	RELATED PARTY						\$	\$			\$	1						
2	PARKVIEW TERRACE PROPERTIES, LLC											2						
3	COLE TAYLOR BANK		X	MORTGAGE	\$31,199.84	04/05	3,345,468	3,214,927	4/08	6.0000	189,457	3						
4	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		111,210	64,873			37,070	4						
5	EAST MOLINE GARDEN PLAZA	X		JR. MORTGAGE			350,000	217,456			15,168	5						
	<b>Working Capital</b>																	
6	COLE TAYLOR BANK	X		LINE OF CREDIT	DEMAND	02/11/04	364,633	842,434		PRIME+	59,581	6						
7	METROBANK		X	BUSINESS LOAN	DEMAND	5/05		5,472			516	7						
8	MGMT ALLOCATION										3,167	8						
9	<b>TOTAL Facility Related</b>				\$31,199.84		\$ 4,171,311	\$ 4,345,162			\$ 304,959	9						
	<b>B. Non-Facility Related*</b>																	
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$ 0	\$ 0			\$ 0	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 4,171,311	\$ 4,345,162			\$ 304,959	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.		\$	<b>76,623</b>	<b>1</b>
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.)		\$	<b>78,385</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>1,762</b>	<b>3</b>
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>79,169</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>80,931</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2001</b>	<b>71,461</b>	<b>8</b>
	<b>2002</b>	<b>74,385</b>	<b>9</b>
	<b>2003</b>	<b>90,911</b>	<b>10</b>
	<b>2004</b>	<b>75,865</b>	<b>11</b>
	<b>2005</b>	<b>78,385</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2005	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

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

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

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

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

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME PARKVIEW TERRACE COUNTY ROCK ISLAND

FACILITY IDPH LICENSE NUMBER 0045294

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>07-514-20-00</u>	<u>NURSING HOME</u>	\$ <u>78,385.20</u>	\$ <u>78,385.20</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>78,385.20</u>	\$ <u>78,385.20</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 PARKVIEW TERRACE

# 0045294

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 27,040 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).

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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>334,546</u>	1
2					2
3	TOTALS			\$ <u>334,546</u>	3

Facility Name & ID Number **PARKVIEW TERRACE**

# **0045294**

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	120	2005		\$ 2,770,922	\$ 100,761	27.5	\$ 100,761	\$	\$ 172,133
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	A-WING PAINTING & REFURBISHING OF RESIDENT ROOMS	2002		6,000		5	1,200	1,200	6,000
10	PAINTING & DECORETING	2003		30,000		5	10,000	10,000	30,000
11	INSTALL ALARM SYSTEM	2004		5,451	198	27.5	198		437
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

Facility Name & ID Number **PARKVIEW TERRACE**

# **0045294**

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	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	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70	
			2,812,373		100,959		112,159	11,200	208,570

\*\*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	\$ 15,763	\$ 1,459	\$ 1,577	\$ 118	10 YRS	\$ 5,259	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets				0			73
74	<b>MGMT ALLOCATION</b>		82,195	82,195	0			74
75	<b>TOTALS</b>	\$ 15,763	\$ 83,654	\$ 83,772	\$ 118		\$ 5,259	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	<b>FACILITY</b>	<b>1998 FORD WINDSTAR</b>	<b>2004</b>	\$ 16,050	\$ 3,082	\$ 3,210	\$ 128	5 YRS	\$ 9,630	76
77	<b>ADMINISTRATIVE</b>	<b>2001 LEXUS</b>	<b>2004</b>	19,856	2,850	3,971	1,121	5 YRS	11,913	77
78							0			78
79							0			79
80	<b>TOTALS</b>			\$ 35,906	\$ 5,932	\$ 7,181	\$ 1,249		\$ 21,543	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)	\$ 3,198,588	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 190,545	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 203,112	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,567	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 235,372	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	<b>TOTALS</b>	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

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

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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: \$ **19,675** 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	<b>ADMINISTRATIVE</b>	<b>2006 LEXUS</b>	\$ <b>#####</b>	\$ <b>13,978</b>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>#####</b>	\$ <b>13,978</b>	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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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	<b>TOTALS</b>	\$ 0	\$ 0	\$ 0	\$ 0
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 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)	
<b>TOTAL TRAINED</b>	

- (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	\$		\$ 138,724	\$		\$ 138,724	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			9,849			9,849	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			117,364			117,364	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				131,774		131,774	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>MEDICAL SUPPLIES</b>	39-2					27,389		27,389	13
14	<b>TOTAL</b>			\$		\$ 265,937	\$ 159,163		\$ 425,100	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 **PARKVIEW TERRACE**

# **0045294**

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 5,186	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,006,247		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,892		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	491,974		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,559,299	\$ 0	10
	<b>B. Long-Term Assets</b>			
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	41,451		15
16	Equipment, at Historical Cost	51,669		16
17	Accumulated Depreciation (book methods)	(72,335)		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): <b>CONSTRUCTION ESCROW</b>	298,554		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 319,339	\$ 0	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,878,638	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,015,972	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,137,601		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	84,131		31
32	Accrued Real Estate Taxes(Sch.IX-B)	79,169		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,316,873	\$ 0	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 0	\$ 0	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,316,873	\$ 0	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (438,235)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,878,638	\$ 0	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(310,303)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>PRIOR YEAR ADJUSTMENT</b>	<b>(37,227)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(347,530)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(90,705)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(90,705)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(438,235)</b>	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,785,668	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,785,668	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	141,159	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 141,159	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 0	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	11	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 11	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 0	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,926,838	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	626,360	31
32	Health Care	1,330,175	32
33	General Administration	959,673	33
<b>B. Capital Expense</b>			
34	Ownership	610,535	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	425,100	35
36	Provider Participation Fee	65,700	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,017,543	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(90,705)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (90,705)	43

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

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

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

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

Facility Name & ID Number PARKVIEW TERRACE

# 0045294

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	1,978	2,040	\$ 63,081	\$ 30.92	1
2	Assistant Director of Nursing	1,922	2,117	39,052	18.45	2
3	Registered Nurses	5,125	5,468	107,150	19.60	3
4	Licensed Practical Nurses	18,505	19,720	314,847	15.97	4
5	CNAs & Orderlies	46,471	49,147	487,923	9.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,891	2,076	21,733	10.47	8
9	Activity Director					9
10	Activity Assistants	4,454	4,736	48,414	10.22	10
11	Social Service Workers	3,686	3,992	50,936	12.76	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,094	16,040	131,774	8.22	15
16	Dishwashers					16
17	Maintenance Workers	3,297	3,399	47,620	14.01	17
18	Housekeepers	11,249	12,217	93,918	7.69	18
19	Laundry	4,780	5,240	43,240	8.25	19
20	Administrator	2,013	2,067	81,016	39.19	20
21	Assistant Administrator	2,148	2,220	45,051	20.29	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,997	4,225	47,648	11.28	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	1,901	2,019	42,188	20.90	31
32	Other Health Care <u>care plan coordin</u>	1,899	2,041	34,710	17.01	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	130,410	138,764	\$ 1,700,301 *	\$ 12.25	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	\$ 6,090	1-3	35
36	Medical Director	O	12,000	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	1,113	10a-3	40
41	Occupational Therapy Consultant	Y	51	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	4,620	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47	<u>PSYCHO-SOCIAL CONSULTANT</u>		7,770	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 32,244		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. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
ROBERT TALBOT	ADMINISTRATOR	0.00%	\$ 81,016	Workers' Compensation Insurance	\$ 32,500	IDPH License Fee	\$ 1,990	
TAMSIN RAMIREZ	ASST ADMIN	0.00%	12,360	Unemployment Compensation Insurance	53,432	Advertising: Employee Recruitment	2,502	
JOYCE CIYOU	ADM CONSULT.	0.00%	32,691	FICA Taxes	142,839	Health Care Worker Background Check	420	
				Employee Health Insurance	25,635	(Indicate # of checks performed <u>42</u> )		
				Employee Meals	0	Patient Background Checks	54	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	580	
				EMPLOYEE BENEFITS - OTHER	3,403	MARKETING/ADV/PROMO	891	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	7,494	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	116	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(580)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	( 0 )	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(891)	
						Yellow page advertising	( 0 )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 126,067	TOTAL (agree to Schedule V, line 22, col.8)	\$ 257,809	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 13,062	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
MELVIN SIEGEL	MANAGEMENT FEES		\$ 60,000				Out-of-State Travel	\$
SUZANNE KOENIG	MANAGEMENT FEES		96,000					
							In-State Travel	
								814
							MGMT CO ALLOC	16,236
							Seminar Expense	
								2,980
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 156,000	TOTAL			(agree to Sch. V, line 24, col. 8)	\$ 20,030
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			173,841					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 173,841					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number PARKVIEW TERRACE# 0045294Report 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? YES  
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE \$6264
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO \_\_\_\_\_ 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. \$ 65,700  
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