



Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN

# 0040303 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	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	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	114		1,745	1,859	8
9	SNF/PED					9
10	ICF	20,911	3,183	255	24,349	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,025	3,183	2,000	26,208	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.53%

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

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

NONE

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 02/01/93

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/01/93 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 10 and days of care provided 1,745

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRAUAL  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 VIEW CARE CENTER-LEWISTC** # **0040303** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	106,841	5,806	10,402	123,049		123,049	0	123,049		1
2	Food Purchase		161,686		161,686	0	161,686	(405)	161,281		2
3	Housekeeping	81,497	22,510	0	104,007		104,007	0	104,007		3
4	Laundry	49,509	17,509	762	67,780	0	67,780	0	67,780		4
5	Heat and Other Utilities			67,001	67,001		67,001	867	67,868		5
6	Maintenance	29,263	30,220	17,046	76,529		76,529	851	77,380		6
7	Other (specify):*			5,617	5,617		5,617	0	5,617		7
8	<b>TOTAL General Services</b>	<b>267,110</b>	<b>237,731</b>	<b>100,828</b>	<b>605,669</b>	<b>0</b>	<b>605,669</b>	<b>1,313</b>	<b>606,982</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		0	0		0	0	0		9
10	Nursing and Medical Records	904,570	79,417	32,288	1,016,275		1,016,275	16,117	1,032,392		10
10a	Therapy	29,706	4,018	2,983	36,707		36,707	0	36,707		10a
11	Activities	72,223	2,705	0	74,928		74,928	0	74,928		11
12	Social Services	49,755		0	49,755		49,755	0	49,755		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			4,135	4,135		4,135	0	4,135		14
15	Other (specify):*				0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,056,254</b>	<b>86,140</b>	<b>39,406</b>	<b>1,181,800</b>	<b>0</b>	<b>1,181,800</b>	<b>16,117</b>	<b>1,197,917</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	619		23,112	23,731		23,731	15,625	39,356		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			124,213	124,213		124,213	(82,622)	41,591		19
20	Dues, Fees, Subscriptions & Promotions			12,158	12,158		12,158	(3,351)	8,807		20
21	Clerical & General Office Expenses	33,705	11,092	153,040	197,837		197,837	(58,695)	139,142		21
22	Employee Benefits & Payroll Taxes			276,022	276,022	0	276,022	11,101	287,123		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			7,472	7,472		7,472	3,882	11,354		24
25	Other Admin. Staff Transportation			9,271	9,271		9,271	6,215	15,486		25
26	Insurance-Prop.Liab.Malpractice			43,149	43,149		43,149	12,449	55,598		26
27	Other (specify):* <b>Marketing</b>	22,707		0	22,707		22,707	(22,707)	0		27
28	<b>TOTAL General Administration</b>	<b>57,031</b>	<b>11,092</b>	<b>648,437</b>	<b>716,560</b>	<b>0</b>	<b>716,560</b>	<b>(118,103)</b>	<b>598,457</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,380,395</b>	<b>334,963</b>	<b>788,671</b>	<b>2,504,029</b>	<b>0</b>	<b>2,504,029</b>	<b>(100,673)</b>	<b>2,403,356</b>		<b>29</b>

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	6,791
	REPAIRS & MAINTENANCE	3,611
		0
		10,402
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	762
		0
		762
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	0
	ELECTRICITY	55,704
	WATER	10,691
	CABLE TV - LOBBY	606
		0
		67,001
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	3,861
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	9,280
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,060
	FIRE SERVICE	2,845
		0
		0
		0
		0
		17,046
7	<b>OTHER</b>	
	SCAVENGER	5,617
	SECURITY SERVICE	0
		0
		0
		5,617
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	0
		0

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	22,590
	LABORATORY & XRAY EXPENSE	54
	PURCHASED SERVICES	894
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	5,970
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,880
	PHARMACY CONSULTANT XVIII B 39-2	900
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		32,288
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	508
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	73
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	2,366
	SPEECH THERAPY CONSULTANT XVIII B 43-2	36
		2,983
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	4,135
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	23,112
	<b>DIRECTORS FEES</b>	
<b>18</b>	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	6,477
	ADMINISTRATIVE CONSULTANTS XIX C	45,378
	PROFESSIONAL FEES XIX C	72,358
		0
		124,213
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	2,618
	EMPLOYEE WANT ADS XIX F	1,304
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	1,609
	LICENSES & PERMITS XIX F	5,894
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	733
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		12,158
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	1,068
	OUTSIDE CLERICAL SERVICES	127,998
	PENALTIES / OVERDRAFT CHARGES VI 18	11,058
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	763
	TELEPHONE	9,271
	MESSENGER SERVICE	2,882
		0
		153,040

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	103,996
	UNEMPLOYMENT COMPENSATION XIX D	25,660
	WORKERS COMPENSATION INSURANC XIX D	73,099
	HOSPITALIZATION INSURANCE XIX D	69,447
	EMPLOYEE BENEFITS - OTHER XIX D	2,035
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	1,785
	CHICAGO HEAD TAX XIX D	0
		0
		276,022
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	324
	TRAVEL XIX G	7,148
		7,472
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	9,271
		9,271
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	43,149
		43,149
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

788,671

PRAIRIE VIEW CARE CENTER-LEWISTOWN  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2006

TOTAL FOOD PURCHASE	161,686	PATIENT MEALS	78624
LESS SALES TAX	(405)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	161,281	TOTAL MEALS/YEAR	78624
TOTAL PATIENT CENSUS	26,208	NET FOOD	161281
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	78624
	-----		
TOTAL PATIENT MEALS	78624	COST PER MEAL	2.05
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name &amp; ID Number

PRAIRIE VIEW CARE CENTER-LEWISTOWN

#0040303

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			15,023	15,023		15,023	106,987	122,010			30
31	Amortization of Pre-Op. & Org.			0	0		0	7,357	7,357			31
32	Interest			76,561	76,561		76,561	296,242	372,803			32
33	Real Estate Taxes			23,941	23,941		23,941	0	23,941			33
34	Rent-Facility & Grounds			158,817	158,817		158,817	(154,476)	4,341			34
35	Rent-Equipment & Vehicles			10,640	10,640		10,640	0	10,640			35
36	Other (specify):*			0	0		0	0	0			36
37	<b>TOTAL Ownership</b>			284,982	284,982	0	284,982	256,110	541,092			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		48,053	146,584	194,637		194,637	0	194,637			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			54,203	54,203		54,203	0	54,203			42
43	Other (specify):*				0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	48,053	200,787	248,840	0	248,840	0	248,840			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,380,395	383,016	1,274,440	3,037,851	0	3,037,851	155,437	3,193,288			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,777)	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	(405)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(11,058)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(2,618)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(733)	20		28
29	Other-Attach Schedule	(62,916)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (81,507)		\$ 0	30

<b>BHF USE ONLY</b>					
48	49	50	51	52	

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	236,944		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 236,944		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 155,437		37

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

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

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

ID# 0040303

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	LEGAL FEES	(40,209)	19	2
3	MARKETING SALARY	(22,707)	27	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(62,916)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN# 0040303

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	(405)	0	0	0	0	0	0	0	0	0	0	(405)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	867	0	0	0	0	0	0	0	0	867	5
6	Maintenance	0	0	851	0	0	0	0	0	0	0	0	851	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(405)</b>	<b>0</b>	<b>1,718</b>	<b>0</b>	<b>1,313</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	16,117	0	0	0	0	0	0	0	0	16,117	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>16,117</b>	<b>0</b>	<b>16,117</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	(23,112)	38,737	0	0	0	0	0	0	0	0	15,625	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(40,209)	(45,378)	2,965	0	0	0	0	0	0	0	0	(82,622)	19
20	Fees, Subscriptions & Promotions	(3,351)	0	0	0	0	0	0	0	0	0	0	(3,351)	20
21	Clerical & General Office Expenses	(11,058)	(127,636)	79,999	0	0	0	0	0	0	0	0	(58,695)	21
22	Employee Benefits & Payroll Taxes	0	0	11,101	0	0	0	0	0	0	0	0	11,101	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,882	0	0	0	0	0	0	0	0	3,882	24
25	Other Admin. Staff Transportation	0	0	6,215	0	0	0	0	0	0	0	0	6,215	25
26	Insurance-Prop.Liab.Malpractice	0	0	12,449	0	0	0	0	0	0	0	0	12,449	26
27	Other (specify):*	(22,707)	0	0	0	0	0	0	0	0	0	0	(22,707)	27
28	<b>TOTAL General Administration</b>	<b>(77,325)</b>	<b>(196,126)</b>	<b>155,348</b>	<b>0</b>	<b>(118,103)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(77,730)</b>	<b>(196,126)</b>	<b>173,183</b>	<b>0</b>	<b>(100,673)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN# 0040303

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	(3,777)	108,331	2,433	0	0	0	0	0	0	0	0	106,987	30
31	Amortization of Pre-Op. & Org.	0	7,357	0	0	0	0	0	0	0	0	0	7,357	31
32	Interest	0	296,242	0	0	0	0	0	0	0	0	0	296,242	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(158,817)	4,341	0	0	0	0	0	0	0	0	(154,476)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(3,777)</b>	<b>253,113</b>	<b>6,774</b>	<b>0</b>	<b>256,110</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(81,507)</b>	<b>56,987</b>	<b>179,957</b>	<b>0</b>	<b>155,437</b>	<b>45</b>							

**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 SCHEDULE		SEE ATTACHED SCHEDULE		CERTIFIED HEALTH MANAGEMENT	SKOKIE	BKKPG/MGMT
				PRAIRIE VIEW CARE CENTER OF LEWISTOWN 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	17 MANAGEMENT FEES	\$ 23,112	CERTIFIED HEALTH MANAGEMENT		\$	\$ (23,112)	1
2	V	21 BOOKKEEPING	127,998				(127,998)	2
3	V	19 ADMIN CONSULTING FEES	45,378				(45,378)	3
4	V							4
5	V							5
6	V							6
7	V	34 RENT	158,817	PRAIRIE VIEW CARE CENTER OF LEWISTOWN LLC			(158,817)	7
8	V	21 OFFICE EXPENSE				362	362	8
9	V	30 DEPRECIATION				108,331	108,331	9
10	V	31 AMORTIZATION				7,357	7,357	10
11	V	32 INTEREST				296,242	296,242	11
12	V							12
13	V							13
14	Total		\$ 355,305			\$ 412,292	\$ * 56,987	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3 HOUSEKEEPING	\$	CERTIFIED HEALTH MANAGEMENT		\$ 0	\$	15
16	V	5 ELECTRIC/GAS		" " "		867		867 16
17	V	6 MAINTENANCE		" " "		851		851 17
18	V	10 NURSING/MEDICAL RECORDS		" " "		16,117		16,117 18
19	V	17 ADMIN SALARIES		" " "		38,737		38,737 19
20	V	19 PROFESSIONAL FEES		" " "		2,965		2,965 20
21	V	20 FEES, SUBSCRIPTIONS		" " "		0		0 21
22	V	21 OFFICE EXP		" " "		79,999		79,999 22
23	V	22 EMPLOYEE BENEFITS		" " "		11,101		11,101 23
24	V	24 TRAVEL/SEMINAR		" " "		3,882		3,882 24
25	V	25 TRANSPORTATION		" " "		6,215		6,215 25
26	V	26 INSURANCE		" " "		12,449		12,449 26
27	V	30 DEPRECIATION		" " "		2,433		2,433 27
28	V	32 INTEREST		" " "		0		0 28
29	V	34 OFFICE RENT		" " "		4,341		4,341 29
30	V	36 EQUIPMENT RENTAL		" " "		0		0 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		\$			\$ 179,957	\$ *	179,957 39

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

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWIST # 0040303 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	BRADLEY ALTER		ADMINISTRATION		SEE ATTACHED SCHEDULE			SALARY	\$ 22,380	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 22,380		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 VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CERTIFIED HEALTH MANAGEMENT  
 Street Address 3865 OAKTON SUITE 200  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number (847) 674-4700  
 Fax Number (847) 674-4733

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	3	HOUSEKEEPING	PER PATIENT DAY	199,244	8	\$ 0	26,208	\$ 0	1
2	5	ELECTRIC/GAS	" " "	199,244	8	6,594	26,208	867	2
3	6	MAINTENANCE	" " "	199,244	8	6,467	26,208	851	3
4	10	NURSING/MEDICAL RECORDS	" " "	199,244	8	122,529	122,529	16,117	4
5	17	ADMIN SALARIES	" " "	199,244	8	294,492	294,492	38,737	5
6	19	PROFESSIONAL FEES	" " "	199,244	8	22,540	26,208	2,965	6
7	20	FEES, SUBSCRIPTIONS	" " "	199,244	8		26,208	0	7
8	21	OFFICE EXP	" " "	199,244	8	608,185	545,133	79,999	8
9	22	EMPLOYEE BENEFITS	" " "	199,244	8	84,392	26,208	11,101	9
10	24	TRAVEL/SEMINAR	" " "	199,244	8	29,513	26,208	3,882	10
11	25	TRANSPORTATION	" " "	199,244	8	47,249	26,208	6,215	11
12	26	INSURANCE	" " "	199,244	8	94,640	26,208	12,449	12
13	30	DEPRECIATION	" " "	199,244	8	18,500	26,208	2,433	13
14	32	INTEREST	" " "	199,244	8	0	26,208	0	14
15	34	OFFICE RENT	" " "	199,244	8	33,000	26,208	4,341	15
16	36	EQUIPMENT RENTAL	" " "	199,244	8	0	26,208	0	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,368,101	\$ 962,154	\$ 179,957	25

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization PRAIRIE VIEW CARE CENTER OF LEWISTOWN  
 Street Address 3856 OAKTON SUITE 200  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number (847) 674-4700  
 Fax Number (847) 674-4733

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 COSTS	1	1	\$ 108,331	\$ 1	\$ 108,331	1
2	31	AMORTIZATION		1	1	7,357	1	7,357	2
3	32	INTEREST		1	1	296,242	1	296,242	3
4	21	OFFICE EXPENSE		1	1	362	1	362	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					\$ 412,292	\$	\$ 412,292	25

Facility Name & ID Number

PRAIRIE VIEW CARE CENTER-LEWISTC

# 0040303

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1							\$	\$			\$	1						
2												2						
3												3						
4	5TH 3RD BANK		X	WORKING CAPITAL								4,270	4					
5	OFFICERS LOANS	X		WORKING CAPITAL									5					
<b>Working Capital</b>																		
6	BANK FINANCIAL		X	WORKING CAPITAL			350,000	350,000		PRIME+		27,913	6					
7	BANK FINANCIAL		X	WORKING CAPITAL-LOC				69,842		PRIME+		43,196	7					
8	INS FINANCING		X									1,182	8					
9	<b>TOTAL Facility Related</b>						\$ 350,000	\$ 419,842				\$ 76,561	9					
<b>B. Non-Facility Related*</b>																		
10	IRS, IDR, ETC		X	LATE FEES									10					
11													11					
12													12					
13													13					
14	<b>TOTAL Non-Facility Related</b>						\$ 0	\$ 0				\$ 0	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 350,000	\$ 419,842				\$ 76,561	15					

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

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

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

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2005 report.	\$	<b>24,020</b>	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.)	\$	<b>23,741</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(279)</b>	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>24,220</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>23,941</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	<b>21,320</b>	8
	2002	<b>21,396</b>	9
	2003	<b>22,444</b>	10
	2004	<b>23,549</b>	11
	2005	<b>23,741</b>	12

**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.**

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

**NOTES:**

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

**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 VIEW CARE CENTER-LEWISTOWN COUNTY FULTON

FACILITY IDPH LICENSE NUMBER 0040303

CONTACT PERSON REGARDING THIS REPORT DON FIETS

TELEPHONE ( 847 ) 674-4700 X40 FAX #: ( 847 ) 674-4733

**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>18-19-27-141-004</u>	<u>NURSING HOME</u>	\$ <u>23,741.42</u>	\$ <u>23,741.42</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>23,741.42</u>	\$ <u>23,741.42</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.

**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).

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				\$	1
2					2
3	TOTALS			\$ 0	3

Facility Name &amp; ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN

# 0040303

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	99	2000		\$ 2,673,000	\$ 108,331	27.5	\$ 97,200	\$ (11,131)	\$ 688,414	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	AUTO SPRINKLER		1993	17,150	439	39	440	1	5,731	9
10	CONDENSOR		1993	2,414	62	39	62	(0)	834	10
11	EXPANDER		1993	6,354	163	39	163	(0)	2,153	11
12	NEW DOOR		1993	620	16	39	16	(0)	214	12
13	FIRE ALARM		1994	6,942	178	39	178		2,307	13
14	CIBICLE TRACKS/CURTAINS		1994	8,149	209	39	209	(0)	2,674	14
15	ARCHITECH CONSULTING		1994	1,050	27	39	27	(0)	336	15
16	TILE		1995	1,113	29	39	29	(0)	344	16
17	REPLACE SHINGLES		1997	1,075	28	39	28	(0)	268	17
18	MODIFIED BITUMEN RUBBER PLUMPING/TILES		1997	13,173	338	39	338	(0)	3,282	18
19	INSTALL METALCAP		1997	2,670	68	39	68	0	655	19
20	ROOF REPAIR		1998	12,640	324	39	324	0	2,741	20
21	FLOOR TILE		1998	8,800	226	39	226	(0)	1,836	21
22	BATHROOM & CEILING REMODELING		1999	18,947	486	39	486	(0)	3,789	22
23	LANDSCAPING		1999	2,935	196	15	196	(0)	1,470	23
24	BOILER REPAIR		2000	2,159	89	7	308	219	2,377	24
25	NEW ROOF WEST WING		2000	6,000	218	27.5	218	0	1,335	25
26	FAUCETS FOR KITCHEN		2001	1,107	40	27.5	40	0	239	26
27	KITCHEN SINK		2001	1,671	61	27.5	61	(0)	353	27
28	A/C UNITS		2001	2,115	77	27.5	77	(0)	433	28
29	BUMPER GUARDS		2001	5,460	198	27.5	199	1	1,053	29
30	WALLPAPER		2001	2,708	387	7	387	(0)	2,322	30
31	DOORS 200/300 HALLS		2002	1,750	64	27.5	64	(0)	288	31
32	ZONE FIRE CONTROL		2003	1,402	51	27.5	51	(0)	198	32
33	WALLCOVERING/BUMPER GUARDS		2003	11,023	1,508	5	2,205	697	7,717	33
34	WINDOW TREATMENTS		2004	1,218	44	27.5	44	0	110	34
35	TILE/BASE COVE		2004	6,014	219	27.5	219	(0)	547	35
36			2004	6,467	235	27.5	235	0	588	36

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

See Page 12A, Line 70 for total

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

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	HANDRAILS/CRASH RAILS	2005	\$ 7,000	\$ 255	27.5	\$ 255	\$ (0)	\$ 382	37
38	FENCE/POSTS/GATES	2005	2,041	136	15	136	0	204	38
39	ALARM SYSTEM	2006	17,481	291	27.5	318	27	318	39
40	HOT WATER SYSTEM REPAIR/REPLACE	2006	2,519	42	27.5	46	4	46	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,855,167	\$ 115,035		\$ 104,849	\$ (10,186)	\$ 735,554	70

\*\*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	\$ 95,149	\$ 7,283	\$ 14,096	\$ 6,813	5-7	\$ 63,866	71
72	Current Year Purchases	6,316	1,036	632	(404)	5	632	72
73	Fully Depreciated Assets	66,949			0			73
74			2,433	2,433	0			74
75	TOTALS	\$ 168,414	\$ 10,752	\$ 17,161	\$ 6,409		\$ 64,498	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	MAINT/NSG/ACT			\$ 20,436	\$ 0	\$	\$ 0		\$ 20,436	76
77	MAINT/NSG/ACT	1985 DODGE VAN	1999	4,476	0		0		4,476	77
78							0			78
79							0			79
80	TOTALS			\$ 24,912	\$ 0	\$ 0	\$ 0		\$ 24,912	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,048,493	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 125,787	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 122,010	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,777)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 824,964	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: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

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

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ 10,640 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			\$ _____	\$ _____	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2007 \$ \_\_\_\_\_

13. \_\_\_\_\_/2008 \$ \_\_\_\_\_

14. \_\_\_\_\_/2009 \$ \_\_\_\_\_

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 70,730	\$		\$ 70,730	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			8,912			8,912	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			66,942			66,942	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				45,853		45,853	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>laboratory</b>						2,200		2,200	13
14	<b>TOTAL</b>			\$		\$ 146,584	\$ 48,053		\$ 194,637	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 VIEW CARE CENTER-LEWISTOWN** # **0040303** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**  
**XV. BALANCE SHEET - Unrestricted Operating Fund.** As of **12/31/2006** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>87,421</u> )	680,743		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,882		6
7	Other Prepaid Expenses	75,263		7
8	Accounts Receivable (owners or related parties)	3,020		8
9	Other(specify): <u>real estate tax escrow</u>	5,472		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 790,380	\$ 0	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	182,165		15
16	Equipment, at Historical Cost	183,874		16
17	Accumulated Depreciation (book methods)	(219,431)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 146,608	\$ 0	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 936,988	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 612,057	\$	26
27	Officer's Accounts Payable	2,505,837		27
28	Accounts Payable-Patient Deposits	500		28
29	Short-Term Notes Payable	1,468,913		29
30	Accrued Salaries Payable	71,801		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,621		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,220		32
33	Accrued Interest Payable	93,428		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,784,377	\$ 0	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 0	\$ 0	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,784,377	\$ 0	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (3,847,389)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 936,988	\$ 0	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(3,646,206)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Additional allow. For bad debt recorded after 05 filing</b>	<b>(72,744)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(3,718,950)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(128,439)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(128,439)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(3,847,389)</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,737,640	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,737,640	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	144,038	6
7	Oxygen	16,387	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 160,425	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 0	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	18	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 18	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>medical transportation</u>	11,329	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 11,329	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,909,412	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	605,669	31
32	Health Care	1,181,800	32
33	General Administration	716,560	33
<b>B. Capital Expense</b>			
34	Ownership	284,982	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	194,637	35
36	Provider Participation Fee	54,203	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,037,851	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(128,439)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (128,439)	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 VIEW CARE CENTER-LEWISTOWN**

# **0040303**

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	2,080	2,080	\$ 53,405	\$ 25.68	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,993	2,009	47,379	23.58	3
4	Licensed Practical Nurses	13,283	13,943	274,359	19.68	4
5	CNAs & Orderlies	43,110	44,088	466,327	10.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,013	2,247	29,706	13.22	8
9	Activity Director	1,904	2,080	28,124	13.52	9
10	Activity Assistants	4,567	4,727	44,099	9.33	10
11	Social Service Workers	3,813	4,160	49,755	11.96	11
12	Dietician					12
13	Food Service Supervisor	1,903	2,101	18,570	8.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,658	8,012	61,989	7.74	15
16	Dishwashers	3,699	3,723	26,282	7.06	16
17	Maintenance Workers	2,411	2,628	29,263	11.14	17
18	Housekeepers	8,390	8,854	81,497	9.20	18
19	Laundry	5,276	5,852	49,509	8.46	19
20	Administrator		24	619	25.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,951	2,185	33,705	15.43	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,087	2,183	22,708	10.40	31
32	Other Health C: Care Plan Coord	1,889	2,065	40,392	19.56	32
33	Other(specify)	1,430	1,494	22,707	15.20	33
34	TOTAL (lines 1 - 33)	109,457	114,455	\$ 1,380,395 *	\$ 12.06	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 6,791	1-3	35
36	Medical Director	O	0	9-3	36
37	Medical Records Consultant	N	1,880	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	900	10-3	39
40	Physical Therapy Consultant	L	508	10a-3	40
41	Occupational Therapy Consultant	Y	73	10a-3	41
42	Respiratory Therapy Consultant		2,366	10a-3	42
43	Speech Therapy Consultant	F	36	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 12,554		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	102	\$ 4,540	10-3	50
51	Licensed Practical Nurses	479	18,050	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	581	\$ 22,590		53





Facility Name &amp; ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN

# 0040303

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? \_\_\_\_\_
- (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? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO 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. \$ 54,203  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. **Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees