



Facility Name & ID Number Pershing Estates

# 0022947 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	137	Intermediate (ICF)	137	50,005	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	137	TOTALS	137	50,005	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
		8	SNF			
9	SNF/PED				9	
10	ICF	37,525	424	1,021	38,970	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,525	424	1,021	38,970	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.93%

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 12/01/1976

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

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

Medicare Intermediary N/A

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 Pershing Estates # 0022947 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				Reclassification 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	126,123	1,560	10,303	137,986		137,986		137,986		1
2	Food Purchase		173,922		173,922	(765)	173,157		173,157		2
3	Housekeeping	132,982			132,982		132,982		132,982		3
4	Laundry										4
5	Heat and Other Utilities			86,349	86,349		86,349		86,349		5
6	Maintenance	39,648	27,902	58,569	126,119		126,119		126,119		6
7	Other (specify):* Resident workers	1,530			1,530		1,530		1,530		7
8	<b>TOTAL General Services</b>	300,283	203,384	155,221	658,888	(765)	658,123		658,123		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			36,000	36,000		36,000		36,000		9
10	Nursing and Medical Records	728,031	35,442	1,800	765,273		765,273		765,273		10
10a	Therapy										10a
11	Activities	57,036	7,771	1,320	66,127		66,127		66,127		11
12	Social Services	133,703		1,320	135,023		135,023		135,023		12
13	CNA Training										13
14	Program Transportation		9,771		9,771		9,771		9,771		14
15	Other (specify):* MI Programmers	63,984			63,984		63,984		63,984		15
16	<b>TOTAL Health Care and Programs</b>	982,754	52,984	40,440	1,076,178		1,076,178		1,076,178		16
	<b>C. General Administration</b>										
17	Administrative	350,814			350,814		350,814		350,814		17
18	Directors Fees										18
19	Professional Services			9,470	9,470		9,470		9,470		19
20	Dues, Fees, Subscriptions & Promotions			26,219	26,219		26,219	(604)	25,615		20
21	Clerical & General Office Expenses	80,691	26,986	21,747	129,424		129,424	(5,590)	123,834		21
22	Employee Benefits & Payroll Taxes			215,270	215,270	765	216,035		216,035		22
23	Inservice Training & Education			2,336	2,336		2,336		2,336		23
24	Travel and Seminar			2,752	2,752		2,752		2,752		24
25	Other Admin. Staff Transportation			1,631	1,631		1,631	(1,631)			25
26	Insurance-Prop.Liab.Malpractice			85,024	85,024		85,024		85,024		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	431,505	26,986	364,449	822,940	765	823,705	(7,825)	815,880		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,714,542	283,354	560,110	2,558,006		2,558,006	(7,825)	2,550,181		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

Facility Name &amp; ID Number

Pershing Estates

#0022947

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			18,389	18,389		18,389	18,814	37,203			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			65,985	65,985		65,985		65,985			32
33	Real Estate Taxes			72,845	72,845		72,845		72,845			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Office rent			30,000	30,000		30,000		30,000			36
37	<b>TOTAL Ownership</b>			187,219	187,219		187,219	18,814	206,033			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	5,433	92		5,525		5,525		5,525			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			75,943	75,943		75,943		75,943			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	5,433	92	75,943	81,468		81,468		81,468			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,719,975	283,446	823,272	2,826,693		2,826,693	10,989	2,837,682			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	20,589	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				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(2,443)	21		15
16	Personal Expenses (Including Transportation)	(1,631)	25		16
17	Non-Care Related Fees	(1,775)	30		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(604)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,147)	21		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 10,989		\$	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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 10,989		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Pershing Estates

ID# 0022947

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			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 Pershing Estates# 0022947

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<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	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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(604)	0	0	0	0	0	0	0	0	0	0	(604)	20
21	Clerical & General Office Expenses	(5,590)	0	0	0	0	0	0	0	0	0	0	(5,590)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(1,631)	0	0	0	0	0	0	0	0	0	0	(1,631)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(7,825)	0	0	0	0	0	0	0	0	0	0	(7,825)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(7,825)	0	0	0	0	0	0	0	0	0	0	(7,825)	29



Facility Name & ID Number Pershing Estates

# 0022947

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
Contemporary Properties, Inc.	100	None		Striglos Companies	Decatur, IL	Retail office
						products store

**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	21 Office expense	\$ 8,613	Striglos Companies	100.00%	\$ 8,613	\$	1
2	V	6 Maintenance	353	Striglos Companies	100.00%	353		2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 8,966			\$ 8,966	\$ *	14

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

Facility Name & ID Number      Pershing Estates      #      0022947      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	Nick Striglos	President	Management	28.00	None	20	50.00	Salary	\$ 215,560	17-1	1
2	Jamie Kolovadis	Res. Serv. Coordin.	Resident services	24.00	None	30	100.00	Salary	18,108	L 12,Col 1	2
3	Jamie Kolovadis	Res. Serv. Coordin.	Resident services	24.00	None	30	100.00	Exp. Reimb.	13,193	21-2	3
4	Jamie Kolovadis	Res. Serv. Coordin.	Resident services	24.00	None	30	100.00	Exp. Reimb.	4,449	14-2	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 251,310		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 Pershing Estates # 0022947 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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number **Pershing Estates**# **0022947**

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
		Related**					Amount of Note					
Name of Lender	Related**	YES	NO	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
<b>Working Capital</b>												
6	Morgan Stanley/	X		Cash flow due to late IDPA	Open	12/28/01	300,000	1,477,000	Open	6.2500	65,985	6
7	Raymond James			pymnts--open line of cr								7
8												8
9	<b>TOTAL Facility Related</b>						\$ 300,000	\$ 1,477,000			\$ 65,985	9
<b>B. Non-Facility Related*</b>												
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ 300,000	\$ 1,477,000			\$ 65,985	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ 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.)



**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,

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

FACILITY NAME Pershing Estates COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0022947

CONTACT PERSON REGARDING THIS REPORT Denise King

TELEPHONE 217-429-2500 FAX #: 217-429-0081

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of total 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>07-07-34-351-013</u>	<u>N450.63 S950.63 W405.2</u>	<u>\$ 69,053.00</u>	<u>\$ 69,053.00</u>
2. _____	<u>E652.2 SW1/4 SW 1/4</u>	<u>\$ _____</u>	<u>\$ _____</u>
3. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
4. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
5. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
6. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
7. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
8. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
9. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
10. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
<b>TOTALS</b>		<u>\$ 69,053.00</u>	<u>\$ 69,053.00</u>

**B. Real Estate Tax Cost Allocation:**

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 &amp; ID Number Pershing Estates

# 0022947

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 28,860 B. General Construction Type: Exterior Masonry Frame Metal Number of Stories 1C. 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 ground (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)

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility/yard	130,680	1976	\$ 38,000	1
2					2
3	TOTALS	130,680		\$ 38,000	3

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

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	127	1976	1973	\$ 423,394	\$	25	\$	\$	\$ 423,394	4
5	10	1998	1998	470,332	12,059	25	18,813	6,754	150,504	5
6	Fixed equip.	1976	1976	70,012		VAR			70,012	6
7										7
8										8
<b>Improvement Type**</b>										
9	Remodeling 1978		1978	16,657		VAR			16,657	9
10	Remodeling 1979		1979	8,066		VAR			8,066	10
11	47 cases floor tile		1982	1,410		7			1,410	11
12	Carpet & tile		1983	2,096		10			2,096	12
13	Floor tile		1984	312		7			312	13
14	1985 Improvements		1985	8,321		13			8,321	14
15	Floor & ceiling tile		1988	1,552		5			1,552	15
16	Water heater		1989	843		12			843	16
17	Flooring		1989	2,288		5			2,288	17
18	Storage shed		1989	454		20	23	23	418	18
19	Flooring		1989	2,919		5			2,919	19
20	Sliding glass door replacement		1989	830	26	11		(26)	830	20
21	Fire wall		1989	1,475	47	11		(47)	1,475	21
22	Laundry room service		1989	900		11			900	22
23	Wallpaper, carpet & floor tile		1990	2,749	34	5		(34)	2,749	23
24	Curtains, water heater, smoke eater, A/C		1990	19,559	246	10		(246)	19,559	24
25	Floor tile & A/C's		1991	5,147		7			5,147	25
26	Water heater, valves & pump		1991	4,974	158	15	272	114	4,974	26
27	Floor tile, carpet, A/C		1992	2,953		7			2,953	27
28	New roof--one wing		1992	5,500	175	9		(175)	5,500	28
29	Carpet & tile		1993	1,657		7			1,657	29
30	A/C & fire suppression system		1993	3,830		10			3,830	30
31	A/C & tile		1994	3,849		7			3,849	31
32	Quarry tile & patio door		1994	3,850	21	10		(21)	3,850	32
33	Carpet, tile, roof (one wing), A/C		1995	8,676	101	7		(101)	8,676	33
34	Water heaters		1995	6,029		15	402	402	4,745	34
35	A/C		1996	975		7			975	35
36										36

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

See Page 12A, Line 70 for total

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

- 1218135 Page 12A
- 5 Page 12B
- Page 12C
- Page 12D
- Page 12E
- Page 12F
- Page 12G
- Page 12H
- Page 12I

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Carpeting 108 yds.	1996	\$ 1,603	\$	7	\$	\$	\$ 1,603	37
38	Floor tile & base	1997	982		7			982	38
39	New roof--one wing	1997	4,245	109	15	283	174	2,618	39
40	Partial roof replacement	1997	875	22	10	88	66	798	40
41	Carpeting 108 yds.	1997	1,142		7			1,142	41
42	Phone lines	1998	1,462		15	97	97	841	42
43	Light fixtures for sidewalk	1998	2,875		15	192	192	1,568	43
44	Phone lines, expand MuZak	1998	690		10	69	69	638	44
45	Furnaces	1998	2,475		7			2,475	45
46	A/C	1998	1,350		7			1,350	46
47	Backflow prevention device, materials adjustment	1998	4,976		15	332	332	2,767	47
48	Roof top furnace	1998	3,000		10	300	300	2,400	48
49	Balance of new addition	1999	25,316	649	25	1,013	364	7,428	49
50	Smoking room	1999	5,534	142	15	369	227	2,398	50
51	Handrails for smoking room	1999	853		15	57	57	456	51
52	A/C--furnace unit	2000	2,900		7	414	414	2,898	52
53	A/C unit & compressor	2000	4,000		7	571	571	3,712	53
54	Carpeting & vinyl	2000	1,593		7	228	228	1,463	54
55	TICA furnace & coil	2000	1,581		7	226	226	1,394	55
56	A/C--furnace unit	2000	2,900		7	414	414	2,519	56
57	New roof--one wing	2000	14,325	367	25	573	206	3,820	57
58	Handicapped access ramp	2001	11,018	280	25	441	161	2,242	58
59	A/C unit & compressor	2001	1,150		7	164	164	930	59
60	Tempstar furnace	2002	1,500	94	7	214	120	1,070	60
61	Goodman A/C 3.5 ton	2002	1,200	75	7	171	96	770	61
62	Goodman A/C 3.5 ton	2002	1,200	75	7	171	96	770	62
63	Simplex nurse call system	2002	24,800	50	15	1,653	1,603	6,888	63
64	Tempstar furnace w/coil	2002	1,469	92	7	210	118	857	64
65	Tempstar furnace w/coil	2002	1,454	91	7	208	117	883	65
66	Tempstar furnace w/coil (2)	2004	3,012		7	430	430	1,111	66
67	Tempstar furnace & coil	2004	1,515		7	216	216	594	67
68	75 gal. water heater	2005	1,625		15	108	108	216	68
69	Panic doors	2005	1,906		15	127	127	212	69
70	TOTAL (lines 4 thru 69)		\$ 1,218,135	\$ 14,913		\$ 28,849	\$ 13,936	\$ 822,274	70

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

Facility Name & ID Number Pershing Estates

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,218,135	\$ 14,913		\$ 28,849	\$ 13,936	\$ 822,274	1
2	Central A/C	2005	1,171		7	167	167	265	2
3	Carpet	2005	3,088		7	441	441	662	3
4	160' x 4' sidewalks	2005	2,550		15	170	170	198	4
5	296' ceiling tile	2005	1,178		7	168	168	196	5
6	3 heat exchangers	2006	2,610	373	7	31	(342)	31	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	TOTAL (lines 1 thru 33)		\$ 1,228,732	\$ 15,286		\$ 29,826	\$ 14,540	\$ 823,626	34

\*\*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	\$ 34,735	\$ 76	\$ 4,504	\$ 4,428		\$ 20,102	71
72	Current Year Purchases	3,402	486	243	(243)		243	72
73	Fully Depreciated Assets	194,292					194,294	73
74								74
75	TOTALS	\$ 232,429	\$ 562	\$ 4,747	\$ 4,185		\$ 214,639	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	Resident transportation	1999 Chevy Express	2001	\$ 10,343	\$ 595	\$ 1,722	\$ 1,127	5	\$ 10,343	76
77	Resident transportation	1994 Buick LeSabre	2003	4,542	171	908	737	5	3,027	77
78										78
79										79
80	TOTALS			\$ 14,885	\$ 766	\$ 2,630	\$ 1,864		\$ 13,370	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)	\$ 1,514,046	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	16,614	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	37,203	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	20,589	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	1,051,635	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	1999 Mercedes	\$ 53,853	\$ 1,775	\$ 28,417	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 53,853	\$ 1,775	\$ 28,417	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

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                      \$ \_\_\_\_\_

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: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(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	<b>TOTAL</b>		\$	\$	21

\* 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.

**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><u>CNAs hired were already certified.</u></p>	<p>2. <b>CLASSROOM PORTION:</b></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. <b>CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

- (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.

**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>	

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$								1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescripts											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	<b>TOTAL</b>			\$		\$		\$		\$		\$		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.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Pershing Estates

# 0022947

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	\$ 64,263	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	957,620		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Employee loans</b>	2,445		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,024,328	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable	372,964		11
12	Long-Term Investments			12
13	Land	38,000		13
14	Buildings, at Historical Cost	1,002,214		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	537,620		16
17	Accumulated Depreciation (book methods)	(1,066,749)		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>Reconcile cash/accrual</b>	(901,334)		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ (17,285)	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,007,043	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 50,834	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,477,000		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			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>	\$ 1,527,834	\$	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>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,527,834	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (520,791)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,007,043	\$	48

\*(See instructions.)

## XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 92,750	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 92,750	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	136,756	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	(464,584)	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)	\$ (327,828)	17
<b>B. Transfers (Itemize):</b>			
18	Reconcile cash/accrual	(285,713)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (285,713)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (520,791)	24 *

\* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Pershing Estates

# 0022947

Report Period Beginning: 01/01/2006

Ending:

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12/31/2006

**VII. 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	\$ 3,072,970	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,072,970	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	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	498	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>	\$ 498	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	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>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,073,468	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	658,123	31
32	Health Care	1,076,178	32
33	General Administration	815,880	33
<b>B. Capital Expense</b>			
34	Ownership	206,033	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	5,525	35
36	Provider Participation Fee	75,943	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,837,682	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	235,786	41
42	<b>Income Taxes</b>	(99,030)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 136,756	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 is on cash b

\*\*\* 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.

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**  
(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,277	2,420	\$ 56,782	\$ 23.46	1
2	Assistant Director of Nursing	1,192	1,292	31,759	24.58	2
3	Registered Nurses	1,366	1,422	29,076	20.45	3
4	Licensed Practical Nurses	14,213	14,776	253,125	17.13	4
5	CNAs & Orderlies	41,818	43,331	357,289	8.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,160	2,256	25,664	11.38	9
10	Activity Assistants	4,456	4,684	31,372	6.70	10
11	Social Service Workers	6,691	6,980	115,595	16.56	11
12	Dietician					12
13	Food Service Supervisor	2,472	2,580	24,849	9.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,232	14,693	101,274	6.89	15
16	Dishwashers					16
17	Maintenance Workers	4,022	4,294	39,648	9.23	17
18	Housekeepers	15,303	16,050	132,982	8.29	18
19	Laundry					19
20	Administrator	2,464	2,600	83,860	32.25	20
21	Assistant Administrator	40	40	805	20.13	21
22	Other Administrative	1,944	2,080	51,394	24.71	22
23	Office Manager	1,944	2,080	31,937	15.35	23
24	Clerical	3,995	4,274	47,949	11.22	24
25	Vocational Instruction	1,040	1,040	215,560	207.27	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,448	7,757	63,984	8.25	28
29	Resident Services Coordinator	1,424	1,560	18,108	11.61	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C; Resident workers	357	357	1,530	4.29	32
33	Other(specify) <u>Beautician</u>	817	836	5,433	6.50	33
34	TOTAL (lines 1 - 33)	131,675	137,402	\$ 1,719,975 *	\$ 12.52	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	209	\$ 10,303	1-3	35
36	Medical Director	Flat fee	36,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Flat fee	1,800	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	1,320	11-3	44
45	Social Service Consultant	44	1,320	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	297	\$ 50,743		49

**C. CONTRACT NURSES**

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





Facility Name & ID Number Pershing Estates# 0022947Report Period Beginning: 01/01/2006 Ending: 12/31/2006**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Council 5266;Alliance for Living 3425.
- (3) Did the nursing home make political contributions or payments to a political 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? 7-15
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (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. N/A
- (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. \$ 75,943  
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 benefit: on Schedule V. \$ 765 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,186
- (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? \_\_\_\_\_  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
**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? N/A 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 \$5,000, 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.