

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

0042671 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>74</u>	Skilled (SNF)	<u>74</u>	<u>27,010</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>52</u>	Intermediate (ICF)	<u>52</u>	<u>18,980</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>126</u>	TOTALS	<u>126</u>	<u>45,990</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>853</u>		<u>3,016</u>	<u>3,869</u>	8
9	SNF/PED					9
10	ICF	<u>22,000</u>	<u>2,390</u>		<u>24,390</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,853</u>	<u>2,390</u>	<u>3,016</u>	<u>28,259</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.45%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 05/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES Date 05/01/97 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 18 and days of care provided 3,016

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number **PRAIRIE VILLAGE HEALTHCARE CENT** # **0042671** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	118,694	18,139	8,343	145,176		145,176	0	145,176		1
2	Food Purchase		115,473		115,473	(13,140)	102,333	(515)	101,818		2
3	Housekeeping	88,304	30,153	0	118,457		118,457	0	118,457		3
4	Laundry	39,747	12,788	405	52,940	0	52,940	0	52,940		4
5	Heat and Other Utilities			100,460	100,460		100,460	21	100,481		5
6	Maintenance	42,812	37,008	15,790	95,610		95,610	3,419	99,029		6
7	Other (specify):*			12,585	12,585		12,585	10	12,595		7
8	TOTAL General Services	289,557	213,561	137,583	640,701	(13,140)	627,561	2,935	630,496		8
	B. Health Care and Programs										
9	Medical Director	0		6,000	6,000		6,000	0	6,000		9
10	Nursing and Medical Records	885,762	52,223	8,382	946,367		946,367	25,238	971,605		10
10a	Therapy	108,413	25,713	102,835	236,961		236,961	(10,715)	226,246		10a
11	Activities	32,801	6,134	0	38,935		38,935	0	38,935		11
12	Social Services	23,493		5,151	28,644		28,644	0	28,644		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			2,539	2,539		2,539	0	2,539		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	1,050,469	84,070	124,907	1,259,446	0	1,259,446	14,523	1,273,969		16
	C. General Administration										
17	Administrative	70,272		0	70,272		70,272	56,952	127,224		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			204,060	204,060		204,060	(140,606)	63,454		19
20	Dues, Fees, Subscriptions & Promotions			31,600	31,600		31,600	(23,818)	7,782		20
21	Clerical & General Office Expenses	122,095	16,656	112,678	251,429		251,429	(81,894)	169,535		21
22	Employee Benefits & Payroll Taxes			242,731	242,731	13,140	255,871	0	255,871		22
23	Inservice Training & Education			5,026	5,026		5,026	1,128	6,154		23
24	Travel and Seminar			665	665		665	604	1,269		24
25	Other Admin. Staff Transportation			10,405	10,405		10,405	1,663	12,068		25
26	Insurance-Prop.Liab.Malpractice			101,980	101,980		101,980	805	102,785		26
27	Other (specify):*			0	0		0	31,204	31,204		27
28	TOTAL General Administration	192,367	16,656	709,145	918,168	13,140	931,308	(153,962)	777,346		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,532,393	314,287	971,635	2,818,315	0	2,818,315	(136,504)	2,681,811		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	8,190
	REPAIRS & MAINTENANCE	153
		0
		8,343
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	405
		0
		405
5	HEAT & OTHER UTILITIES	
	GAS HEAT	45,267
	ELECTRICITY	35,890
	WATER	13,167
	CABLE TV - LOBBY	6,136
		0
		100,460
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,440
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	8,015
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,880
	FIRE SERVICE	2,455
		0
		0
		0
		0
		15,790
7	OTHER	
	SCAVENGER	12,585
	SECURITY SERVICE	0
		0
		0
		12,585
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	488
	PURCHASED SERVICES	1,104
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,290
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B 47-2	5,500
	RN CONSULTANT XVIII B 38-2	0
	DENTAL SERVICES	0
	MEDICARE & PUBLIC AID CONSULTAN XVIII B 48-2	8,382
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	4,037
	SPEECH THERAPY SERVICES	4,608
	OCCUPATIONAL THERAPY SERVICES	2,772
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	5,400
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	5,400
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	THERAPY CONTRACT SERVICES	80,618
		102,835
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	5,151
		0
		5,151
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	2,539
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	24,625
	ADMINISTRATIVE CONSULTANTS XIX C	138,000
	PROFESSIONAL FEES XIX C	41,435
		0
		204,060
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	24,721
	EMPLOYEE WANT ADS XIX F	3,675
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	50
	LICENSES & PERMITS XIX F	2,500
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	175
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	300
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	179
	PATIENT BACKGROUND CHECKS XIX F	0
		0
		31,600
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	2,394
	OUTSIDE CLERICAL SERVICES	75,600
	PENALTIES / OVERDRAFT CHARGES VI 18	18,893
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	124
	TELEPHONE	13,202
	MESSENGER SERVICE	2,465
		0
		112,678

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	116,883
	UNEMPLOYMENT COMPENSATION XIX D	38,313
	WORKERS COMPENSATION INSURANC XIX D	59,338
	HOSPITALIZATION INSURANCE XIX D	24,321
	EMPLOYEE BENEFITS - OTHER XIX D	1,536
	EMPLOYEE PHYSICAL EXAMS XIX D	2,340
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		242,731
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	5,026
		5,026
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	665
		665
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	10,405
		10,405
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	85,290
	GENERAL INSURANCE EXPENSE	16,690
		101,980
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

971,635

PRAIRIE VILLAGE HEALTHCARE CENTER
SCHEDULES
12/31/2006

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	115,473
LESS SALES TAX	(515)
NET FOOD	114,958
TOTAL PATIENT CENSUS	28,259
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	84,777
ADD # EMPLOYEE MEALS/DAY	30
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	10,950
PATIENT MEALS	84,777
ADD EMPLOYEE MEALS	10,950
TOTAL MEALS/YEAR	95,727
NET FOOD	114,958
DIVIDE TOTAL MEALS/YEAR	95,727
COST PER MEAL	1.20
TIME EMPLOYEE MEALS	10,950
EMPLOYEE MEAL RECLASSIFICATION	13,140

PROFESSIONAL FEES
PAGE 21 SCHEDULE XIX PART C

CAREPLUS MGT	12,000
ACHIEVE HEALTHCARE	3,659
AMERICAN DATA	3,527
NATIONAL DATA CARE	1,862
e-HEALTH DATA SOLUTIONS	3,550
ADAPTASOFT	27
CAREPLUS MGT	138,000
KRUPNICK, BOKOR, KAGDA, LTD	23,400
MEYER MAGENCE	8,136
RECORD COPY SERVICE	80
JUDICIAL COURT MORGAN CNTY	105
PERSONNEL PLANNER	4,914
RICHARD PEELO	4,800
TOTAL PROFESSIONAL FEES	204,060

EQUIPMENT RENTAL EXPENSE
PAGE 14 SCHEDULE XII PART B LINES 15

CAREPLUS REHAB	RELATED PARTY EQUIP RENT	57,147
UNIVERSAL HOSPITAL SERVICES	NURSING EQUIPMENT	2,160
QUALITY WATER SERVICE	PLANT EQUIPMENT	2,326
AMERICAN RENTAL	PLANT EQUIPMENT	16
FLYNN SALES & SERVICE	WASHER/DRYER	7,500
GE CAPITAL	COPIER	4,351
TOTAL EQUIPMENT RENTAL EXPENSE		73,500

TRANSPORTATION - STAFF
PAGE 3 SCHEDULE V COLUMN 3 LINE 25

		R.SAXER				C.ZULAUF										TOTAL
FLEET	CAR	D.BLACKKETTER	A.HUNT	L.DAVIS	P.BROWN	L.KNIGHT	K.ROTHERING	D.WEBB	P.SEIFER	G.DORAN	B.NOLTING					
FUELING	ALLOW	P/C	P/C	P/C	P/C	P/C	P/C	P/C	P/C	P/C	P/C	P/C	P/C			
JAN		156	82				311									
FEB		124	98	21	22		145									
MAR		61					174									
APR			53				39	304	278							
MAY			28				47	419								
JUN			155		67	200	138	32	251	8						
JUL						25	111									
AUG						138	50							33		
SEP						47	414									
OCT			53			12	199									
NOV						139										
DEC		3,833	1,856			143								109		
TOTAL		3,833	1,856	394	416	21	89	790	2,265	310	251	8	30	109	33	10,405

GASOLINE FOR FACILITY BANKING, MAINTENANCE, MARKETING, AND ACTIVITIES

EDUCATION & SEMINARS
PAGE 3 SCHEDULE V COLUMN 3 LINE 23

DATE	SPONSOR OF SEMINAR	PURPOSE OF SEMINAR	PERSONNEL ATTENDING	LOC	COST OF SEMINAR
01/06	CROSS COUNTRY EDUCATION	MEETING THE PSYCHOSOCIAL SURVERY REQUIREMENTS	LISA DAVIS	IL	179
	LINCOLN LAND COMMUNITY COLLEGE	BASIC REHAB/RESTORATIVE NURSING COURSE	KELLY ROTHERING	IL	430
	LINCOLN LAND COMMUNITY COLLEGE	BASIC NURSE ASST TRAINING	KRISTI LUTTRELL	IL	408
	LINCOLN LAND COMMUNITY COLLEGE	CNA BOOK			59
03/06	LINCOLN LAND COMMUNITY COLLEGE	RESTORATIVE CLASS	KELLY ROTHERING	IL	430
	IL HEALTH CARE ASSOC	MDS CLASS	RITA MOORE	IL	190
	LINCOLN LAND COMMUNITY COLLEGE	CNA BOOK	HEATHER TAPSCOTT		59
04/06	IL HEALTH CARE ASSOC	THE NEW PSYCHIATRIC MDS SECTION S	JANIE FARMER	IL	290
			HEATHER TAPSCOTT		
05/06	CLINICAL SOLUTIONS	IMPLEMENT MDS SECTION S	PAM BROWN	IL	99
	RAMIREZ CONSULTING GROUP	ACTIVITY DIRECTOR CERTIFICATION	CARRIE ZULAUF	IL	500
	LINCOLN LAND COMMUNITY COLLEGE	BOOK FOR BASIC NURSE ASST TRAINING	TONYA ATKINSON	IL	59
	LINCOLN LAND COMMUNITY COLLEGE	BASIC NURSE ASST TRAINING	TONYA ATKINSON	IL	408
	ICLTC	SKILLS TRAINING FOR PSYCHIATRIC REHABILITATION	JANIE FARMER	IL	235
	ICLTC	PUBLICATIONS		IL	104
	LINCOLN LAND COMMUNITY COLLEGE	BASIC NURSE ASST TRAINING	MIRANDA LAWSON	IL	408
7/06	HCPRO	CMS RELEASES NEW F-TAGS AND SURVEYOR GUIDANCE	IN SERVICE	IL	209
	INR	MEMORY, AGING, & SLEEP	PAM BROWN	IL	79
	ELDERCARE COMMUNICATION	RESIDENT TRANSFER	IN SERVICE	IL	142
	LSN FOUNDATION	JUST ADD ONE! RESTORATIVE NURSING IN ILLINOIS	KELLY ROTHERING	IL	250
			PAM BROWN		
	POLARIS GROUP	URINARY CONTINENCE AND CATHETERS SURVEY PROTOC	IN SERVICE	IL	99
8/06	SUNBURST VISUAL MEDIA	COPING SKILLS	IN SERVICE	IL	79
10/06	SIU SCHOOL OF MEDICINE CENTER	ANNUAL CONF FOR HEALTH CARE ASSTS CARING FOR PEOPLE WITH DEMENTIA	TERI CARLS	IL	20
			AMBER WILLIAMS		
	ICLTC	THE MOST FREQUENT LIFE SAFETY CODE VIOLATIONS	RICHARD NOLTING	IL	290
			JEFFREY HENDUSON		
TOTAL EDUCATION & SEMINARS					5,026

Facility Name & ID Number

PRAIRIE VILLAGE HEALTHCARE CENTER

#0042671

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			7,152	7,152		7,152	80,199	87,351			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			3,500	3,500		3,500	192,950	196,450			32
33	Real Estate Taxes			26,702	26,702		26,702	2,545	29,247			33
34	Rent-Facility & Grounds			261,920	261,920		261,920	(261,920)	0			34
35	Rent-Equipment & Vehicles			83,524	83,524		83,524	(52,426)	31,098			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			382,798	382,798	0	382,798	(38,652)	344,146			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		126,755	106,598	233,353		233,353	(12,875)	220,478			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			68,985	68,985		68,985	0	68,985			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	126,755	175,583	302,338	0	302,338	(12,875)	289,463			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,532,393	441,042	1,530,016	3,503,451	0	3,503,451	(188,031)	3,315,420			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,350	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(515)	2		13
14	Non-Care Related Interest	(49)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(175)	20		17
18	Fines and Penalties	(18,893)	21		18
19	Entertainment				19
20	Contributions	(300)	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				24
25	Fund Raising, Advertising and Promotional	(24,721)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>MARKETING SALARY</u>	(26,395)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (60,698)		\$ 0	30

BHF USE ONLY					
48	49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(127,333)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (127,333)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (188,031)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID# 0042671

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	MARKETING SALARY	(26,395)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(26,395)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER# 0042671

Report Period Beginning:

01/01/2006

Ending:

12/31/2006**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(515)	0	0	0	0	0	0	0	0	0	0	(515)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	21	0	0	0	0	0	0	0	0	0	21	5
6	Maintenance	0	3,419	0	0	0	0	0	0	0	0	0	3,419	6
7	Other (specify):*	0	10	0	0	0	0	0	0	0	0	0	10	7
8	TOTAL General Services	(515)	3,450	0	0	0	0	0	0	0	0	0	2,935	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	25,238	0	0	0	0	0	0	0	0	0	25,238	10
10a	Therapy	0	1,706	(12,421)	0	0	0	0	0	0	0	0	(10,715)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	26,944	(12,421)	0	0	0	0	0	0	0	0	14,523	16
	C. General Administration													
17	Administrative	0	0	56,952	0	0	0	0	0	0	0	0	56,952	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(150,000)	1,894	7,500	0	0	0	0	0	0	0	(140,606)	19
20	Fees, Subscriptions & Promotions	(25,196)	0	1,378	0	0	0	0	0	0	0	0	(23,818)	20
21	Clerical & General Office Expenses	(45,288)	(75,600)	38,994	0	0	0	0	0	0	0	0	(81,894)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,128	0	0	0	0	0	0	0	0	1,128	23
24	Travel and Seminar	0	0	604	0	0	0	0	0	0	0	0	604	24
25	Other Admin. Staff Transportation	0	0	1,663	0	0	0	0	0	0	0	0	1,663	25
26	Insurance-Prop.Liab.Malpractice	0	0	805	0	0	0	0	0	0	0	0	805	26
27	Other (specify):*	0	(6,531)	37,735	0	0	0	0	0	0	0	0	31,204	27
28	TOTAL General Administration	(70,484)	(232,131)	141,153	7,500	0	(153,962)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(70,999)	(201,737)	128,732	7,500	0	(136,504)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	10,350	0	14,709	55,140	0	0	0	0	0	0	0	80,199	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(49)	0	22,613	170,386	0	0	0	0	0	0	0	192,950	32
33	Real Estate Taxes	0	0	2,545	0	0	0	0	0	0	0	0	2,545	33
34	Rent-Facility & Grounds	0	0	0	(261,920)	0	0	0	0	0	0	0	(261,920)	34
35	Rent-Equipment & Vehicles	0	0	(52,426)	0	0	0	0	0	0	0	0	(52,426)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	10,301	0	(12,559)	(36,394)	0	(38,652)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(12,875)	0	0	0	0	0	0	0	0	(12,875)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	(12,875)	0	0	0	0	0	0	0	0	(12,875)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(60,698)	(201,737)	103,298	(28,894)	0	(188,031)	45						

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					SKOKIE	THERAPY
				PRAIRIE VILLAGE HEALTHCARE CENTER LLC		
					SKOKIE	REAL ESTATE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$	CAREPLUS MGMT INC		\$		1
2	V	19 ADMIN. CONSULTANT FEES	138,000	" "			(138,000)	2
3	V	19 DATA PROCESSING FEES	12,000	" "			(12,000)	3
4	V	21 CLERICAL FEES	75,600	" "			(75,600)	4
5	V	27 W/C INSURANCE	6,531	" "			(6,531)	5
6	V			" "				6
7	V			" "				7
8	V	5 UTILITIES		" "		21	21	8
9	V	6 REPAIRS		" "		854	854	9
10	V	6 MAINTENANCE SALARIES		" "		2,565	2,565	10
11	V	7 SECURITY		" "		10	10	11
12	V	10 NURSING		" "		25,238	25,238	12
13	V	10a THERAPY SALARIES		" "		1,706	1,706	13
14	Total		\$ 232,131			\$ 30,394	\$ * (201,737)	14

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

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER# 0042671Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	17 ADMIN SALARIES	\$	CAREPLUS MGMT INC		\$ 56,952	\$ 56,952
16	V	19 PROFESSIONAL FEES		" "		1,894	1,894
17	V	20 DUES/LICENSES/WANT ADS		" "		1,378	1,378
18	V	21 OFFICE EXPENSES		" "		8,404	8,404
19	V	21 CLERICAL SALARIES		" "		30,590	30,590
20	V	23 SEMINARS		" "		1,128	1,128
21	V	24 TRAVEL		" "		604	604
22	V	25 TRANSPORTATION		" "		1,663	1,663
23	V	26 INSURANCE		" "		805	805
24	V	27 EMPLOYEE BENEFITS		" "		37,735	37,735
25	V	30 SL DEPRECIATION		" "		6,324	6,324
26	V	32 INTEREST		" "		18,380	18,380
27	V	33 REAL ESTATE TAX		" "		2,545	2,545
28	V	35 EQUIP RENT/AUTO LEASE		" "		4,721	4,721
29	V						
30	V	10a THERAPY SERVICES	102,834	CAREPLUS REHABILITATIVE SERVICES		90,413	(12,421)
31	V	39 ANCILLARY THERAPY	106,597	" "		93,722	(12,875)
32	V	35 EQUIPMENT RENT EXPENSE	57,147	" "			(57,147)
33	V	30 SL DEPRECIATION		" "		8,385	8,385
34	V	32 INTEREST		" "		4,233	4,233
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 266,578			\$ 369,876	\$ * 103,298

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 RENT	\$ 261,920	PRAIRIE VILLAGE HEALTHCARE CENTER LLC		\$	\$ (261,920)
16	V	30 SL DEPRECIATION		" "		55,140	55,140
17	V	32 INTEREST		" "		156,721	156,721
18	V	32 MIP INSURANCE		" "		13,665	13,665
19	V	19 ACCOUNTING FEES		" "		7,500	7,500
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 261,920			\$ 233,026	\$ * (28,894)

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

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CEN # 0042671 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								\$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	32.02	SEE ATTACHED	3.1	5.11	SALARY	10,216	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	32.02	SCHEDULES	3.1	5.11	" "	10,216	17-7	3
4	JAMEE O'BRIEN	REGIONAL DIR.	ADMIN	1.70	" "	3.1	5.11	" "	7,043	17-7	4
5	JOE ZIMMERMAN	CFO	CLERICAL	1.70	" "	3.1	5.11	" "	5,134	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 32,609		13

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

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

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

0042671

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization CAREPLUS MANAGEMENT INC
 Street Address 8320 SKOKIE BLVD
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847)329-1555
 Fax Number (847)329-9555

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		CENSUS DAYS			\$	\$		\$	1
2	5	UTILITIES	553,205	13 FACILITIES	408		28,259	21	2
3	6	REPAIRS	553,205	13 FACILITIES	16,722		28,259	854	3
4	6	MAINTENANCE SALARIES	553,205	13 FACILITIES	50,215	50,215	28,259	2,565	4
5	7	SECURITY	553,205	13 FACILITIES	194		28,259	10	5
6	10	NURSING	553,205	13 FACILITIES	494,063	494,063	28,259	25,238	6
7	10a	THERAPY SALARIES	553,205	13 FACILITIES	33,400	33,400	28,259	1,706	7
8	17	ADMIN SALARIES	553,205	13 FACILITIES	1,114,897	1,114,897	28,259	56,952	8
9	19	PROFESSIONAL FEES	553,205	13 FACILITIES	37,085		28,259	1,894	9
10	20	DUES/LICENSES/WANT ADS	553,205	13 FACILITIES	26,974		28,259	1,378	10
11	21	OFFICE EXPENSES	553,205	13 FACILITIES	164,515		28,259	8,404	11
12	21	CLERICAL SALARIES	553,205	13 FACILITIES	598,842	598,842	28,259	30,590	12
13	23	SEMINARS	553,205	13 FACILITIES	22,090		28,259	1,128	13
14	24	TRAVEL	553,205	13 FACILITIES	11,815		28,259	604	14
15	25	TRANSPORTATION	553,205	13 FACILITIES	32,553		28,259	1,663	15
16	26	INSURANCE	553,205	13 FACILITIES	15,760		28,259	805	16
17	27	EMPLOYEE BENEFITS	553,205	13 FACILITIES	738,700		28,259	37,735	17
18	30	SL DEPRECIATION	553,205	13 FACILITIES	123,804		28,259	6,324	18
19	32	INTEREST	553,205	13 FACILITIES	359,819		28,259	18,380	19
20	33	REAL ESTATE TAX	553,205	13 FACILITIES	49,822		28,259	2,545	20
21	35	EQUIP RENT/AUTO LEASE	553,205	13 FACILITIES	92,424		28,259	4,721	21
22									22
23									23
24									24
25	TOTALS				\$ 3,984,102	\$ 2,291,417		\$ 203,517	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	RELATED PARTY: PRAIRIE VILLAGE HEALTHCARE CENTER LLC						\$	\$			\$	1						
2	CAMBRIDGE/HEARTLAND		X	MORTGAGE	\$16,072.41	11/03	2,830,700	2,709,730	10/33			153,012	2					
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN	11/03	76,676	68,689	10/33			2,556	3					
4	MIP INSURANCE		X	MORTGAGE INSURANCE								13,665	4					
5	CAREPLUS MGT - FIRST BK	X		CAPITAL IMPROVEMENT	\$882.75	01/04	37,157	11,213	01/09	PRIME+		1,153	5					
Working Capital																		
6	INSURANCE FINANCING		X	INSUR. FINANCE								3,451	6					
7	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC											18,380	7					
8	CAREPLUS REHAB ALLOCATION: EQUIP LOAN											4,233	8					
9	TOTAL Facility Related				\$16,955.16		\$ 2,944,533	\$ 2,789,632				\$ 196,450	9					
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								49	10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$ 0	\$ 0				\$ 49	14					
15	TOTALS (line 9+line14)						\$ 2,944,533	\$ 2,789,632				\$ 196,499	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 13,665 Line # 32-7

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

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.	\$	25,060	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	25,752	2
3. Under or (over) accrual (line 2 minus line 1).	\$	692	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	26,010	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	26,702	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	23,337	8
	2002	23,390	9
	2003	23,687	10
	2004	24,815	11
	2005	25,752	12

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

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

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

NOTES:

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

IMPORTANT NOTICE

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

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

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

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

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRAIRIE VILLAGE HEALTHCARE CENTER COUNTY MORGAN

FACILITY IDPH LICENSE NUMBER 0042671

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-17-100-012</u>	<u>NURSING HOME</u>	\$ <u>25,752.16</u>	\$ <u>25,752.16</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>25,752.16</u>	\$ <u>25,752.16</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

0042671

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,028 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1 + BASEMENT

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>RELATED PARTY:PRAIRIE VILLAGE HEALTHCARE CENTER LLC</u>				<u>1</u>
2	<u>NURSING HOME: ACRES</u>	<u>8.686</u>	<u>1997</u>	<u>170,000</u>	<u>2</u>
3	TOTALS			\$ 170,000	3

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

0042671

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	RELATED PARTY: PRAIRIE VILLAGE HEALTHCARE CENTER LLC:			\$	\$		\$	\$	\$	4
5	126	1997		1,114,539	28,577	39	28,577		270,312	5
6										6
7										7
8										8
	Improvement Type**									
9	ELECTRIC PANEL IN BOILER ROOM		1997	1,192	31	39	31		296	9
10	NURSE CALL SYSTEM		1997	17,863	458	39	458		4,312	10
11	40 TON A/C AND GAS LINE		1997	114,953	2,947	39	2,947		27,384	11
12	NEW ROOF		1997	35,981	923	39	923		8,499	12
13	CUBICLE TRACK / PAINTING / HAND & BUMPER RAILS		1997	18,875	484	39	484		4,457	13
14	CEILING TILE / LIGHT FIXTURES / CUBICLE TRACK		1997	44,010	1,128	39	1,128		10,293	14
15	MECHANICAL, PLUMBING, HVAC & ELECTRICAL OVERHAUL		1997	165,706	4,249	39	4,249		38,773	15
16	FLOOR TILE		1997	35,928	921	39	921		8,327	16
17	REMODELLING / PAINTING / WALLCOVERINGS / BUMPER RAIL		1997	52,605	1,349	39	1,349		12,197	17
18	REMODELLING / WALLCOVERINGS / RAILS / WINDOW TREATM		1998	58,466	1,500	39	1,500		13,112	18
19	TILING / FLOORING / DOORS		1998	36,939	948	39	948		8,217	19
20	ELECTRICAL / ELEVATOR / PLUMBING REPAIRS		1998	69,378	1,778	39	1,778		15,333	20
21	GENERATOR		1998	21,049	540	39	540		4,613	21
22	JFK CONTEMPORARY DESIGNS		1999	3,549	91	39	91		641	22
23	CANOPY/BARRIERS/CORNER GUARDS/KICKPLATES		2000	9,164	333	27.5	333		2,102	23
24	SHAYMAN,SALK ARENSON SETTLEMENT / PUMP		2001	54,531	1,983	27.5	1,983		11,452	24
25										25
26	CONCRETE WORK / DRYWALL / DOORS		2002	4,490	163	27.5	163		676	26
27	DOOR INSTALLATIONS / 6 VENTILATOR RECEPTACLES		2003	9,733	353	27.5	354	1	1,241	27
28	CONCRETE SLABS OUTSIDE EXIT DOORS		2003	3,350	223	15	223		781	28
29	OUTLET INSTALLATION AND REWIRING		2004	5,343	194	27.5	194		574	29
30	SIDEWALKS		2005	4,475	298	15	298		447	30
31	SHOWER REMODEL / ROOFING		2006	11,421	164	27.5	164		164	31
32	PAVING		2006	1,600	53	15	53		53	32
33										33
34	RELATED PARTY ALLOCATION - CAREPLUS MGMT									34
35	BUILDING-TAG-18 PROPERTIES		2004	36,308	820	39	820		1,751	35
36	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES		2004	14,264	485	39	485		1,034	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

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		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70	TOTAL (lines 4 thru 69)	\$ 1,945,712	\$ 50,993		\$ 50,994	\$ 1	\$ 447,041

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 203,198	\$ 2,658	\$ 15,273	\$ 12,615	8-15 YRS	\$ 132,249	71
72	Current Year Purchases	15,228	3,046	780	(2,266)	8-10 YRS	780	72
73	Fully Depreciated Assets				0			73
74	**REL'D PARTY-SL DEPN:CAREPL MGT, 5,019 /CP REHAB, 8,385/PRAIRIE VILL LLC, 6,900	20,304	20,304	20,304	0	8-15 YRS		74
75	TOTALS	\$ 218,426	\$ 26,008	\$ 36,357	\$ 10,349		\$ 133,029	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,334,138	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 77,001	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 87,351	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,350	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 580,070	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ **73,500** Description: **SEE SCHEDULE ATTACHED**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ACTIVITY/HSKP/	2005 CHEVY VAN	\$	7,261	17
18	MAINT/BANKING/	MISC RENTALS-ADMIN		220	18
19	ADMIN/ETC	MISC RENTALS-DON		167	19
20	MGMT CO ALLOC-SEE ATTACHED			2,376	20
21	TOTAL		\$	10,024	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2007 \$ _____

13. _____/2008 \$ _____

14. _____/2009 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 39,587	\$		\$ 39,587	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			21,455			21,455	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			39,697			39,697	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				96,096		96,096	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2/39-3				5,859	24,539		30,398	12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					6,120		6,120	13
14	TOTAL			\$		\$ 106,598	\$ 126,755		\$ 233,353	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

0042671

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>50,000</u>)	642,146		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments	272,624		5
6	Prepaid Insurance	67,615		6
7	Other Prepaid Expenses	13,360		7
8	Accounts Receivable (owners or related parties)	62,603		8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,058,348	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	42,973		15
16	Equipment, at Historical Cost	215,865		16
17	Accumulated Depreciation (book methods)	(204,161)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 54,677	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,113,025	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 543,929	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	84,758		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,818		31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,010		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	_____			36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 662,515	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>DUE TO LLC</u>	126,410		43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 126,410	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 788,925	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ 324,100	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,113,025	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 760,737	1
2	Restatements (describe):		2
3	ROUNDING	(3)	3
4	POST-CLOSING INTEREST ADJUSTMENT	(134,074)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 626,660	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(302,560)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (302,560)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 324,100	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,212,280	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,212,280	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,345	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 19,345	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,231,625	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	640,701	31
32	Health Care	1,259,446	32
33	General Administration	918,168	33
	B. Capital Expense		
34	Ownership	382,798	34
	C. Ancillary Expense		
35	Special Cost Centers	233,353	35
36	Provider Participation Fee	68,985	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	30,734	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,534,185	40
41	Income before Income Taxes (line 30 minus line 40)**	(302,560)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (302,560)	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number **PRAIRIE VILLAGE HEALTHCARE CENTER**

0042671

Report Period Beginning: **01/01/2006**

Ending:

12/31/2006

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,917	2,076	\$ 57,577	\$ 27.73	1
2	Assistant Director of Nursing	1,044	1,101	27,563	25.03	2
3	Registered Nurses	5,076	5,217	104,712	20.07	3
4	Licensed Practical Nurses	18,303	18,987	320,308	16.87	4
5	CNAs & Orderlies	39,075	39,864	355,587	8.92	5
6	CNA Trainees					6
7	Licensed Therapist	3,534	3,734	72,939	19.53	7
8	Rehab/Therapy Aides	2,984	3,156	35,474	11.24	8
9	Activity Director	2,134	2,162	16,450	7.61	9
10	Activity Assistants	2,451	2,493	16,351	6.56	10
11	Social Service Workers	1,814	1,834	23,493	12.81	11
12	Dietician					12
13	Food Service Supervisor	3,973	4,218	42,389	10.05	13
14	Head Cook	4,399	4,502	32,863	7.30	14
15	Cook Helpers/Assistants	6,523	6,653	43,442	6.53	15
16	Dishwashers					16
17	Maintenance Workers	3,892	4,009	42,812	10.68	17
18	Housekeepers	12,412	12,594	88,304	7.01	18
19	Laundry	5,544	5,811	39,747	6.84	19
20	Administrator	1,860	2,023	52,699	26.05	20
21	Assistant Administrator	1,046	1,062	17,573	16.55	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,266	7,916	95,700	12.09	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	1,926	2,030	20,015	9.86	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MARKETING</u>	1,237	1,386	26,395	19.04	33
34	TOTAL (lines 1 - 33)	128,410	132,828	\$ 1,532,393 *	\$ 11.54	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 8,190	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	1,290	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	5,151	12-3	45
46	Other(specify)	S			46
47	<u>PSYCHIATRIC</u>		5,500	10-3	47
48	<u>M/C & PA CONSULTING</u>		0	10-3	48
49	TOTAL (lines 35 - 48)		\$ 36,931		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
DIANNA BLACKKETTER	ADMIN	0	\$ 15,926	Workers' Compensation Insurance	\$ 59,338	IDPH License Fee	\$	
PAMELA BROWN	ADMIN	0	36,773	Unemployment Compensation Insurance	38,313	Advertising: Employee Recruitment	3,675	
PAMELA BROWN	ASST ADMIN		17,573	FICA Taxes	116,883	Health Care Worker Background Check	179	
				Employee Health Insurance	24,321	(Indicate # of checks performed <u>115</u>)		
				Employee Meals	13,140	Patient Background Checks	36	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	475	
				EMPLOYEE BENEFITS - OTHER	1,536	MARKETING/ADV/PROMO	24,721	
				EMPLOYEE PHYSICAL EXAMS	2,340	LICENSES/DUES/SUBSCRIPTIONS	2,550	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOCATION	1,378	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(475)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(24,721)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 70,272	TOTAL (agree to Schedule V, line 22, col.8)	\$ 255,871	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 7,782	
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
			\$ 0			\$	Out-of-State Travel	\$
							In-State Travel	
							TRAVEL & LODGING	665
							MGMT CO ALLOCATION	604
							(IL LODGING BETW FACIL & MGT CO)	
							Seminar Expense	0
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL	\$ 1,269
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			204,060					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 204,060					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

0042671

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? 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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO 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. \$ 68,985
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. \$ 13,140 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees