



Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011 Report Period Beginning: 01/01/05 Ending: 12/31/05

## III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>146</u>	Skilled (SNF)	<u>146</u>	<u>53,290</u>	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	<u>146</u>	TOTALS	<u>146</u>	<u>53,290</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>26,851</u>	<u>411</u>	<u>14,828</u>	<u>42,090</u>	8
9	SNF/PED					9
10	ICF		<u>5,762</u>		<u>5,762</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,851</u>	<u>6,173</u>	<u>14,828</u>	<u>47,852</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.80%

D. How many bed-hold days during this year were paid by the Department?

None (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)

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

G. Do pages 3 &amp; 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 12/1/02

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

YES  Date 12/1/02 NO 

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

YES  NO  If YES, enter number of beds certified 146 and days of care provided 14,296Medicare Intermediary AdminaStar Federal, Inc.

## IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	206,264	48,060	14,837	269,161		269,161	(5,992)	263,169			1
2	Food Purchase		201,336		201,336		201,336	2,763	204,099			2
3	Housekeeping	161,641	37,460		199,101		199,101	(3,214)	195,887			3
4	Laundry	67,083	20,541		87,624		87,624	(14)	87,610			4
5	Heat and Other Utilities			214,467	214,467		214,467	1,892	216,359			5
6	Maintenance	83,607	41	247,814	331,462		331,462	(5,964)	325,498			6
7	Other (specify):*							16,550	16,550			7
8	<b>TOTAL General Services</b>	<b>518,595</b>	<b>307,438</b>	<b>477,118</b>	<b>1,303,151</b>		<b>1,303,151</b>	<b>6,021</b>	<b>1,309,172</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			27,000	27,000		27,000		27,000			9
10	Nursing and Medical Records	2,236,173	103,400	11,919	2,351,492		2,351,492	(9,229)	2,342,263			10
10a	Therapy	109,670		2,046	111,716		111,716	452	112,168			10a
11	Activities	114,474	4,789		119,263		119,263		119,263			11
12	Social Services	126,055		72	126,127		126,127		126,127			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							1,321	1,321			15
16	<b>TOTAL Health Care and Programs</b>	<b>2,586,372</b>	<b>108,189</b>	<b>41,037</b>	<b>2,735,598</b>		<b>2,735,598</b>	<b>(7,456)</b>	<b>2,728,142</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	104,046			104,046		104,046	28,207	132,253			17
18	Directors Fees											18
19	Professional Services			391,612	391,612		391,612	(157,885)	233,727			19
20	Dues, Fees, Subscriptions & Promotions			55,831	55,831		55,831	(34,296)	21,535			20
21	Clerical & General Office Expenses	76,000	26,791	324,472	427,263		427,263	(124,500)	302,763			21
22	Employee Benefits & Payroll Taxes			477,446	477,446		477,446	(18,571)	458,875			22
23	Inservice Training & Education			45	45		45		45			23
24	Travel and Seminar			127	127		127	4,011	4,138			24
25	Other Admin. Staff Transportation			2,457	2,457		2,457		2,457			25
26	Insurance-Prop.Liab.Malpractice			144,967	144,967		144,967	1,467	146,434			26
27	Other (specify):*							26,102	26,102			27
28	<b>TOTAL General Administration</b>	<b>180,046</b>	<b>26,791</b>	<b>1,396,957</b>	<b>1,603,794</b>		<b>1,603,794</b>	<b>(275,465)</b>	<b>1,328,329</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,285,013</b>	<b>442,418</b>	<b>1,915,112</b>	<b>5,642,543</b>		<b>5,642,543</b>	<b>(276,900)</b>	<b>5,365,643</b>			<b>29</b>

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

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 Manor Nursing & Rehab Center #0046011 Report Period Beginning: 01/01/05 Ending: 12/31/05

## 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			61,851	61,851	61,851	252,402	314,253				30
31	Amortization of Pre-Op. & Org.						7,979	7,979				31
32	Interest			254	254	254	244,472	244,726				32
33	Real Estate Taxes			454,227	454,227	454,227	1,555	455,782				33
34	Rent-Facility & Grounds			438,050	438,050	438,050	(430,684)	7,366				34
35	Rent-Equipment & Vehicles			7,363	7,363	7,363	1,333	8,696				35
36	Other (specify):*			2,664	2,664	2,664		2,664				36
37	<b>TOTAL Ownership</b>			964,409	964,409	964,409	77,057	1,041,466				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		524,756	1,688,672	2,213,428	2,213,428	(14,602)	2,198,826				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,935	79,935	79,935		79,935				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		524,756	1,768,607	2,293,363	2,293,363	(14,602)	2,278,761				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,285,013	967,174	4,648,128	8,900,315	8,900,315	(214,445)	8,685,870				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 Manor Nursing & Rehab Center

# 0046011

Report Period Beginning:

01/01/05

Ending:

12/31/05

**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	(16)	02		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	(8,977)	30		9
10	Interest and Other Investment Income	(82,757)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(256)	02		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	(15,486)	21		18
19	Entertainment				19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(125,064)	21		24
25	Fund Raising, Advertising and Promotional	(37,364)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(110,866)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (388,787)		\$	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)	174,342		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 174,342		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (214,445)		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

OHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1	Other Income	21
2	Item Don't Income	19
3	Theft Loss	21
4	Collection Expense	21
5	Building Co. - Misc. Expense	21
6	Capitalized R&M	6
7	Non-Allowable Expense	21
8	Non-Allowable Legal	19
9	Non-Allowable Professional Fees	19
10	Accrued Legal Fees	19
11		11
12		12
13		13
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94		94
95		95
96		96
97		97
98		98
99		99
100		100
101	Total	101

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011

Report Period Beginning:

01/01/05

Ending:

12/31/05**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			301		(1,900)	(4,364)			(29)			(5,992)	1
2	Food Purchase	(272)					3,035						2,763	2
3	Housekeeping									(3,214)			(3,214)	3
4	Laundry									(14)			(14)	4
5	Heat and Other Utilities			1,892									1,892	5
6	Maintenance	(14,396)		4,623		4,170	11			(372)			(5,964)	6
7	Other (specify):*				15,292	1,092	166						16,550	7
8	<b>TOTAL General Services</b>	<b>(14,668)</b>		<b>6,816</b>	<b>15,292</b>	<b>3,362</b>	<b>(1,152)</b>			<b>(3,628)</b>			<b>6,021</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(69)								(9,160)			(9,229)	10
10a	Therapy					452							452	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				1,259	62							1,321	15
16	<b>TOTAL Health Care and Programs</b>	<b>(69)</b>			<b>1,259</b>	<b>514</b>				<b>(9,160)</b>			<b>(7,456)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			3,100		25,027	80						28,207	17
18	Directors Fees													18
19	Professional Services	33,674		(191,561)			2						(157,885)	19
20	Fees, Subscriptions & Promotions	(38,364)		4,066			2						(34,296)	20
21	Clerical & General Office Expenses	(277,625)	987	15,112		136,842	184						(124,500)	21
22	Employee Benefits & Payroll Taxes				(18,571)								(18,571)	22
23	Inservice Training & Education													23
24	Travel and Seminar			3,947			64						4,011	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,410			57						1,467	26
27	Other (specify):*				2,878	23,224							26,102	27
28	<b>TOTAL General Administration</b>	<b>(282,315)</b>	<b>987</b>	<b>(163,926)</b>	<b>(15,693)</b>	<b>185,093</b>	<b>389</b>						<b>(275,465)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(297,052)</b>	<b>987</b>	<b>(157,110)</b>	<b>858</b>	<b>188,969</b>	<b>(763)</b>			<b>(12,788)</b>			<b>(276,900)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning:

01/01/05 Ending:

12/31/05

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(8,977)	239,218	19,705			31	2,425					252,402	30
31	Amortization of Pre-Op. & Org.		7,979										7,979	31
32	Interest	(82,757)	322,978	3,290			103	858					244,472	32
33	Real Estate Taxes			1,555									1,555	33
34	Rent-Facility & Grounds		(438,050)	7,366									(430,684)	34
35	Rent-Equipment & Vehicles			1,327			6						1,333	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(91,734)</b>	<b>132,125</b>	<b>33,243</b>			<b>140</b>	<b>3,283</b>					<b>77,057</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(259)	(7,285)		(7,058)			(14,602)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>						<b>(259)</b>	<b>(7,285)</b>		<b>(7,058)</b>			<b>(14,602)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(388,787)</b>	<b>133,112</b>	<b>(123,867)</b>	<b>858</b>	<b>188,969</b>	<b>(882)</b>	<b>(4,002)</b>		<b>(19,846)</b>			<b>(214,445)</b>	<b>45</b>

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning:

01/01/05

Ending:

12/31/05

**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
See Attached		See Attached		See Attached		
				Prairie Manor Healthcare Properties		Building Co.

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	34 Rent	\$ 438,050	Prairie Manor Healthcare Properties		\$	\$ (438,050)	1
2	V	32 Interest	199			323,177	322,978	2
3	V	21 Misc. Admin. Expenses				987	987	3
4	V	30 Depreciation				239,218	239,218	4
5	V	31 Amortization				7,979	7,979	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		\$ 438,249			\$ 571,361	\$ * 133,112	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/05Ending: 12/31/05

## VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary	\$	Care Centers, Inc.	100.00%	\$ 301	\$ 301	15	
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,892	1,892	16	
17	V	06	Maintenance		Care Centers, Inc.	100.00%	4,623	4,623	17	
18	V				Care Centers, Inc.	100.00%			18	
19	V	17	Administration		Care Centers, Inc.	100.00%	3,100	3,100	19	
20	V	19	Professional Fees	208,920	Care Centers, Inc.	100.00%	17,359	(191,561)	20	
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	4,066	4,066	21	
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	15,112	15,112	22	
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	3,947	3,947	23	
24	V	26	Insurance		Care Centers, Inc.	100.00%	1,410	1,410	24	
25	V	30	Depreciation		Care Centers, Inc.	100.00%	19,705	19,705	25	
26	V	32	Interest		Care Centers, Inc.	100.00%	3,290	3,290	26	
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,555	1,555	27	
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	7,366	7,366	28	
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,327	1,327	29	
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			30	
31	V	02	Food		Care Centers, Inc.	100.00%			31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 208,920			\$ 85,053	\$ * (123,867)	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/05Ending: 12/31/05

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06 Maintenance Salary	\$ 98,322	Care Centers, Inc.	100.00%	\$ 98,322		15
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	15,292	15,292	16
17	V	10 Nursing Salary	8,352	Care Centers, Inc.	100.00%	8,352		17
18	V	10a Rehab Salary	129	Care Centers, Inc.	100.00%	129		18
19	V							19
20	V							20
21	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,259	1,259	21
22	V	17 Administration Salary		Care Centers, Inc.	100.00%			22
23	V	21 Office Salary	18,152	Care Centers, Inc.	100.00%	18,152		23
24	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	2,878	2,878	24
25	V	22 Employee Benefits	18,571	Care Centers, Inc.	100.00%		(18,571)	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 143,526			\$ 144,384	\$ * 858	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary Salary	\$ 5,328	Care Centers, Inc.	100.00%	\$ 3,428	\$ (1,900)	15
16	V							16
17	V	06 Maintenance Salary		Care Centers, Inc.	100.00%	4,170	4,170	17
18	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,092	1,092	18
19	V							19
20	V	10a Rehab Salary		Care Centers, Inc.	100.00%	452	452	20
21	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	62	62	21
22	V							22
23	V	17 Administration Salary		Care Centers, Inc.	100.00%	25,027	25,027	23
24	V	21 Office Salary		Care Centers, Inc.	100.00%	136,842	136,842	24
25	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	23,224	23,224	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 5,328			\$ 194,297	\$ * 188,969	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/05Ending: 12/31/05

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$ 5,769	Care Centers, Inc. - Health Systems Division	100.00%	\$ 313	\$ (5,456)	15
16	V	02 Food		Care Centers, Inc. - Health Systems Division	100.00%	3,035	3,035	16
17	V	06 Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	11	11	17
18	V	17 Administration		Care Centers, Inc. - Health Systems Division	100.00%	80	80	18
19	V	19 Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	2	2	19
20	V	20 Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	2	2	20
21	V	21 Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	184	184	21
22	V	24 Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	64	64	22
23	V	26 Insurance		Care Centers, Inc. - Health Systems Division	100.00%	57	57	23
24	V	30 Depreciaton		Care Centers, Inc. - Health Systems Division	100.00%	31	31	24
25	V	32 Interest		Care Centers, Inc. - Health Systems Division	100.00%	103	103	25
26	V	35 Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	6	6	26
27	V	39 Ancillary Enteral Supplies	547	Care Centers, Inc. - Health Systems Division	100.00%	288	(259)	27
28	V	01 Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	1,092	1,092	28
29	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	166	166	29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 6,316			\$ 5,434	\$ * (882)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30 Depreciation	\$	Vent Lease, LLC.	100.00%	\$ 2,425	\$ 2,425	15
16	V	32 Interest		Vent Lease, LLC.	100.00%	858	858	16
17	V	39 Vent Reimbursement	7,285	Vent Lease, LLC.	100.00%		(7,285)	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 7,285			\$ 3,283	\$ * (4,002)	39

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning: 01/01/05

Ending: 12/31/05

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 119,243	\$ 119,243	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	119,243	CCS EMPLOYEE BENEFIT GROUP	100.00%		(119,243)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 119,243			\$ 119,243	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/05Ending: 12/31/05

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01 DIETARY	\$ 291	XCEL MEDICAL SUPPLY, LLC	100.00%	\$ 263	\$	(29)	15
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%				16
17	V	03 HOUSEKEEPING	32,418	XCEL MEDICAL SUPPLY, LLC	100.00%	29,204		(3,214)	17
18	V	04 LAUNDRY	141	XCEL MEDICAL SUPPLY, LLC	100.00%	127		(14)	18
19	V	06 REPAIRS & MAINTENANCE	3,748	XCEL MEDICAL SUPPLY, LLC	100.00%	3,376		(372)	19
20	V	10 NURSING	92,394	XCEL MEDICAL SUPPLY, LLC	100.00%	83,234		(9,160)	20
21	V	11 ACTIVITIES		XCEL MEDICAL SUPPLY, LLC	100.00%				21
22	V	20 DUES, FEES, SUBSCRIPTIONS & PROM		XCEL MEDICAL SUPPLY, LLC	100.00%				22
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%				23
24	V	22 EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%				24
25	V	39 ANCILLARY	71,192	XCEL MEDICAL SUPPLY, LLC	100.00%	64,134		(7,058)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 200,184			\$ 180,337	\$ *	(19,846)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning: 01/01/05

Ending: 12/31/05

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning: 01/01/05

Ending: 12/31/05

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/05 Ending: 12/31/05

## 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	Eric Rothner	Owner	Administrative	1.00%	See Attached	1.01	2.19%	Alloc Salary	\$ 2,442	17-7	1
2	Gale Rothner	Relative	Administrative	0.00%	See Attached	1.12	3.20%	Alloc Salary	2,493	17-7	2
3	Mark Steinberg	Relative	Administrative	0.00%	See Attached	1.76	3.20%	Alloc Salary	2,351	17-7	3
4	Adam Vales	Relative	Clerical	0.00%	See Attached	0.79	1.98%	Alloc Salary	972	22-7	4
5	Kimberly Rudolph	Relative	Clerical	0.00%	See Attached	0.75	2.14%	Alloc Salary	1,080	22-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,338		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 Manor Nursing & Rehab Center

# 0046011

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Care Centers, Inc.  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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	01	Dietary	Patient Days	1,497,287	32	\$ 9,406	\$ 47,852	\$ 301	1
2	05	Utilities	Patient Days	1,497,287	32	59,188	47,852	1,892	2
3	06	Maintenance	Patient Days	1,497,287	32	144,661	47,852	4,623	3
4									4
5	17	Administration	Patient Days	1,497,287	32	97,000	47,852	3,100	5
6	19	Professional Fees	Patient Days	1,497,287	32	543,148	47,852	17,359	6
7	20	Dues and Subscriptions	Patient Days	1,497,287	32	127,217	47,852	4,066	7
8	21	Office & Clerical	Patient Days	1,497,287	32	472,845	47,852	15,112	8
9	24	Travel and Seminar	Patient Days	1,497,287	32	123,511	47,852	3,947	9
10	26	Insurance	Patient Days	1,497,287	32	44,126	47,852	1,410	10
11	30	Depreciation	Patient Days	1,497,287	32	616,575	47,852	19,705	11
12	32	Interest	Patient Days	1,497,287	32	102,930	47,852	3,290	12
13	33	Real Estate Taxes	Patient Days	1,497,287	32	48,662	47,852	1,555	13
14	34	Rent - Building	Patient Days	1,497,287	32	230,488	47,852	7,366	14
15	35	Rent - Equipment & Auto	Patient Days	1,497,287	32	41,530	47,852	1,327	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,661,288	\$	\$ 85,053	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Care Centers, Inc.  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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	06	Maintenance Salary	Direct Cost		301,710	301,710		98,322	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost		46,639			15,292	2
3	10	Nursing Salary	Direct Cost		425,833	425,833		8,352	3
4	10a	Rehab Salary	Direct Cost		55,464	55,464		129	4
5									5
6									6
7	15	Emp. Ben. - Healthcare	Direct Cost		67,757			1,259	7
8	17	Administration Salary	Direct Cost		5,566	5,566			8
9	21	Office Salary	Direct Cost		419,879	419,879		18,152	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost		71,906			2,878	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				\$ 1,394,755	\$ 1,208,453		\$ 144,384	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Care Centers, Inc.  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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	01	Dietary Salary	Patient Days	1,497,287	32	107,276	107,276	47,852	3,428	1
2										2
3	06	Maintenance Salary	Patient Days	1,497,287	32	130,484	130,484	47,852	4,170	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,497,287	32	34,158		47,852	1,092	4
5										5
6	10a	Rehab Salary	Patient Days	1,497,287	32	14,139	14,139	47,852	452	6
7	15	Emp. Ben. - Healthcare	Patient Days	1,497,287	32	1,933		47,852	62	7
8										8
9	17	Administration Salary	Patient Days	1,497,287	32	783,083	783,083	47,852	25,027	9
10	21	Office Salary	Patient Days	1,497,287	32	4,281,771	4,281,771	47,852	136,842	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,497,287	32	726,674		47,852	23,224	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					\$ 6,079,517	\$ 5,316,753		\$ 194,297	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Care Centers, Inc.  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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	01	Dietary	Billable Income	928,452		46,000	6,316	313	1
2	02	Food	Income			160,931		3,035	2
3	06	Maintenance	Billable Income	928,452		1,614	6,316	11	3
4	17	Administration	Billable Income	928,452		11,797	6,316	80	4
5	19	Professional Fees	Billable Income	928,452		262	6,316	2	5
6	20	Dues & Subscriptions	Billable Income	928,452		342	6,316	2	6
7	21	Office & Clerical	Billable Income	928,452		27,087	6,316	184	7
8	24	Travel & Seminar	Billable Income	928,452		9,381	6,316	64	8
9	26	Insurance	Billable Income	928,452		8,379	6,316	57	9
10	30	Depreciaton	Billable Income	928,452		4,499	6,316	31	10
11	32	Interest	Billable Income	928,452		15,077	6,316	103	11
12	35	Rent - Equipment & Auto	Billable Income	928,452		843	6,316	6	12
13	39	Ancillary Enteral Supplies	Income			327,517		288	13
14	01	Dietary - Salary	Billable Income	928,452		160,568	160,568	1,092	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	928,452		24,382	6,316	166	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 798,679	\$ 160,568	\$ 5,434	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Vent Lease, LLC  
 Street Address 2201 W. Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 674-1180  
 Fax Number ( 847) 673-7741

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Direct Billing	593,410	29	\$ 197,493	\$ 7,285	\$ 2,425	1
2	32	Interest	Direct Billing	593,410	29	69,863	7,285	858	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					\$ 267,356	\$	\$ 3,283	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.  
 Street Address 4101 W. MAIN ST.  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

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	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 119,243	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				\$	\$		\$ 119,243	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization XCEL MEDICAL SUPPLY, LLC  
 Street Address 2201 W. MAIN STREET  
 City / State / Zip Code EVANSTON, IL 60202  
 Phone Number ( 847)328-7600  
 Fax Number ( 847)328-7615

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	01	DIETARY	Direct Allocation		\$	\$		\$ 263	1
2	02	FOOD	Direct Allocation						2
3	03	HOUSEKEEPING	Direct Allocation					29,204	3
4	04	LAUNDRY	Direct Allocation					127	4
5	06	REPAIRS & MAINTENANCE	Direct Allocation					3,376	5
6	10	NURSING	Direct Allocation					83,234	6
7	11	ACTIVITIES	Direct Allocation						7
8	20	DUES, FEES, SUBSCRIPTIONS	Direct Allocation						8
9	21	CLERICAL & GENERAL OFFICE	Direct Allocation						9
10	22	EMPLOYEE BENEFITS	Direct Allocation						10
11	39	ANCILLARY	Direct Allocation					64,134	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				\$	\$		\$ 180,337	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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	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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	First Choice		X	1st Mortgage			\$	\$ 4,739,689			\$ 311,348	1
2	First Choice		X	2nd Mortgage				174,000			11,829	2
3												3
4												4
5	See Supplemental Schedule											5
	<b>Working Capital</b>											
6	Diawa		X	Line of Credit							211	6
7	Patient Trust Fund										43	7
8	See Supplemental Schedule										4,251	8
9	TOTAL Facility Related						\$	\$ 4,913,689			\$ 327,682	9
	<b>B. Non-Facility Related*</b>											
10	Interest Income										(82,757)	10
11	Interest Income (Bldg Co)										(199)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			(82,956)	14
15	TOTALS (line 9+line14)						\$	\$ 4,913,689			\$ 244,726	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #           

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

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.)

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/05 Ending: 12/31/05

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense
		YES	NO				Original	Balance			
	<b>A. Directly Facility Related</b>										
	<b>Long-Term</b>										
1							\$	\$			\$
2											
3											
4											
5											
6											
7	<b>TOTAL Long-Term</b>										
	<b>Working Capital</b>										
8	<b>Alloc from Vent Lease</b>		X				\$	\$			\$ 858
9	<b>Alloc from Care Centers</b>		X								3,393
10											
11											
12											
13											
14	<b>TOTAL Working Capital</b>										4,251
	<b>B. Non-Facility Related*</b>										
15							\$	\$			\$
16											
17											
18											
19											
20	<b>TOTAL Non-Facility Related</b>										

\* 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:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 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.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Prairie Manor Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046011

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

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

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(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>32-17-131-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>441,315.92</u>	\$ <u>441,315.92</u>
2. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>113,458.70</u>	\$ <u>1,555.21</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>554,774.62</u>	\$ <u>442,871.13</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? X YES        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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 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.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Prairie Manor Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046011

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

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

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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        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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior \_\_\_\_\_ Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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: 39,968 2. Number of Years Over Which it is Being Amortized: 5 yrs  
3. Current Period Amortization: 7,979 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: Financing & Organization Fees

(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	<u>Facility</u>		<u>2002</u>	<u>\$ 450,000</u>	1
2	<u>2201 Main LLC allocation</u>		<u>2002</u>	<u>11,240</u>	2
3	<b>TOTALS</b>			<b>\$ 461,240</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning:

01/01/05

Ending:

12/31/05

**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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
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

\*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 Manor Nursing & Rehab Center

# 0046011

Report Period Beginning:

01/01/05

Ending:

12/31/05

**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		4,650,000	122,290		121,667	(623)	403,634	67
68		44,112	1,808		1,808		5,448	68
69			61,851			(61,851)		69
70		\$ 4,694,112	\$ 185,949		\$ 123,475	\$ (62,474)	\$ 409,082	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Prairie Manor Nursing &amp; Rehab Center

# 0046011

Report Period Beginning:

01/01/05

Ending:

12/31/05

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,694,112	\$ 185,949		\$ 123,475	\$ (62,474)	\$ 409,082	1
2	Electrical Repairs	2003	5,460		20	273	273	728	2
3	Plumbing	2003	2,163		20	108	108	270	3
4	Painting Supplies	2003	1,318		20	66	66	154	4
5	Plumbing	2003	2,299		20	115	115	268	5
6	Painting	2003	922		20	46	46	104	6
7	Painting	2003	938		20	47	47	106	7
8	Electrical Work	2003	996		20	50	50	112	8
9	Generator Repair	2003	710		20	142	142	379	9
10	Tuckpointing	2003	950		20	190	190	475	10
11	Door Frames & Hinges	2003	1,580		20	316	316	790	11
12	Painting & Decorating	2003	658		20	33	33	69	12
13	Painting & Decorating	2003	1,043		20	52	52	109	13
14	Painting & Decorating	2003	745		20	37	37	78	14
15	Painting & Decorating	2003	862		20	43	43	90	15
16	Painting & Decorating	2003	917		20	46	46	95	16
17	Dialysis Room Construction	2004	12,155		20	608	608	1,216	17
18	Vinyl Flooring	2004	20,559		20	1,371	1,371	2,741	18
19	Install New Phone Line	2004	842		20	84	84	161	19
20	Hvac Work	2004	1,211		20	242	242	444	20
21	New Windows	2004	558		20	112	112	205	21
22	Svc On Fire Alarm System	2004	953		20	136	136	250	22
23	Roof Repairs	2004	4,800		20	240	240	420	23
24	Elevator Service	2004	5,910		20	296	296	493	24
25	Install New Tile -1St Floor	2004	18,570		20	929	929	1,470	25
26	Install New Tile -3Rd Floor	2004	18,570		20	929	929	1,470	26
27	Replace Fire Doors	2004	10,400		20	520	520	823	27
28	Automatic Entrance Doors	2004	4,485		20	224	224	355	28
29	Generator Maintenance	2004	1,819		20	260	260	411	29
30	Remove Carpeting, Install Tile	2004	19,282		20	964	964	1,366	30
31	Window, Hardware, Tools	2004	3,799		20	190	190	269	31
32	Locking System And Keypads	2004	6,956		20	348	348	493	32
33	Electro-Mech Door Closer	2004	7,197		20	1,439	1,439	2,039	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,853,739	\$ 185,949		\$ 133,931	\$ (52,018)	\$ 427,535	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Prairie Manor Nursing &amp; Rehab Center

# 0046011

Report Period Beginning:

01/01/05

Ending:

12/31/05

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 4,853,739	\$ 185,949		\$ 133,931	\$ (52,018)	\$ 427,535	1
2	Analog Module Phone System	2004	7,698		20	1,540	1,540	2,053	2
3	Repair Pot Holes, Reseal	2004	5,025		20	251	251	335	3
4	Repair Generator	2004	2,525		20	126	126	168	4
5	Home Depot- Hardware	2004	3,892		20	195	195	243	5
6	Locking System And Keypads	2004	6,956		20	1,391	1,391	1,739	6
7	Casework And Tops	2004	6,570		20	329	329	411	7
8	Plastic Nameplates	2004	4,399		20	220	220	275	8
9	Heat Startup	2004	2,289		20	114	114	143	9
10	Construction On Room 346	2004	15,467		20	773	773	902	10
11	Carpeting For Admissions Office	2004	916		20	46	46	50	11
12	Bumpers For Resident Walls	2004	6,411		20	321	321	347	12
13	Double Egress Doors	2004	8,987		20	449	449	487	13
14	Single Door Replacement	2004	2,480		20	124	124	134	14
15	Replacement Valve	2004	2,683		20	134	134	268	15
16	Boiler Flow Switch	2004	1,064		20	53	53	102	16
17	Painting & Decorating	2004	2,194		20	110	110	183	17
18	Painting & Decorating	2004	2,789		20	139	139	232	18
19	Repair Leak Behind Dishwasher	2004	1,679		20	84	84	119	19
20	Painting & Decorating	2004	1,381		20	69	69	98	20
21	Painting & Decorating	2004	1,719		20	86	86	115	21
22	Painting & Decorating	2004	887		20	44	44	59	22
23	Painting & Decorating	2004	750		20	38	38	47	23
24	Painting & Decorating	2004	581		20	29	29	31	24
25	Tuckpointing	2005	6,865		20	343	343	343	25
26	Pedestrian Door	2005	2,645		20	110	110	110	26
27	Blinds	2005	3,915		20	718	718	718	27
28	Bumper Guards	2005	3,265		20	599	599	599	28
29	Items For Electric Door Opener	2005	3,035		20	126	126	126	29
30	Exit Device For Door	2005	2,975		20	496	496	496	30
31	44 Cubicle Curtains	2005	5,067		20	845	845	845	31
32	45 Cubicle Curtains	2005	5,067		20	845	845	845	32
33	Midwest Mechanical Group	2005	3,663		20	137	137	137	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,979,578	\$ 185,949		\$ 144,815	\$ (41,134)	\$ 440,295	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning:

01/01/05

Ending:

12/31/05

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 4,979,578	\$ 185,949		\$ 144,815	\$ (41,134)	\$ 440,295	1
2	Bumper Guards & End Caps	2005	9,884		20	1,483	1,483	1,483	2
3	Installation Of Handrails	2005	9,980		20	1,164	1,164	1,164	3
4	38 Kickplates"	2005	6,072		20	708	708	708	4
5	Installation Of Blinds	2005	3,335		20	97	97	97	5
6	Installation Of Blinds	2005	3,915		20	114	114	114	6
7	Installed Receptacles For Tv'S	2005	2,870		20	72	72	72	7
8	Basedoard Materials	2005	3,816		20	95	95	95	8
9	Excavated Grass & Laid Down Asphalt	2005	7,980		20	133	133	133	9
10	Tiling	2005	5,819		20	97	97	97	10
11	Draperies	2005	2,340		20	49	49	49	11
12	Electrical Work	2005	1,800		20	15	15	15	12
13	Asphalt Paving	2005	2,160		20	18	18	18	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,039,549	\$ 185,949		\$ 148,860	\$ (37,089)	\$ 444,340	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12D, Carried Forward</b>		\$ <b>5,039,549</b>	\$ <b>185,949</b>		\$ <b>148,860</b>	\$ <b>(37,089)</b>	\$ <b>444,340</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>5,039,549</b>	\$ <b>185,949</b>		\$ <b>148,860</b>	\$ <b>(37,089)</b>	\$ <b>444,340</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Prairie Manor Nursing & Rehab Center**

# **0046011**

Report Period Beginning:

**01/01/05**

Ending:

**12/31/05**

**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	
1		\$ 5,039,549	\$ 185,949		\$ 148,860	\$ (37,089)	\$ 444,340	1
2								2
3								3
4								4
5								5
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8								8
9								9
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12								12
13								13
14								14
15								15
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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)	\$ 5,039,549	\$ 185,949		\$ 148,860	\$ (37,089)	\$ 444,340	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12F, Carried Forward</b>		\$ <b>5,039,549</b>	\$ <b>185,949</b>		\$ <b>148,860</b>	\$ <b>(37,089)</b>	\$ <b>444,340</b>	1
2									2
3									3
4									4
5									5
6									6
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27									27
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30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>5,039,549</b>	\$ <b>185,949</b>		\$ <b>148,860</b>	\$ <b>(37,089)</b>	\$ <b>444,340</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Prairie Manor Nursing & Rehab Center**

# **0046011**

Report Period Beginning:

**01/01/05**

Ending:

**12/31/05**

**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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12G, Carried Forward</b>		\$ <b>5,039,549</b>	\$ <b>185,949</b>		\$ <b>148,860</b>	\$ <b>(37,089)</b>	\$ <b>444,340</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
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9									9
10									10
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26									26
27									27
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29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>5,039,549</b>	\$ <b>185,949</b>		\$ <b>148,860</b>	\$ <b>(37,089)</b>	\$ <b>444,340</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Prairie Manor Nursing & Rehab Center**

# **0046011**

Report Period Beginning:

**01/01/05**

Ending:

**12/31/05**

**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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12H, Carried Forward</b>		\$ <b>5,039,549</b>	\$ <b>185,949</b>		\$ <b>148,860</b>	\$ <b>(37,089)</b>	\$ <b>444,340</b>	1
2									2
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>5,039,549</b>	\$ <b>185,949</b>		\$ <b>148,860</b>	\$ <b>(37,089)</b>	\$ <b>444,340</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Prairie Manor Nursing & Rehab Center**

# **0046011**

Report Period Beginning:

**01/01/05**

Ending:

**12/31/05**

**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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12I, Carried Forward</b>		\$ <b>5,039,549</b>	\$ <b>185,949</b>		\$ <b>148,860</b>	\$ <b>(37,089)</b>	\$ <b>444,340</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>5,039,549</b>	\$ <b>185,949</b>		\$ <b>148,860</b>	\$ <b>(37,089)</b>	\$ <b>444,340</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 5,039,549	\$ 185,949		\$ 148,860	\$ (37,089)	\$ 444,340	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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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)	\$ 5,039,549	\$ 185,949		\$ 148,860	\$ (37,089)	\$ 444,340	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning:

01/01/05

Ending:

12/31/05

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF 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	146		2002	1988	\$ 4,550,000	\$ 116,667	39	\$ 116,667	\$ (0)	\$ 354,861	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	Site Improvements		2002		100,000	5,623	20	5,000	(623)	48,773	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
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning:

01/01/05

Ending:

12/31/05

**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
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56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70
		4,650,000	122,290		121,667	(623)	403,634	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning:

01/01/05

Ending:

12/31/05

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF 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			2002	2002	\$ 15,489	\$ 397	39	\$ 397	\$	\$ 1,307	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9		Allocation from 2201 Main LLC		2002	12,795	640	20	640		2,239	9
10		Allocation from 2201 Main LLC		2003	15,079	754	20	754		1,885	10
11		Allocation from 2201 Main LLC		2005	749	17	20	17		17	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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21											21
22											22
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25											25
26											26
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning:

01/01/05

Ending:

12/31/05

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	<b>TOTAL (lines 4 thru 69)</b>	\$	44,112	\$	1,808	\$	1,808	\$	5,448	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 Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	\$ 1,377,084	\$ 135,387	\$ 152,151	\$ 16,764	10	\$ 1,113,620	71
72	Current Year Purchases	84,523	313	11,661	11,348	10	11,661	72
73	Fully Depreciated Assets	27,084				10	27,084	73
74								74
75	TOTALS	\$ 1,488,691	\$ 135,700	\$ 163,812	\$ 28,112		\$ 1,152,365	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		Care Centers Allocation		\$ 21,581	\$ 1,581	\$ 1,581		5	\$ 16,342	76
77										77
78										78
79										79
80	TOTALS			\$ 21,581	\$ 1,581	\$ 1,581			\$ 16,342	80

E. Summary of Care-Related Assets

	1 Description	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)	\$ 7,011,061	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 323,230	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 314,253	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,977)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,613,047	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

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

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:				\$			3
4	Additions							4
5								5
6	Allocation from Care Centers				7,366			6
7	TOTAL				\$ 7,366			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.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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: \$ 8,696 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

\* 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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 700,448	\$		\$ 700,448	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			123,346			123,346	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			812,397			812,397	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				371,420		371,420	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <a href="#">See Supplemental</a>					52,481	153,336		205,817	13
14	<b>TOTAL</b>			\$		\$ 1,688,672	\$ 524,756		\$ 2,213,428	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 Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/05

Ending:

12/31/05

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 57,304	\$ 147,458	1
2	Cash-Patient Deposits	35,264	35,264	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,726,379	1,726,379	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	202,641	202,641	6
7	Other Prepaid Expenses	3,278	3,278	7
8	Accounts Receivable (owners or related parties)	437,988		8
9	Other(specify): <u>See Attached Schedule</u>	1,398,185	1,509,454	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,861,039	\$ 3,624,474	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		450,000	13
14	Buildings, at Historical Cost		4,550,000	14
15	Leasehold Improvements, at Historical Cost	230,721	330,721	15
16	Equipment, at Historical Cost	274,036	1,474,036	16
17	Accumulated Depreciation (book methods)	(117,510)	(1,546,376)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		39,968	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(22,283)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 387,247	\$ 5,276,066	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,248,286	\$ 8,900,540	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,699,411	\$ 1,699,411	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,959	23,959	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	178,554	178,554	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,387	6,387	31
32	Accrued Real Estate Taxes(Sch.IX-B)	463,382	463,382	32
33	Accrued Interest Payable		27,103	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	19,003	980,554	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,390,696	\$ 3,379,350	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,913,689	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 4,913,689	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,390,696	\$ 8,293,039	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,857,590	\$ 607,501	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,248,286	\$ 8,900,540	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 870,054	1
2	Restatements (describe):		2
3	<u>Bad Debt</u>	(216,762)	3
4	<u>Depreciation</u>	(3,062)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 650,230	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,307,360	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	(100,000)	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)	\$ 1,207,360	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,857,590	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/05Ending: 12/31/05**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,774,519	1
2	Discounts and Allowances for all Levels	(5,497,478)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,277,041	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,195,710	6
7	Oxygen	16,569	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 5,212,279	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	2,956	13
14	Non-Patient Meals	16	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	363,948	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	79,492	19
20	Radiology and X-Ray		20
21	Other Medical Services	149,709	21
22	Laundry	36,585	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 632,706	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	82,757	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 82,757	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	2,892	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,892	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,207,675	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,303,151	31
32	Health Care	2,735,598	32
33	General Administration	1,603,794	33
<b>B. Capital Expense</b>			
34	Ownership	964,409	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,213,428	35
36	Provider Participation Fee	79,935	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,900,315	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,307,360	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,307,360	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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 Manor Nursing & Rehab Center

# 0046011

Report Period Beginning:

01/01/05

Ending:

12/31/05

**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	2,142	2,247	\$ 76,483	\$ 34.04	1
2	Assistant Director of Nursing	1,237	1,371	36,768	26.82	2
3	Registered Nurses	18,712	20,591	502,695	24.41	3
4	Licensed Practical Nurses	29,179	32,253	678,677	21.04	4
5	CNAs & Orderlies	95,610	104,728	914,372	8.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,763	8,756	109,670	12.53	8
9	Activity Director	1,527	1,596	25,589	16.03	9
10	Activity Assistants	10,323	11,558	88,885	7.69	10
11	Social Service Workers	7,354	8,264	126,055	15.25	11
12	Dietician	234	272	3,536	13.00	12
13	Food Service Supervisor	1,734	1,892	32,307	17.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,577	19,246	170,421	8.85	15
16	Dishwashers					16
17	Maintenance Workers	5,374	5,932	83,607	14.09	17
18	Housekeepers	18,087	20,460	161,641	7.90	18
19	Laundry	8,126	9,122	67,083	7.35	19
20	Administrator	1,958	2,137	91,006	42.59	20
21	Assistant Administrator	650	678	13,040	19.23	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,096	4,734	76,000	16.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,935	2,194	27,178	12.39	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	233,618	258,031	\$ 3,285,013 *	\$ 12.73	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	\$ 9,509	01-03	35
36	Medical Director	monthly	27,000	09-03	36
37	Medical Records Consultant	monthly	888	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	2,679	10-03	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
45	Social Service Consultant	2	72	12-03	45
46	Other(specify)				46
47	<u>Therapy Program Set-Up</u>	N/A	1,917	10A-3	47
48	<u>CCI - See Attached</u>		13,809	various	48
49	TOTAL (lines 35 - 48)	211	\$ 55,874		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

# 0046011

Report Period Beginning: 01/01/05

Ending: 12/31/05

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount			
Kay Ross	Administrator	0	\$ 91,006	Workers' Compensation Insurance	\$ 70,022	IDPH License Fee	\$ 1,235			
Charles Slagle	Asst. Admin.	0	13,040	Unemployment Compensation Insurance	69,790	Advertising: Employee Recruitment	7,346			
				FICA Taxes	248,108	Health Care Worker Background Check	3,806			
				Employee Health Insurance	61,817	(Indicate # of checks performed <u>171</u> )				
				Employee Meals		Dues & Subscriptions	4,065			
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	1,015			
				Other Employee Welfare	5,703	Advertising & Promotion	37,364			
				Holiday Expense	3,435	Allocated from Care Centers	4,068			
TOTAL (agree to Schedule V, line 17, col. 1)										
(List each licensed administrator separately.)			\$ 104,046							
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description	Amount			Description	Line #	Amount	Description	Amount		
	\$					\$	Out-of-State Travel	\$		
							In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 458,875	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 21,535
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount		
Care Centers, Inc.	Accounting	\$ 15,000				\$	Out-of-State Travel	\$		
Care Centers, Inc.	Data Processing	5,256								
Care Centers, Inc.	Other Professional Fees	5,400								
Care Centers, Inc.	Bookkeeping	29,784					In-State Travel			
Care Centers, Inc.	Home Office Expense	122,640								
Care Centers, Inc.	Ancillary Admin Services	17,520								
Care Centers, Inc.	Legal	13,320								
Frost, Ruttenberg & Rothblatt	Accounting	9,996					Seminar Expense	127		
Personnel Planners	Unemployment Consult	3,390					Allocated from Care Centers	4,011		
ADP, Inc.	Payroll	14,182								
Keane Care	Data Processing	4,848								
See Supplemental Schedule		150,276					Entertainment Expense	( )		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 4,138
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 391,612							

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**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 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Prairie Manor Nursing &amp; Rehab 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. ICLTC \$3495
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,001 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. \_\_\_\_\_
- (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. \$ 79,935  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 16
- (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? None  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**