

		FOR BHF USE				

LL1

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

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045377

Facility Name: Prairie City Health Care Center

Address: 825 East Main St, R R #2, Box #97 Prairie City 61470
 Number City Zip Code

County: McDonough

Telephone Number: (309)775-3313 **Fax #** (309)775-3311

HFS ID Number: 371409457001

Date of Initial License for Current Owners: 04/30/2001

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Eddie Franciskovich **Telephone Number:** (309)775-3313

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date) _____

(Type or Print Name) Eddie Franciscovich

(Title) Administrator

Paid Preparer

(Signed) _____ (Date) _____

(Print Name and Title) See Accountant's Compilation Report

(Firm Name & Address) Ginoli & Company, Ltd
411 Hamilton Blvd, Ste 1616; Peoria, IL 61602-1104

(Telephone) (309)671-2350 Fax # (309)671-5459

MAIL TO: BUREAU OF HEALTH FINANCE
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center

0045377 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	43	Skilled (SNF)	47	16,075	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	43	TOTALS	47	16,075	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF			900	900	8
9	SNF/PED					9
10	ICF	7,532	3,107		10,639	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,532	3,107	900	11,539	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.78%

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)

Meals on wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 04/30/01

J. Was the facility purchased or leased after January 1, 1978?

YES Date 04/30/01 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 9 and days of care provided 900

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	87,838	4,750	5,424	98,012	(752)	97,260		97,260		1
2	Food Purchase		54,658		54,658		54,658	(1,229)	53,429		2
3	Housekeeping	65,041	12,553		77,594		77,594		77,594		3
4	Laundry	11,344	7,062		18,406		18,406		18,406		4
5	Heat and Other Utilities			38,495	38,495	(4,150)	34,345		34,345		5
6	Maintenance	11,607	6,370	20,052	38,029		38,029		38,029		6
7	Other (specify):*										7
8	TOTAL General Services	175,830	85,393	63,971	325,194	(4,902)	320,292	(1,229)	319,063		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	380,887	55,244	38,019	474,150		474,150		474,150		10
10a	Therapy		166	48,067	48,233		48,233		48,233		10a
11	Activities	39,924	196	1,064	41,184		41,184		41,184		11
12	Social Services	25,089	369	1,508	26,966	(444)	26,522		26,522		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	445,900	55,975	88,658	590,533	(444)	590,089		590,089		16
	C. General Administration										
17	Administrative	53,498			53,498		53,498		53,498		17
18	Directors Fees										18
19	Professional Services			46,643	46,643	(25,205)	21,438		21,438		19
20	Dues, Fees, Subscriptions & Promotions			9,900	9,900	(3,468)	6,432		6,432		20
21	Clerical & General Office Expenses	25,314	3,443	9,050	37,807		37,807		37,807		21
22	Employee Benefits & Payroll Taxes			120,856	120,856		120,856		120,856		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,156	3,156		3,156		3,156		24
25	Other Admin. Staff Transportation			5,355	5,355		5,355		5,355		25
26	Insurance-Prop.Liab.Malpractice					8,302	8,302		8,302		26
27	Other (specify):* CARE PLAN COORI	30,996		32,797	63,793	(32,797)	30,996		30,996		27
28	TOTAL General Administration	109,808	3,443	227,757	341,008	(53,168)	287,840		287,840		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	731,538	144,811	380,386	1,256,735	(58,514)	1,198,221	(1,229)	1,196,992		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Prairie City Health Care Center #0045377 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			15,783	15,783	(1,590)	14,193	7,613	21,806			30
31	Amortization of Pre-Op. & Org.			569	569		569		569			31
32	Interest			23,079	23,079		23,079	(29)	23,050			32
33	Real Estate Taxes			4,216	4,216		4,216		4,216			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			8,302	8,302	(8,302)						36
37	TOTAL Ownership			51,949	51,949	(9,892)	42,057	7,584	49,641			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					25,205	25,205		25,205			42
43	Other (specify):*					43,201	43,201	(43,201)				43
44	TOTAL Special Cost Centers					68,406	68,406	(43,201)	25,205			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	731,538	144,811	432,335	1,308,684		1,308,684	(36,846)	1,271,838			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center

0045377

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	(1,229)	43		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	7,613			9
10	Interest and Other Investment Income	(29)	43		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				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				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				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,590)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 4,765		\$	30

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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 4,765		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			43,201		46
47	TOTAL (C): (sum of lines 38-46)			\$ 43,201		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie City Health Care Center

ID# _____

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	NON-CARE AUTO DEPRECIATION	\$ 1,590	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	Total	1,590	49

STATE OF ILLINOIS

Facility Name & ID Number Prairie City Health Care Center

0045377

Report Period Beginning:

01/01/06 Ending:

Summary B

12/31/06

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,258)	0	0	0	0	0	0	0	0	0	0	(1,258)	43
44	TOTAL Special Cost Centers	(1,258)	0	(1,258)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,258)	0	(1,258)	45									

Facility Name & ID Number Prairie City Health Care Center

0045377

Report Period Beginning:

01/01/06

Ending:

12/31/06

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
EDDIE FRANCISCOVICH	100.00					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V	N/A	\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	EDDIE FRANCISOVICH	ADMINISTRATOR	ADMINISTRATOR	100.00	0	40	100.00	SALARY	\$ 53,498	L.17C.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								TOTAL	\$ 53,498		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center

0045377

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	N/A				\$	\$		\$	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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	IPAVA BANK		X	MORTGAGE	\$2,677.97	4/21/06	\$ 320,000	\$ 312,154	4/21/16	8.0000	\$ 16,837	1					
2	EDDIE FRANCISOVICH	X		LONG TERM WORKING CA	N/A	VAR		481,182				2					
3	JAMES PETERSEN	X		LONG TERM WORKING CA	N/A	VAR		10,000				3					
4												4					
5												5					
Working Capital																	
6	IPAVA BANK		X	VARIOUS LOANS	VAR	VAR	VAR				6,242	6					
7												7					
8												8					
9	TOTAL Facility Related				\$2,677.97		\$ 320,000	\$ 803,336			\$ 23,079	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$	\$ 803,336			\$ 23,079	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ 4,350	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 4,216	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (134)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 4,350	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 4,216	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	3,806	8
	2002	3,874	9
	2003	3,994	10
	2004	4,144	11
	2005	4,216	12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Prairie City Health Care Center COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0045377

CONTACT PERSON REGARDING THIS REPORT EDDIE FRANCISCOVICH

TELEPHONE (309)775-3313 FAX #: (309)775-3311

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>15-000-002-05</u>	<u>FACILITY-GROUNDS</u>	\$ <u>4,216.00</u>	\$ <u>4,216.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>4,216.00</u>	\$ <u>4,216.00</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 Prairie City Health Care Center

0045377 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,500 B. General Construction Type: Exterior BRICK Frame CINDERBLOCK Number of Stories 1 FLOOR

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).

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: 6,825 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 569 4. Dates Incurred: 2001

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>LAND</u>	<u>216,058</u>	<u>2001</u>	<u>\$ 9,000</u>	1
2					2
3	TOTALS	216,058		\$ 9,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Prairie City Health Care Center**

0045377

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2001	1970	\$ 53,000	\$ 1,359	39	\$ 1,359	\$	\$ 7,474	4
5											5
6											6
7											7
8											8
Improvement Type**											
9		SEWER HOOKUP		2001	2,894	74	39	74		408	9
10		ARCHITECTURAL DESIGN		2001	2,903	75	39	75		372	10
11		ROOFING MATERIALS		2002	878	23	39	23		103	11
12		2 NEW BATHROOMS		2002	13,854	355	39	355		1,628	12
13		INSTALL GREASE TRAP		2002	1,318	34	39	34		155	13
14		FLOOR TILES AND CARPET		2002	7,578	194	39	194		874	14
15		SPRINKLER HEADS		2002	2,649	68	39	68		306	15
16		ARCHITECTURAL DESIGN		2002	10,792	277	39	277		1,245	16
17		UPGRADE SHOWER AND BATH		2002	3,370	86	39	86		382	17
18		ARCHITECTURAL DESIGN		2002	500	13	39	13		54	18
19		LIGHTING FIXTURES AND WALLPAPER		2002	4,097	105	39	105		438	19
20		CEILING TILES		2002	2,152	55	39	55		253	20
21		HARDWOOD ITEMS		2002	1,771	45	39	45		208	21
22		BUILDING MATERIALS		2002	728	19	39	19		82	22
23		UPGRADE DRAINAGE SYSTEM		2002	1,067	27	39	27		121	23
24		PAINTING		2003	4,320	288	15	288		1,104	24
25		HEATER REPAIR		2003	2,300	153	15	153		588	25
26		FIREWALL INSTALLATION		2005	24,119	619	39	619		670	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Prairie City Health Care Center**

0045377

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	140,290	\$	3,869	\$	3,869	\$	16,465	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	\$ 85,178	\$ 7,323	\$ 12,774	\$ 5,451	5,7	\$ 65,922	71
72	Current Year Purchases	1,775	355	115	(240)	5,7	115	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 86,953	\$ 7,678	\$ 12,889	\$ 5,211		\$ 66,037	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	FACILITY	2001 CHEVY VAN	2001	\$ 50,473	\$ 2,646	\$ 5,048	\$ 2,402	5	\$ 50,473	76
77										77
78										78
79										79
80	TOTALS			\$ 50,473	\$ 2,646	\$ 5,048	\$ 2,402		\$ 50,473	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)	\$ 286,716	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,193	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,806	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,613	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 132,975	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	2001 TRUCK	\$ 28,915	\$ 1,775	\$ 15,215	86
87	BEAUTY SHOP EQUIPMENT	920	82	715	87
88					88
89					89
90					90
91	TOTALS	\$ 29,835	\$ 1,857	\$ 15,930	91

G. Construction-in-Progress

	Description	Cost	
92	NA		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center

0045377

Report Period Beginning: 01/01/06

Ending: 12/31/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

PLEASE ENTER ONLY DATES IN CELLS W16 AND W17

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning N/A

Ending _____

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

Fiscal Year Ending Annual Rent

12.	<u>/2007</u>	\$ <u>N/A</u>
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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 _____.

N/A
N/A

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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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.

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>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	4					
					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	TOTAL			\$		\$	\$		\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center# 0045377Report Period Beginning: 01/01/06

Ending:

12/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/06

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 25,580	\$ 25,580	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	92,266	92,266	3
4	Supply Inventory (priced at)	2,026	2,026	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):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 119,872	\$ 119,872	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,000	9,000	13
14	Buildings, at Historical Cost	140,290	140,290	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	167,261	167,261	16
17	Accumulated Depreciation (book methods)	(155,375)	(155,375)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 161,176	\$ 161,176	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 281,048	\$ 281,048	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 93,174	\$ 93,174	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	30,120	30,120	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,483	1,483	31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,350	4,350	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 129,127	\$ 129,127	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	491,182	491,182	39
40	Mortgage Payable	312,154	312,154	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 803,336	\$ 803,336	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 932,463	\$ 932,463	46
47	TOTAL EQUITY(page 18, line 24)	\$ (651,415)	\$ (651,415)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 281,048	\$ 281,048	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (469,707)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (469,707)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(181,708)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (181,708)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (651,415)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center

0045377

Report Period Beginning: 01/01/06

Ending: 12/31/06

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,105,718	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,105,718	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	29	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 29	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING MACHINES AND MEAL INCOME	1,229	28
28a	ESTATE BEQUEST	20,000	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 21,229	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,126,976	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	325,194	31
32	Health Care	590,533	32
33	General Administration	341,008	33
B. Capital Expense			
34	Ownership	51,949	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,308,684	40
41	Income before Income Taxes (line 30 minus line 40)**	(181,708)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (181,708)	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Prairie City Health Care Center

0045377

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	840	840	\$ 14,843	\$ 17.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,845	5,845	115,724	19.80	3
4	Licensed Practical Nurses	3,461	3,461	55,484	16.03	4
5	CNAs & Orderlies	26,345	26,345	194,836	7.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	2,040	20,167	9.89	9
10	Activity Assistants	2,321	2,321	19,757	8.51	10
11	Social Service Workers	2,000	2,080	25,089	12.06	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	21,266	10.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,740	9,740	66,572	6.83	15
16	Dishwashers					16
17	Maintenance Workers	1,306	1,306	11,607	8.89	17
18	Housekeepers	9,492	9,492	65,041	6.85	18
19	Laundry	1,482	1,482	11,344	7.65	19
20	Administrator	2,000	2,080	53,498	25.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,000	2,080	25,314	12.17	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>CARE PLAN COORDINATOR</u>		2,080	30,996	14.90	33
34	TOTAL (lines 1 - 33)	70,832	73,272	\$ 731,538 *	\$ 9.98	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	96	\$ 4,672	L1,C3	35
36	Medical Director				36
37	Medical Records Consultant	17	260	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	38	1,500	L10,C3	39
40	Physical Therapy Consultant		26,901	L10A,C3	40
41	Occupational Therapy Consultant		21,166	L10A,C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	1,064	L11,C3	44
45	Social Service Consultant	16	1,064	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	183	\$ 56,627		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center

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 NURSING HOME ADMIN. ASSN \$100
- (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? 7 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,025 Line 10
- (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. \$ 25,205
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. \$ N/A Has any meal income been offset against related costs? NO Indicate the amount. \$ N/A
- (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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
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? N/A
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: N/A 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie City Health Care Center
0045377
12/31/06
Detail Schedules

Part V, Schedule C, Line 27

General Administration - Other

Care Plan Coordinator	\$ 30,996
Pet expense	30
Bad debts	<u>32,767</u>
Total	<u>\$ 63,793</u>
Less unallowable costs reclassified	
Pet expense	
Bad debts	(30)
Total after reclassifications	<u>(32,797)</u>
	<u><u>\$ 30,966</u></u>

Part VI, Schedule C, Line 45

	Amount	Line
Beauty shop depreciation	\$ 82	30
Resident flowers	444	12
Charitable contributions	724	20
Promotional advertising	2,061	20
Special events	599	1
Bad Debts	32,767	27
Non-care auto depreciation	1,508	30
In-room cable TV	4,150	5
Sales tax	153	1
Service charges - vendors	683	20
Pet Expense	30	27
	<u><u>\$ 43,201</u></u>	

Part V, Schedule C, Line 36

Capital Expense - Other

General insurance	\$ 5,872
Auto insurance	<u>2,430</u>
Total per general ledger	<u>\$ 8,302</u>
Less insurance reclassified	<u>(8,302)</u>
Total after reclassifications	<u><u>\$ -</u></u>

SEE ACCOUNTANT'S COMPILATION REPORT

Prairie City Health Care Center
0045377
12/31/2006

Reconciliation to Taxable Income

Income (Loss) per Books	\$ (181,708)
Expenses recorded on books not deducted on return:	
Charitable Contributions	724
Revenue received not included in taxable income:	
Estate bequest not included in taxable income	<u>(20,000)</u>
Taxable Income (Loss)	<u><u>\$ (200,984)</u></u>

SEE ACCOUNTANT'S COMPILATION REPORT