

		FOR BHF USE					

LL1

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

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

I. IDPH Facility ID Number: 0012955

Facility Name: Prophets Riverview

Address: 310 Mosher Drive Prophetstown 61277
 Number City Zip Code

County: Whiteside

Telephone Number: 825 537-5175 **Fax #** 815 537-2628

HFS ID Number: 45-0228055

Date of Initial License for Current Owners: _____

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Kim Kouri **Telephone Number:** 605 362-3178

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2006 to 12/31/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Raye Nae Nylander</u>	
	(Title) <u>Vice President/CFO</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

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

Facility Name & ID Number Prophets Riverview

0012955 Report Period Beginning: 1/1/2006 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	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,550	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	9,873	10,108	2,405	22,386	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,873	10,108	2,405	22,386	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.62%

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

Outpatient Therapy

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 09/20/1967

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

YES Date _____ NO

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

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

Medicare Intermediary Noridian

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Prophets Riverview # 0012955 Report Period Beginning: 1/1/2006 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	185,533	9,019	4,831	199,383		199,383	(135)	199,248			1
2	Food Purchase		126,606		126,606		126,606	(10,134)	116,472			2
3	Housekeeping	55,807	17,032		72,839		72,839	(311)	72,528			3
4	Laundry	47,688	14,310		61,998		61,998	(284)	61,714			4
5	Heat and Other Utilities			71,209	71,209		71,209		71,209			5
6	Maintenance	75,619	2,800	47,841	126,260		126,260	(8,451)	117,809			6
7	Other (specify):*			7,655	7,655		7,655	(68)	7,587			7
8	TOTAL General Services	364,647	169,767	131,536	665,950		665,950	(19,383)	646,567			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,016,292	162,575	13,081	1,191,948		1,191,948	(97,637)	1,094,311			10
10a	Therapy		2,089	248,436	250,525		250,525	(89,229)	161,296			10a
11	Activities	70,735	3,360	8,721	82,816		82,816	(6,371)	76,445			11
12	Social Services	36,688	239	350	37,277		37,277	(5)	37,272			12
13	CNA Training											13
14	Program Transportation			4,023	4,023		4,023		4,023			14
15	Other (specify):*	28,913			28,913		28,913		28,913			15
16	TOTAL Health Care and Programs	1,152,628	168,263	274,611	1,595,502		1,595,502	(193,242)	1,402,260			16
	C. General Administration											
17	Administrative	59,060		129,886	188,946		188,946	2,081	191,027			17
18	Directors Fees											18
19	Professional Services			1,896	1,896		1,896		1,896			19
20	Dues, Fees, Subscriptions & Promotions			15,247	15,247		15,247	(9,860)	5,387			20
21	Clerical & General Office Expenses	116,232	11,665	38,894	166,791		166,791	(919)	165,872			21
22	Employee Benefits & Payroll Taxes			353,281	353,281		353,281	1,624	354,905			22
23	Inservice Training & Education			9,173	9,173		9,173	(29)	9,144			23
24	Travel and Seminar			3,128	3,128		3,128	(2,444)	684			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			30,047	30,047		30,047	(6,994)	23,053			26
27	Other (specify):*			11,750	11,750		11,750	(11,750)				27
28	TOTAL General Administration	175,292	11,665	593,302	780,259		780,259	(28,291)	751,968			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,692,567	349,695	999,449	3,041,711		3,041,711	(240,916)	2,800,795			29

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

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

Facility Name & ID Number Prophets Riverview #0012955 Report Period Beginning: 1/1/2006 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			175,342	175,342	175,342		175,342			30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			4,571	4,571	4,571		4,571			35
36	Other (specify):*										36
37	TOTAL Ownership			179,913	179,913	179,913		179,913			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops		30	3,041	3,071	3,071	(3,071)				40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			38,194	38,194	38,194		38,194			42
43	Other (specify):*			6,598	6,598	6,598	(6,598)				43
44	TOTAL Special Cost Centers		30	47,833	47,863	47,863	(9,669)	38,194			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,692,567	349,725	1,227,195	3,269,487	3,269,487	(250,585)	3,018,902			45

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

Facility Name & ID Number Prophets Riverview

0012955

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

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	(10,134)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,304)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	2,366	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,860)	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	(223,364)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (247,296)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(3,289)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (3,289)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (250,585)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

Prophets Riverview

ID# 0012955

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	UNIFORM INCOME	\$ (688)	21	1
2	WANDERGARD	(1,300)	10	2
3	TRANSPORTATION	(8,425)	6	3
4	RESIDENT SUPPLIES	(68)	7	4
5	INT INC PAST DUE ACCTS	(18)	21	5
6	BANK CHARGES	(34)	21	6
7	COLLECTION AGENCY FEES	(243)	21	7
8	PRESCR DRUGS REIMB	(83,607)	10	8
9	BARBER/BEAUTY EXPENSE	(3,071)	40	9
10	SUPPLIES RES DEV	(230)	21	10
11	SM EQUIPMENT RES DEV	(150)	21	11
12	NEWSLETTER RES DEV	(215)	27	12
13	STAFF DEV RES DEV	(29)	23	13
14	TRAVEL RES DEV	(202)	24	14
15	C/SERV-SHARED EMPL	(11,535)	27	15
16	THERAPY OFFSET	(89,229)	10A	16
17	MARKETING EXPENSE	(1,545)	21	17
18	PURCH SVC LABORATORY	(4,701)	43	18
19	PURCH SVC RADIOLOGY	(1,897)	43	19
20	PARM INOCULATIONS	(2,059)	10	20
21	MED SUPPLIES PART B	(8,810)	10	21
22	ADMIN/DISCOUNT ALLOWANCE	(162)	21	22
23	DISCOUNT ALLOWANCE NURSING	(1,337)	10	23
24	DISCOUNT ALLOWANCE THERAPY	(18)	10	24
25	DISCOUNT ALLOWANCE HIM	(20)	10	25
26	DISCOUNT ALLOWANCE ACTIVITIES	(67)	11	26
27	DISCOUNT ALLOWANCE SS	(5)	12	27
28	DISCOUNT ALLOWANCE LAUNDRY	(284)	4	28
29	DISCOUNT ALLOWANCE HSK	(311)	3	29
30	DISCOUNT ALLOWANCE DIETARY	(135)	1	30
31	DISCOUNT ALLOWANCE PLANT	-26	6	31
32	LESS OUT OF STATE TRAVEL	-2242	24	32
33	Clinic	-486	10	33
34	Newletter Activities	-215	21	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	(223,364)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prophets Riverview

0012955

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(135)	0	0	0	0	0	0	0	0	0	0	(135)	1
2	Food Purchase	(10,134)	0	0	0	0	0	0	0	0	0	0	(10,134)	2
3	Housekeeping	(311)	0	0	0	0	0	0	0	0	0	0	(311)	3
4	Laundry	(284)	0	0	0	0	0	0	0	0	0	0	(284)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(8,451)	0	0	0	0	0	0	0	0	0	0	(8,451)	6
7	Other (specify):*	(68)	0	0	0	0	0	0	0	0	0	0	(68)	7
8	TOTAL General Services	(19,383)	0	0	0	0	0	0	0	0	0	0	(19,383)	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	(97,637)	0	0	0	0	0	0	0	0	0	0	(97,637)	10
10a	Therapy	(89,229)	0	0	0	0	0	0	0	0	0	0	(89,229)	10a
11	Activities	(6,371)	0	0	0	0	0	0	0	0	0	0	(6,371)	11
12	Social Services	(5)	0	0	0	0	0	0	0	0	0	0	(5)	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	(193,242)	0	0	0	0	0	0	0	0	0	0	(193,242)	16
	C. General Administration													
17	Administrative	0	2,081	0	0	0	0	0	0	0	0	0	2,081	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(9,860)	0	0	0	0	0	0	0	0	0	0	(9,860)	20
21	Clerical & General Office Expenses	(919)	0	0	0	0	0	0	0	0	0	0	(919)	21
22	Employee Benefits & Payroll Taxes	0	1,624	0	0	0	0	0	0	0	0	0	1,624	22
23	Inservice Training & Education	(29)	0	0	0	0	0	0	0	0	0	0	(29)	23
24	Travel and Seminar	(2,444)	0	0	0	0	0	0	0	0	0	0	(2,444)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	(6,994)	0	0	0	0	0	0	0	0	0	(6,994)	26
27	Other (specify):*	(11,750)	0	0	0	0	0	0	0	0	0	0	(11,750)	27
28	TOTAL General Administration	(25,002)	(3,289)	0	(28,291)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(237,627)	(3,289)	0	(240,916)	29								

STATE OF ILLINOIS

Facility Name & ID Number Prophets Riverview

0012955

Report Period Beginning:

1/1/2006 Ending:

Summary B

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(3,071)	0	0	0	0	0	0	0	0	0	0	(3,071)	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):*	(6,598)	0	0	0	0	0	0	0	0	0	0	(6,598)	43
44	TOTAL Special Cost Centers	(9,669)	0	0	0	0	0	0	0	0	0	0	(9,669)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(247,296)	(3,289)	0	(250,585)	45								

Facility Name & ID Number Prophets Riverview

0012955

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Evangelical Lutheran Good Samaritan Society 100</u>						

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	<u>17 Admin/Acctg</u>	\$ <u>129,885</u>	<u>The Evangelical Lutheran Good Samaritan Society</u>	<u>100.00%</u>	\$ <u>131,966</u>	\$ <u>2,081</u>	1
2	V	<u>22 Unemployment</u>	<u>4,012</u>			<u>4,186</u>	<u>174</u>	2
3	V	<u>22 Workers Comp</u>	<u>47,345</u>			<u>49,250</u>	<u>1,905</u>	3
4	V	<u>26 Insurance</u>	<u>30,046</u>			<u>23,052</u>	<u>(6,994)</u>	4
5	V	<u>22 Health Insurance</u>	<u>142,353</u>			<u>141,898</u>	<u>(455)</u>	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 353,641			\$ 350,352	\$ * (3,289)	14

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

Facility Name & ID Number Prophets Riverview # 0012955 Report Period Beginning: 1/1/2006 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									\$		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	\$		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 Prophets Riverview

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
		A. Directly Facility Related										
Long-Term												
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
Working Capital												
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
B. Non-Facility Related*												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	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.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	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.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2001	_____	8		
2002	_____	9		
2003	_____	10		
2004	_____	11		
2005	_____	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2005	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

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 Prophets Riverview COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0012955

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 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 Prophets Riverview

0012955 Report Period Beginning:

1/1/2006 Ending:

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,259 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).

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			1966	\$ 15,000	1
2					2
3	TOTALS			\$ 15,000	3

Facility Name & ID Number Prophets Riverview

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XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1967	\$ 347,119	\$ 8,678	40	\$ 8,678		\$ 340,610	4
5											5
6											6
7											7
8											8
Improvement Type**											
9				1973	669	17	40	17		555	9
10				1974	483	12	40	12		392	10
11				1975	31,653	791	varies	791		25,323	11
12				1977	4,676		20			4,676	12
13				1979	7,265		20			7,265	13
14				1980	2,114	9	varies	9		2,000	14
15				1981	58,599	1,404	varies	1,404		37,871	15
16				1982	8,455		varies			8,455	16
17				1983	14,821		varies			14,821	17
18				1984	8,772		varies			8,772	18
19				1985	25,345		varies			25,345	19
20				1986	7,033	9	varies	9		7,033	20
21				1987	78,081	3,616	varies	3,616		74,812	21
22				1988	48,071	1,120	varies	1,120		44,281	22
23				1989	102,492	21	varies	21		102,447	23
24				1990	922,005	40,867	varies	40,867		800,313	24
25				1991	5,729	119	varies	119		5,722	25
26				1992	24,955	534	varies	534		23,689	26
27				1993	11,809	283	varies	283		10,696	27
28				1994	45,574	959	varies	959		41,253	28
29				1995	31,371	693	varies	693		27,532	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,787,091	\$ 59,132		\$ 59,132	\$	\$ 1,613,863	70

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,787,091	\$ 59,132		\$ 59,132	\$	\$ 1,613,863	1
2	FLOOR COVERING FOR MAINT RM	1996	605		10			605	2
3	BATH CABINETS FOR RESIDENT	1996	784	39	20	39		431	3
4	CEILING TILE	1996	496		10			496	4
5	FRP BOARD AND SUPPLIES FOR 200	1996	205	14	15	14		149	5
6	REPLACE WATER LINES FROM BOILER	1996	6,000	240	25	240		2,589	6
7	SANITIZING ROOM 1/2 DOWN	1996	5,497	46	10	46		5,497	7
8	INSTALL DEMLITE IN 200 WING CL	1996	453	23	20	23		246	8
9	COUNTER TOP/DINING ROOM	1996	365	18	20	18		195	9
10	LAVATORY WATER CLOSET TANK FAU	1996	445	22	20	22		237	10
11	YORK A/C ROOF UNIT FOR 300 WING	1996	7,100	473	15	473		4,970	11
12	INSULATION VALVES ON CIRCULATION	1996	1,300	76	10	76		1,300	12
13	REMOVE AND REPLACE COUNTER	1996	600	40	15	40		416	13
14	AT & PARTNER SYS CONFIGURATION	1996	8,646		6			8,226	14
15	STEEL FIRE DOORS	1996	2,857	143	20	143		1,488	15
16	AIR COMPRESSOR FOR AIR HANDLER	1996	511		5			488	16
17	INSTALL WINDOWS AND SCREENS	1996	420	28	15	28		289	17
18	WATER SYSTEM	1996	4,500	225	20	225		2,306	18
19	SIX BIRCH DOORS	1997	590	39	15	39		387	19
20	AMPLIFIER INTERCOM	1997	617	62	10	62		602	20
21	1200 BUT GOODMAN AIR CONDITIONER	1997	377		5			377	21
22	GREEN LOUVERED SHUTTERS	1997	475	47	10	47		459	22
23	INSTALL NEW BOOSTER HEATER	1997	1,286	129	10	129		1,233	23
24	REPLACE MOTOR COUPLING	1997	1,559	156	10	156		1,494	24
25	RECONFIGURED WATER HEAT LOOP	1997	1,800	180	10	180		1,725	25
26	18 ROOM/CLOSET DOOR/COMPLETE	1997	6,320	421	15	421		4,003	26
27	OUTDOOR HOME SIGN	1997	1,000	67	15	67		633	27
28	36" DOOR FROAM GUARDS/CONTACT	1997	1,127	75	15	75		645	28
29	OUTDOOR NURSING HOME SIGN	1997	2,000	200	10	200		1,883	29
30	REMODLE BATH/CLEAN & SOILED UTILITY	1997	33,471	1,339	25	1,339		13,165	30
31	PLUMBING REMODEL 100 WING	1997	504	25	20	25		248	31
32	CABINETS	1998	858	57	15	57		500	32
33	COUNTER TOPS	1998	2,326	155	15	155		1,357	33
34	TOTAL (lines 1 thru 33)		\$ 1,882,185	\$ 63,471		\$ 63,471	\$	\$ 1,672,502	34

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,882,185	\$ 63,471		\$ 63,471	\$	\$ 1,672,502	1
2	PHOTO ELECTRIC SMOKE DETECTOR	1998	420	42	10	42		361	2
3	LACATORY FAUCET WITH POP UP	1998	362	18	20	18		157	3
4	PLASTERING WALLS	1998	2,500		5			2,500	4
5	LABOR MATERIAL FOR WALLPAPER	1998	3,966	397	10	397		3,371	5
6	WALLPAPER & BOARDER-DINING ROOM	1998	1,529		5			1,529	6
7	WALLPAPER & BOARDER-DINING ROOM	1998	2,925		5			2,925	7
8	MATERIAL FOR WALL AND PAINTING	1998	6,125		5			6,125	8
9	TOILET AND TANK	1998	373	37	10	37		314	9
10	DINING ROOM AND DOORS KOROGARD	1998	5,925	395	10	395		3,324	10
11	NURSES STATION	1998	6,401	427	5	427		3,521	11
12	WALLCOVERING	1998	5,209		5			5,209	12
13	CARPET 450 SQ YARDS	1998	10,077		5			10,077	13
14	MATERIAL AND LOBOR TO CABLE	1998	6,033	302	20	302		2,514	14
15	STAFF ENTERANCE HALL FLOORING	1998	1,151		5			1,151	15
16	PLUMBING REPAIR	1999	2,644	264	10	264		2,115	16
17	CARPET	1998	3,750		5			3,750	17
18	DOOR ON 300 WING	1999	600	40	15	40		320	18
19	GREASE TRAP	1999	626	63	10	63		501	19
20	LAVATORY FAUCETS	1999	732	37	20	37		290	20
21	ENTRANCE ON 300 WING	1999	600	40	15	40		310	21
22	PULLED STOOL FLANGE	1999	443	44	10	44		343	22
23	BOILER	1999	694	69	10	69		533	23
24	GUTTERS REPLACEMENT	1999	8,260	826	10	826		6,264	24
25	REBUILT CORNER/ OVERHEAD PORCH	1999	560	56	10	56		420	25
26	FAUCETS	1999	1,070	54	20	54		401	26
27	TOILET AND TANK	1999	1,628	81	20	81		611	27
28	WATER HEATER	2000	4,981	498	10	498		3,445	28
29	FLOORING	2000	1,338		5			1,338	29
30	AM STANDARD FAUCETS	2000	953	48	20	48		308	30
31	GENERATOR REPAIR	2000	966	97	10	97		612	31
32	VINAL FLOOR FINSH RESIDENTS ROOM	2000	7,427	743	10	743		4,516	32
33	VINYL FLOORING	2001	477	48	10	48		286	33
34	TOTAL (lines 1 thru 33)		\$ 1,972,930	\$ 68,097		\$ 68,097	\$	\$ 1,741,943	34

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,972,930	\$ 68,097		\$ 68,097	\$	\$ 1,741,943	1
2	LOCKSET	2001	1,314	88	15	88		526	2
3	DOOR LOCKS	2001	1,825	122	15	122		730	3
4	TOILET	2001	353	18	20	18		103	4
5	FIRE ALARM PANEL	2001	395	25	15	25		167	5
6	CARPET FOR WING HALLS	2001	13,485	450	5	450		13,485	6
7	CARPET FOR CHAPEL	2001	5,820	291	5	291		5,820	7
8	TOILETS	2001	353	18	20	18		103	8
9	AIR CONDITIONER	2001	708	47	5	47		708	9
10	AC FOR BEAUTY SHOP	2001	329	22	5	22		329	10
11	CEILING FOR DINING ROOM	2001	1,394	93	15	93		488	11
12	WALL UNIT PANELS PRIV SCREEN	2001	968	65	5	65		350	12
13	CENTILAITON	2001	143,372	9,558	15	9,558		47,791	13
14	CORNER GUARDS-RESIDENT ROOMS	2001	162	16	10	16		82	14
15	DOORS-RESIDENT ROOMS	2001	1,770	118	15	118		600	15
16	DUCT WORK RESIDENT ROOMS	2001	2,139	107	20	107		544	16
17	INTERIOR PARTITONS RESIDENT ROOMS	2001	844	56	15	56		286	17
18	PAINT RESIDENT ROOM REMODEL	2001	181	33	5	33		181	18
19	CORNER GARDERS RESIDENT ROOMS	2001	558	56	10	56		284	19
20	WALL PAPER RESIDENT ROOM REMODEL	2001	6,694	1,228	5	1,228		6,694	20
21	CARPET	2002	1,107	221	5	221		1,052	21
22	CABINET WINDOW KITCHEN	2002	1,726	173	10	173		791	22
23	BLINDS REMODEL 8 ROOMS	2002	217	43	5	43		177	23
24	BUILDING REMODEL 8 ROOMS	2002	924	37	25	37		151	24
25	CORNER GARDS REMODEL 8 ROOMS	2002	139	14	10	14		57	25
26	DRAPES REMODEL 8 ROOMS	2002	14	3	5	3		11	26
27	DUCT WORK REMODEL 8 ROOMS	2002	1,115	56	20	56		228	27
28	PLUMBING REMODEL 8 ROOMS	2002	354	24	15	24		96	28
29	SHADES	2002	364	73	5	73		297	29
30	GARAGE STORAGE BUILDING	2003	60,774	4,052	15	4,052		16,206	30
31	DINING ROOM COUNTER TOP AND BASE	2003	509	34	15	34		136	31
32	WATER SOFENER	2002	6,291	629	10	629		2,517	32
33	DIETARY ENTERANCE DOOR	2003	1,960	131	15	131		414	33
34	TOTAL (lines 1 thru 33)		\$ 2,231,088	\$ 85,998		\$ 85,998	\$	\$ 1,843,347	34

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,231,088	\$ 85,998		\$ 85,998	\$	\$ 1,843,347	1
2	TOLIET BOWL, TANK, SINK	2004	1,693	85	20	85		221	2
3	FLOOR FOR ROOM 108	2004	1,897	190	10	190		522	3
4	FIRE ALARM SYSTEM	2004	59,225	5,923	10	5,923		16,780	4
5	WOOD FLOOR/BEAUTY SHOP	2004	4,969	248	20	248		642	5
6	SHOWER UNIT	2004	445	44	10	44		107	6
7	FIRE ALARM SYSTEM	2004	556	28	20	28		60	7
8	HERITAGE GREEN SHUTTER	2005	936	94	10	94		156	8
9	SIEMENS HIPATH 3750 OHNE SYSTEM	2005	20,546	2,055	10	2,055		3,092	9
10	ENTERANCE DOORS AND AUTO OPENERS	2005	8,319	416	20	416		451	10
11	BLINDS REMODEL RESIDENT ROOMS	2005	138	28	5	28		30	11
12	BUILDING REMODEL RESIDENT ROOMS	2005	17,662	1,766	10	1,766		1,913	12
13	CORNER GARD REMODEL RESIDENT ROOMS	2005	88	18	5	18		19	13
14	PAINT REMODEL RESIDENT ROOMS	2005	390	78	5	78		84	14
15	WALLPAPER REMODEL RESIDENT ROOMS	2005	710	142	5	142		154	15
16	RESIDENT ROOM FLOORING	2005	58,123	5,812	10	5,812		9,203	16
17	ESCIERIOR MASONRY RESTORATION	2006	43,228	1,261	20	1,261		1,261	17
18	WATER HEATE	2006	3,895	227	10	227		227	18
19	REPLACE VENTILATION SYSTEM	2006	75,926	5,062	15	5,062		5,062	19
20	GUTTERS DOWNSPOUT	2006	1,275	57	15	57		57	20
21	BUILDING REMODEL LOUNGE INTO ACTIVITY	2006	11,453	38	25	38		38	21
22	CABI REMODEL LOUNGE INTO ACTIVITY	2006	19,850	110	15	110		110	22
23	FAN REMODEL LOUNGE INTO ACTIVITY	2006	326	3	10	3		3	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,562,738	\$ 109,683		\$ 109,683	\$	\$ 1,883,539	34

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

Facility Name & ID Number Prophets Riverview

0012955

Report Period Beginning:

1/1/2006

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 2,562,738	\$ 109,683		\$ 109,683	\$	\$ 1,883,539	1
2	LAND IMPROVEMENT								2
3	CEMENT	1991	461	15	15	15		461	3
4	SIDEWALKS 1967	1967	1,223		15			1,223	4
5	WALKS-DIVES-PARKING	1975	3,363		15			3,363	5
6	BLACKTOP PARKING LOT	1978	2,250		15			2,250	6
7	FENCE SEARS	1978	604		15			604	7
8	PARKING LOT PAVE	1979	2,940		15			2,940	8
9	TREES PLANTS AND OVERALL LANDS	1981	2,147		10			2,147	9
10	LANDSCAPING CKS 4016+4041+418	1982	2,492		10			2,492	10
11	TREES	1983	850		10			850	11
12	LANDSCAPING	1983	400		10			400	12
13	TREES SHRUBS AND PLANTING MATTER	1990	560		10			560	13
14	FLOWERS TOPSOIL ROCK FOR LANDS	1990	858		10			858	14
15	GATE AND FENCE CONSTRUCTION	1991	726		10			726	15
16	NEW OUTSIDE SIGN	1992	2,895		12			2,895	16
17	SIDEWALK	1992	1,200	80	15	80		1,160	17
18	LANDSCAPING AROUND SIGN	1992	536		10			536	18
19	LANDSCAPING	1992	2,446		10			2,446	19
20	FIELD SERVEY & PEAT PREP OF EX	1991	1,381	38	15	38		1,381	20
21	BLACKTOP PARKING LOT	1993	428		10			428	21
22	FENCE	1994	1,049	70	15	70		885	22
23	LANDSCAPING FOR FRONT	1995	4,152		10			4,152	23
24	1 COAT OF SEALER TO PARKING LOT	1995	1,500		5			1,500	24
25	GAZEBO AND PREPARATION	1996	3,234	162	20	162		1,725	25
26	REMOVE EXISTING PAYMENT	1997	7,843	392	20	392		3,693	26
27	SEAL COAT FRONT PARKING LOT	1997	2,500	250	10	250		2,354	27
28	MULCH EDGING FABRIC WEED	1998	582		5			582	28
29	EDGING PIPEDRAIN ELBOW	1998	1,062	106	10	106		912	29
30	GUTTER SCREEN RETAINING WALL	1998	902	90	10	90		760	30
31	PERENNIAL/PLANTING/LANDSCAPPING	1999	1,726	155	10	155		1,104	31
32	LANDSCAPING	2000	1,094	109	10	109		702	32
33	PARKING LOT OVERLAY/SEAL	2000	22,000	1,100	20	1,100		5,867	33
34	TOTAL (lines 1 thru 33)		\$ 2,638,142	\$ 112,250		\$ 112,250	\$	\$ 1,935,495	34

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

Facility Name & ID Number Prophets Riverview

0012955

Report Period Beginning:

1/1/2006

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 2,638,142	\$ 112,250		\$ 112,250	\$	\$ 1,935,495	1
2	LANDSCAPING	2005	1,300	65	20	65		81	2
3	BLACK DIRT	2006	1,305	80	15	80		80	3
4	LANDSCAPING	2006	3,433	134	15	134		134	4
5	CHIST STATUE	2006	9,940	249	20	249		249	5
6	BULK MULCH PREEN LANDSCAPING	2006	2,094	157	10	157		157	6
7	LANDSCAPING 200/300 WING	2006	32,006	800	10	800		800	7
8	LANDSCAPE MEMORIAL GARDENS	2005	110,518	7,368	15	7,368		9,210	8
9	FIELD SURVEY AND PEAT PREP	1991	1,400		10			1,374	9
10									10
11									11
12									12
13									13
14	PIOR YEAR DEPRCIATION			247		247			14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,800,138	\$ 121,350		\$ 121,350	\$	\$ 1,947,580	34

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

Facility Name & ID Number Prophets Riverview # 0012955 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

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	\$ 492,793	\$ 45,470	\$ 45,470	\$		\$ 329,384	71
72	Current Year Purchases	47,636	3,106	3,106			3,106	72
73	Fully Depreciated Assets	312,778	2,604	2,604			312,778	73
74								74
75	TOTALS	\$ 853,207	\$ 51,180	\$ 51,180	\$		\$ 645,268	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT CARE	VAN AND LICENSE	1992	\$ 35,985	\$	\$	\$	4	\$ 35,985	76
77	RESIDENT CARE	2002 OLS MINI VAN	2004	16,850	2,812	2,812		6	6,538	77
78										78
79										79
80	TOTALS			\$ 52,835	\$ 2,812	\$ 2,812	\$		\$ 42,523	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)		\$ 3,721,180	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 175,342	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 175,342	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,635,371	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	APARTMENTS UNIT 40	\$	\$	\$	86
87	BUILDING	70,002	1,999	53,168	87
88	FFE	8,528	106	8,218	88
89					89
90					90
91	TOTALS	\$ 78,530	\$ 2,105	\$ 61,386	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 134,583	92
93			93
94			94
95		\$ 134,583	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	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 4,571 Description: COMPUTER EQUIP LEASE, COMOPANION REMAN PUMP DISHWASHER

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
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	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Ln 10a, Col 3	1510 hrs	\$ 97,022		\$		1,510	\$ 97,022	1
2	Licensed Speech and Language Development Therapist	Ln 10a, Col 3	457 hrs	33,143				457	33,143	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a, Col 3	1849 hrs	118,127				1,849	118,127	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$ 248,292		\$	\$	3,816	\$ 248,292	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 Prophets Riverview# 0012955Report Period Beginning: 1/1/2006

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 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 83,430	\$	1
2	Cash-Patient Deposits	2,351		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	487,250		3
4	Supply Inventory (priced at)	13,775		4
5	Short-Term Investments	1,032,956		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,025		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,620,787	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000		13
14	Buildings, at Historical Cost	2,632,744		14
15	Leasehold Improvements, at Historical Cost	237,399		15
16	Equipment, at Historical Cost	914,570		16
17	Accumulated Depreciation (book methods)	(2,696,737)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	244,055		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Asset mang CIP</u>	134,582		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,481,613	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,102,400	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 67,124	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,351		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	144,610		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,360		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Group insurance</u>	(37)		36
37	<u>Security apt.</u>	1,615		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 221,023	\$	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 221,023	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,881,377	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,102,400	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,553,471	1
2	Restatements (describe):		2
3	Apartments	26,467	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,579,938	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	332,035	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) Dnr Rst Prop Gft Cash	1,189	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 333,224	17
B. Transfers (Itemize):			
18	Cash Asset Assessment-Co	(28,935)	18
19	Dnr Rst Oper Gft Cash	(2,850)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (31,785)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,881,377	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Prophets Riverview

0012955

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

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	\$ 3,046,235	1
2	Discounts and Allowances for all Levels	(770,428)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,275,807	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	702,043	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 702,043	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	3,033	13
14	Non-Patient Meals	12,361	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	219,260	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	687	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 235,341	23
D. Non-Operating Revenue			
24	Contributions	189,246	24
25	Interest and Other Investment Income***	127,151	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 316,397	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NSG AND MED SUPPLES	42,919	28
28a	SCHEDULE ATTACHED	29,015	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 71,934	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,601,522	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	665,950	31
32	Health Care	1,595,502	32
33	General Administration	780,259	33
B. Capital Expense			
34	Ownership	179,913	34
C. Ancillary Expense			
35	Special Cost Centers	3,070	35
36	Provider Participation Fee	38,193	36
D. Other Expenses (specify):			
37	Lab and Radiology expenses	6,597	37
38			38
39	Rounding	3	39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,269,487	40
41	Income before Income Taxes (line 30 minus line 40)**	332,035	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 332,035	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

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

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

Facility Name & ID Number Prophets Riverview

0012955

Report Period Beginning: 1/1/2006

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	1,950	2,086	\$ 57,002	\$ 27.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,010	5,438	112,726	20.73	3
4	Licensed Practical Nurses	12,362	14,062	232,384	16.53	4
5	CNAs & Orderlies	46,658	51,374	498,341	9.70	5
6	CNA Trainees	867	921	7,869	8.54	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,281	3,850	38,889	10.10	8
9	Activity Director	1,827	2,065	29,635	14.35	9
10	Activity Assistants	4,124	4,635	41,201	8.89	10
11	Social Service Workers	1,839	1,995	35,678	17.88	11
12	Dietician	1,528	1,771	27,774	15.68	12
13	Food Service Supervisor					13
14	Head Cook	5,147	5,351	56,269	10.52	14
15	Cook Helpers/Assistants	9,747	11,922	104,780	8.79	15
16	Dishwashers					16
17	Maintenance Workers	5,567	6,286	76,694	12.20	17
18	Housekeepers	5,928	6,649	56,079	8.43	18
19	Laundry	5,319	5,961	49,341	8.28	19
20	Administrator	1,869	2,145	58,671	27.35	20
21	Assistant Administrator					21
22	Other Administrative	5,578	6,249	82,290	13.17	22
23	Office Manager	1,859	2,019	26,692	13.22	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	1,716	1,965	24,814	12.63	31
32	Other Health Care(specify)	4,279	4,864	92,706	19.06	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	126,455	141,608	\$ 1,709,835 *	\$ 12.07	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	110	\$ 5,089	Ln 1 Col 3	35
36	Medical Director		3,600	Ln 10, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,133	Ln 10 Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	3	150	Ln 11 Col 3	44
45	Social Service Consultant	7	350	Ln12 Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	120	\$ 11,322		49

C. CONTRACT NURSES

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

Facility Name & ID Number Prophets Riverview

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report?
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? 6 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,374 Line 10 Col 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. \$ 38,194
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. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,134
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? _____
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. \$ Yes
c. What percent of all travel expense relates to transportation of nurses and patients? 45%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Henry Scholten & Comopany 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.