

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2

0031393 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	111	Intermediate (ICF)	111	40,515	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	111	TOTALS	111	40,515	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	
8	SNF				8
9	SNF/PED				9
10	ICF	25,858	911	12,329	39,098
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	25,858	911	12,329	39,098

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.50%

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 12/01/86

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/01/86 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 _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number **SKOKIE MEADOWS N CENTER #2** # **0031393** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	136,214	14,849	9,044	160,107		160,107	0	160,107		1
2	Food Purchase		146,102		146,102	0	146,102	(92)	146,010		2
3	Housekeeping	172,829	22,158	0	194,987		194,987	0	194,987		3
4	Laundry	78,594	7,595	0	86,189	0	86,189	0	86,189		4
5	Heat and Other Utilities			69,710	69,710		69,710	185	69,895		5
6	Maintenance	0	12,596	23,685	36,281		36,281	766	37,047		6
7	Other (specify):*			9,922	9,922		9,922	0	9,922		7
8	TOTAL General Services	387,637	203,300	112,361	703,298	0	703,298	859	704,157		8
	B. Health Care and Programs										
9	Medical Director	0		6,600	6,600		6,600	0	6,600		9
10	Nursing and Medical Records	1,015,363	162,435	40,798	1,218,596		1,218,596	0	1,218,596		10
10a	Therapy	0		0	0		0	0	0		10a
11	Activities	72,531	6,946	0	79,477		79,477	0	79,477		11
12	Social Services	170,869		4,342	175,211		175,211	0	175,211		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			395	395		395	0	395		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	1,258,763	169,381	52,135	1,480,279	0	1,480,279	0	1,480,279		16
	C. General Administration										
17	Administrative	0		130,684	130,684		130,684	30,779	161,463		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			30,978	30,978		30,978	21,142	52,120		19
20	Dues, Fees, Subscriptions & Promotions			15,500	15,500		15,500	(8,311)	7,189		20
21	Clerical & General Office Expenses	40,550	8,071	249,461	298,082		298,082	(142,831)	155,251		21
22	Employee Benefits & Payroll Taxes			347,448	347,448	0	347,448	0	347,448		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			24,030	24,030		24,030	0	24,030		24
25	Other Admin. Staff Transportation			5,202	5,202		5,202	0	5,202		25
26	Insurance-Prop.Liab.Malpractice			71,252	71,252		71,252	6,060	77,312		26
27	Other (specify):*			0	0		0	13,532	13,532		27
28	TOTAL General Administration	40,550	8,071	874,555	923,176	0	923,176	(79,629)	843,547		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,686,950	380,752	1,039,051	3,106,753	0	3,106,753	(78,770)	3,027,983		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	8,294
	REPAIRS & MAINTENANCE	750
		0
		9,044
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	36,254
	ELECTRICITY	27,528
	WATER	5,928
	CABLE TV - LOBBY	0
		0
		69,710
6	MAINTENANCE	
	GROUNDS MAINTENANCE	13,137
	PAINTING & DECORATING	413
	BUILDING REPAIRS	1,933
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	1,504
	ELEVATOR MAINTENANCE & REPAIR	4,036
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,066
	FIRE SERVICE	1,596
		0
		0
		0
		0
		23,685
7	OTHER	
	SCAVENGER	7,924
	SECURITY SERVICE	1,998
		0
		0
		9,922
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,600
		6,600

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	6,165
	PURCHASED SERVICES	25,569
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,224
	PHARMACY CONSULTANT XVIII B 39-2	2,040
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	2,800
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		40,798
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	4,342
		0
		4,342
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	395
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	130,684
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	4,486
	ADMINISTRATIVE CONSULTANTS XIX C	3,000
	PROFESSIONAL FEES XIX C	23,492
		0
		30,978
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	5,728
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	50
	DUES & SUBSCRIPTIONS XIX F	6,114
	LICENSES & PERMITS XIX F	925
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	624
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,909
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	150
	PATIENT BACKGROUND CHECKS XIX F	0
		15,500
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,848
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	205,000
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	13,347
	MESSENGER SERVICE	0
	OUTSIDE SERVICES	29,266
		249,461

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	121,910
	UNEMPLOYMENT COMPENSATION XIX D	15,168
	WORKERS COMPENSATION INSURANC XIX D	23,045
	HOSPITALIZATION INSURANCE XIX D	160,808
	EMPLOYEE BENEFITS - OTHER XIX D	5,549
	EMPLOYEE PHYSICAL EXAMS XIX D	1,750
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	19,218
	CHICAGO HEAD TAX XIX D	0
		0
		347,448
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	285
	TRAVEL XIX G	23,745
		24,030
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	5,202
		5,202
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	71,252
		71,252
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,039,051

SKOKIE MEADOWS N CENTER #2
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	146,102	PATIENT MEALS	117294
LESS SALES TAX	(92)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	146,010	TOTAL MEALS/YEAR	117294
TOTAL PATIENT CENSUS	39,098	NET FOOD	146010
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	117294

TOTAL PATIENT MEALS	117294	COST PER MEAL	1.24
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number **SKOKIE MEADOWS N CENTER #2**

#0031393

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			18,785	18,785		18,785	88,708	107,493			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			53,343	53,343		53,343	466,053	519,396			32
33	Real Estate Taxes			162,797	162,797		162,797	0	162,797			33
34	Rent-Facility & Grounds			528,748	528,748		528,748	(528,748)	0			34
35	Rent-Equipment & Vehicles			23,395	23,395		23,395	4,379	27,774			35
36	Other (specify):* Amort Comp Soft			4,254	4,254		4,254	0	4,254			36
37	TOTAL Ownership			791,322	791,322	0	791,322	30,392	821,714			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			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			60,773	60,773		60,773	0	60,773			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	60,773	60,773	0	60,773	0	60,773			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,686,950	380,752	1,891,146	3,958,848	0	3,958,848	(48,378)	3,910,470			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,454	30		9
10	Interest and Other Investment Income	(36)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(92)	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	0	21		18
19	Entertainment	0	20		19
20	Contributions	(1,959)	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	(5,728)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(624)	20		28
29	Other-Attach Schedule	(235,348)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (242,333)		\$ 0	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	193,955		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 193,955		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (48,378)		37

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

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

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

SKOKIE MEADOWS N CENTER #2

ID# 0031393

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 766	6	1
2	BANK CHARGE	(1,848)	21	2
3	OUTSIDE CLERICAL SERVICE	(205,000)	21	3
4	OUTSIDE SERVICES	(29,266)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(235,348)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2# 0031393

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	(92)	0	0	0	0	0	0	0	0	0	0	(92)	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	185	0	0	0	0	0	0	0	0	0	185	5
6	Maintenance	766	0	0	0	0	0	0	0	0	0	0	766	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	674	185	0	0	0	0	0	0	0	0	0	859	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	30,779	0	0	0	0	0	0	0	0	0	30,779	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	21,142	0	0	0	0	0	0	0	0	0	21,142	19
20	Fees, Subscriptions & Promotions	(8,311)	0	0	0	0	0	0	0	0	0	0	(8,311)	20
21	Clerical & General Office Expenses	(236,114)	93,283	0	0	0	0	0	0	0	0	0	(142,831)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	1,124	4,936	0	0	0	0	0	0	0	0	6,060	26
27	Other (specify):*	0	13,532	0	0	0	0	0	0	0	0	0	13,532	27
28	TOTAL General Administration	(244,425)	159,860	4,936	0	(79,629)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(243,751)	160,045	4,936	0	(78,770)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2

0031393

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,454	0	87,254	0	0	0	0	0	0	0	0	88,708	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(36)	0	466,089	0	0	0	0	0	0	0	0	466,053	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(528,748)	0	0	0	0	0	0	0	0	(528,748)	34
35	Rent-Equipment & Vehicles	0	4,379	0	0	0	0	0	0	0	0	0	4,379	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,418	4,379	24,595	0	30,392	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(242,333)	164,424	29,531	0	(48,378)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JACOB GRAFF	100	SKOKIE MEADOWS I	SKOKIE	PREMIER		MANAGEMENT
		MOMENCE MEADOWS		MANAGEMENT	SKOKIE	BOOKKEEPING

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 FEE	\$ 130,684	PREMIER MANAGEMENT		\$	(130,684)	1	
2	V	5 UTILITIES				185	185	2	
3	V	17 OFFICER SALARIES				77,000	77,000	3	
4	V	17 ADMINISTRATIVE SALARIES				49,503	49,503	4	
5	V	17 ADMINISTRATIVE SALARIES				34,960	34,960	5	
6	V	19 PROFESSIONAL FEES				21,142	21,142	6	
7	V	21 CLERICAL SALARIES				45,939	45,939	7	
8	V	21 CLERICAL SALARIES				16,046	16,046	8	
9	V	21 CLERICAL SALARIES				15,380	15,380	9	
10	V	21 OFFICE EXPENSE				15,918	15,918	10	
11	V	26 INSURANCE				1,124	1,124	11	
12	V	27 PAYR.TAXES/HEALTH INS				13,532	13,532	12	
13	V	35 OFFICE RENTAL				4,379	4,379	13	
14	Total		\$ 130,684			\$ 295,108	\$ *	164,424	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	34 RENT	\$ 528,748	M O SKOKIE MEADOWS		\$	(528,748)	15
16	V	26 INSURANCE				4,936	4,936	16
17	V	30 DEPRECIATION				87,254	87,254	17
18	V	32 INTEREST				466,089	466,089	18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 528,748			\$ 558,279	\$ * 29,531	39

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

Facility Name & ID Number **SKOKIE MEADOWS N CENTER #2** # **0031393** 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	JACOB GRAFF	PRESIDENT	ADMINISTRATIV	100.00	SEE ATTACHED	SEE ATTACHED		SALARY	\$ 77,000	17-7	1
2			BANKING								2
3			FINANCE								3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 77,000		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 SKOKIE MEADOWS N CENTER #2

0031393

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization PREMIER MANAGEMENT
 Street Address 9933 N. LAWLER
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847) 679-7733
 Fax Number (847) 679-7736

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	5	UTILITIES	PER RESIDENT DAY	253,882	8	\$ 1,200	\$ 39,098	\$ 185	1	
2	17	OFFICER SALARIES	PER RESIDENT DAY	253,882	8	500,000	500,000	39,098	77,000	2
3	17	ADMINISTRATIVE SALARIES	DIRECT	10	3	123,758	123,758	4	49,503	3
4	17	ADMINISTRATIVE SALARIES	PER RESIDENT DAY	253,882	8	227,013	227,013	39,098	34,960	4
5	19	PROFESSIONAL FEES	PER RESIDENT DAY	253,882	8	137,283	39,098	39,098	21,142	5
6	21	CLERICAL SALARIES	DIRECT	10	3	114,848	114,848	4	45,939	6
7	21	CLERICAL SALARIES	DIRECT	10	4	53,487	53,487	3	16,046	7
8	21	CLERICAL SALARIES	PER RESIDENT DAY	253,882	8	99,870	99,870	39,098	15,380	8
9	21	OFFICE EXPENSE	PER RESIDENT DAY	253,882	8	103,364	39,098	39,098	15,918	9
10	26	INSURANCE	PER RESIDENT DAY	253,882	8	7,300	39,098	39,098	1,124	10
11	27	PAYR.TAXES/HEALTH INS	PER RESIDENT DAY	253,882	8	87,868	39,098	39,098	13,532	11
12	35	OFFICE RENTAL	PER RESIDENT DAY	253,882	8	28,435	39,098	39,098	4,379	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,484,426	\$ 1,118,976		\$ 295,108	25

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2

0031393 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 M O SKOKIE MEADOWS NURSING
 Street Address 9615 N KNOX
 City / State / Zip Code SKOKIE,IL 60076
 Phone Number (847)679-7733
 Fax Number (847)679-7734

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	26	INSURANCE	DIRECT	1	1	\$ 4,936	\$ 1	\$ 4,936	1
2	30	DEPRECIATION	DIRECT	1	1	87,254	1	87,254	2
3	32	INTEREST	DIRECT	1	1	466,089	1	466,089	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					\$ 558,279	\$	\$ 558,279	25

Facility Name & ID Number

SKOKIE MEADOWS N CENTER #2

0031393

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			
A. Directly Facility Related																		
Long-Term																		
1	CAMBRIDGE		X	MORTGAGE	\$44,062.00	8/16/01	\$ 6,822,050	\$ 6,540,676	8/16/36	0.0710	\$ 466,089	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	IST EQUITY		X	WORKING CAPITAL	INT ONLY			524,852			53,343	6						
7												7						
8												8						
9	TOTAL Facility Related				\$44,062.00		\$ 6,822,050	\$ 7,065,528			\$ 519,432	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14						
15	TOTALS (line 9+line14)						\$ 6,822,050	\$ 7,065,528			\$ 519,432	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.		\$	196,015	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.)		\$	179,406	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(16,609)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	179,406	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.		\$	162,797	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	185,310	8
	2002	189,123	9
	2003	169,742	10
	2004	196,015	11
	2005	179,406	12

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

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

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

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 SKOKIE MEADOWS N CENTER #2 COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031393

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>10-10-304-042-0000</u>	<u>NURSING HOME</u>	\$ <u>179,406.48</u>	\$ <u>179,406.48</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>179,406.48</u>	\$ <u>179,406.48</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2

0031393

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	111	1990		\$ 1,934,075	\$ 61,399	31.5	\$ 61,399	\$	\$ 1,005,447	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	IMPROVEMENTS		1987	1,200	38	15	0	(38)	1,200	9
10	IMPROVEMENTS		1987	1,353	43	20	67	24	1,302	10
11	IMPROVEMENTS		1987	2,329	74	10		(74)	2,329	11
12	IMPROVEMENTS		1989	6,500	206	31.5	206		3,647	12
13	IMPROVEMENTS		1990	159,219	5,055	31.5	5,055		81,846	13
14	IMPROVEMENTS		1991	1,680	53	31.5	53		852	14
15	IMPROVEMENTS		1993	6,920	177	39	177		2,379	15
16	IMPROVEMENTS		1994	21,365	548	39	548		6,725	16
17	ELECTRICAL		1996	3,351	86	39	86		935	17
18	NURSE STATION		1996	18,097	464	39	464		5,047	18
19	RAILS		1996	1,458	37	39	37		403	19
20	NEW CEILING		1996	14,883	382	39	382		4,153	20
21	WINDOW		1996	600	15	39	15		163	21
22	SHOWER ROOM VENTILATION		1996	575	15	39	15		163	22
23	NEW FLOORS		1996	15,709	403	39	403		4,383	23
24	ROOF		1996	23,100	592	39	592		5,994	24
25	PARKING LOT		1997	14,500	967	15	967		9,226	25
26	NEW STAIRCASE		1997	3,600	92	39	92		840	26
27	HOT WATER HEATER		1998	5,557	142	39	142		1,261	27
28	GREASE TRAP		1998	1,967	51	39	51		440	28
29	AWNINGS		1998	3,381	87	39	87		750	29
30	REPAIRS, PATCH, PAINT CEILING		1998	8,970	229	39	229		1,976	30
31	PAINTING, WALLCOVERING, BORDER PAPER		1999	25,619	657	39	657		4,955	31
32	TILING, HAND RAILS, PAINTING, WALL LIGHTS		1999	105,477	2,705	39	2,705		20,400	32
33	WALLCOVERINGS		1999	2,492	64	39	64		483	33
34	DOORS		1999	2,115	54	39	54		407	34
35	FAUCETS		1999	1,208	31	39	31		234	35
36	WALLCOVERINGS		1999	3,016	77	39	77		581	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.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2

0031393

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	PAINTING	1999	\$ 1,422	\$ 36	39	\$ 36		\$ 272	37
38	SIGNS	1999	1,327	34	39	34		256	38
39	WALLCOVERINGS, CHAIR RAILS, KICK PLATES	1999	19,179	492	39	492		3,710	39
40	PAINTING, WALLCOVERINGS, CHAIR RAILS	1999	15,420	395	39	395		2,979	40
41	CUTOM CABINETRY	1999	12,838	329	39	329		2,481	41
42	NEW SHED	1999	1,093	28	39	28		211	42
43	KICK PLATE, WALL BUMPER	1999	9,653	248	39	248		1,870	43
44	LIGHT FIXTURES	1999	380	10	39	10		75	44
45	WINDOWS	1999	51,312	1,316	39	1,316		9,925	45
46	WINDOW WELLS & WATERPROOFING	1999	4,560	117	39	117		882	46
47	LANDSCAPING	1999	38,175	2,545	15	2,545		19,194	47
48	WALLPAPERING	1999	922	24	39	24		181	48
49	SIGNS	1999	2,166	55	39	55		415	49
50	PAINTING & HANDRAILS	1999	2,262	58	39	58		437	50
51	REBUILD WALL & INSTALL WINDOWS	1999	1,409	36	39	36		272	51
52	WATERPROOFING	1999	3,220	83	39	83		626	52
53	NEW VENT FOR DRYER	1999	4,271	109	39	109		822	53
54	GENERATOR	2000	3,900	142	27.5	142		923	54
55	HOT WATER BOILER	2000	3,335	121	27.5	121		787	55
56	FIRE/SMOKE DAMPERS	2000	12,049	438	27.5	438		2,847	56
57	PVC BUMPERS,PAINTING	2000	5,337	477	7	544	67	5,337	57
58	ROOF	2001	8,860	322	27.5	322		1,785	58
59	AWNING	2001	9,135	332	27.5	332		1,840	59
60	CONCRETE	2001	4,242	283	15	283		1,568	60
61	PAVING PARKING LOT	2002	13,500	900	15	900		4,050	61
62	ROOF	2002	66,100	2,404	27.5	2,404		10,918	62
63	TILING IN 4 SHOWER ROOMS	2002	23,400	851	27.5	851		3,865	63
64	TUCKPOINTING	2002	9,360	340	27.5	340		1,544	64
65	ROOF TOP UNITS	2003	12,900	469	27.5	469		1,661	65
66	ROOF TOP UNITS	2003	5,100	185	27.5	185		655	66
67	HATCHES AND INTERIOR FIRE WALLS	2003	18,120	659	27.5	659		2,334	67
68	BLINDS	2003	993	57	5	199	142	796	68
69	HOT WATER BOILER	2004	6,420	233	27.5	233		670	69
70	TOTAL (lines 4 thru 69)		\$ 2,762,676	\$ 88,871		\$ 88,992	\$ 121	\$ 1,254,709	70

**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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,762,676	\$ 88,871		\$ 88,992	\$ 121	\$ 1,254,709	1
2	GENERATOR	2004	25,000	909	27.5	909		1,856	2
3	SIDEWALKS	2006	4,300	215	15	287	72	287	3
4	2 SHOWER ROOMS	2006	6,700	92	27.5	92		92	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	TOTAL (lines 1 thru 33)		\$ 2,798,676	\$ 90,087		\$ 90,280	\$ 193	\$ 1,256,944	34

**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	\$ 165,002	\$ 14,470	\$ 16,842	\$ 2,372	10 YRS	\$ 99,474	71
72	Current Year Purchases	7,412	1,482	371	(1,111)	10 YRS	371	72
73	Fully Depreciated Assets	329,795			0		329,795	73
74					0			74
75	TOTALS	\$ 502,209	\$ 15,952	\$ 17,213	\$ 1,261		\$ 429,640	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 AND ACTIVITIES	1990 DODGE VAN	1990	\$ 20,012	\$	\$	\$ 0		\$ 20,012	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 20,012	\$ 0	\$ 0	\$ 0		\$ 20,012	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)	\$ 3,662,322	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 106,039	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 107,493	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,454	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,706,596	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	TOTAL				\$			7

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

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

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

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

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

16. Rental Amount for movable equipment: \$ 6,936 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	EXE. DIRECTOR	2004 CADI DEVILLE	\$ #####	\$ 14,404	17
18	DUTTON MOTORS	DOWN PAYMENT		1,500	18
19		FORD VAN		555	19
20					20
21	TOTAL		\$ #####	\$ 16,459	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2007 \$ _____

13. _____/2008 \$ _____

14. _____/2009 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							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 prescrpts							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			\$		\$	\$		\$	0

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 SKOKIE MEADOWS N CENTER #2

0031393

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits	7,738		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,088,863		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,005		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,139,606	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	213,137		15
16	Equipment, at Historical Cost	92,166		16
17	Accumulated Depreciation (book methods)	(104,650)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 200,653	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,340,259	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 203,689	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	617,895		29
30	Accrued Salaries Payable	85,183		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	179,406		32
33	Accrued Interest Payable	2,975		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,089,148	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,089,148	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ 251,111	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,340,259	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,000,539)	1
2	Restatements (describe):		2
3	SKOKIE 1 ELIMINATION & POST CLOSING ENTRIES	3,760,019	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (240,520)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	491,631	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 491,631	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 251,111	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,449,053	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,449,053	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	36	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 36	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	1,390	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,390	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,450,479	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	703,298	31
32	Health Care	1,480,279	32
33	General Administration	923,176	33
	B. Capital Expense		
34	Ownership	791,322	34
	C. Ancillary Expense		
35	Special Cost Centers	0	35
36	Provider Participation Fee	60,773	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,958,848	40
41	Income before Income Taxes (line 30 minus line 40)**	491,631	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 491,631	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 NOT COMPLETED AS OF COST REPORT FILING DATE

*** 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 **SKOKIE MEADOWS N CENTER #2**

0031393

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	5,632	6,224	\$ 190,620	\$ 30.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,906	15,091	435,643	28.87	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	33,390	36,472	389,100	10.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,927	6,593	72,531	11.00	10
11	Social Service Workers	8,888	10,040	170,869	17.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,039	15,011	136,214	9.07	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	16,310	17,846	172,829	9.68	18
19	Laundry	7,221	8,206	78,594	9.58	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,161	4,244	40,550	9.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	109,474	119,727	\$ 1,686,950 *	\$ 14.09	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 8,294	1-3	35
36	Medical Director	O	6,600	9-3	36
37	Medical Records Consultant	N	4,224	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,040	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	4,342	12-3	45
46	Other(specify) <u>PHYSICIANS</u>	S	2,800	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 28,300		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
	ADMINISTRATOR		\$ 0	Workers' Compensation Insurance	\$ 23,045	IDPH License Fee	\$	
	ASST ADMIN		0	Unemployment Compensation Insurance	15,168	Advertising: Employee Recruitment	0	
				FICA Taxes	121,910	Health Care Worker Background Check	150	
				Employee Health Insurance	160,808	(Indicate # of checks performed)		
				Employee Meals	0	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,959	
				EMPLOYEE BENEFITS - OTHER	5,549	MARKETING/ADV/PROMO	6,352	
				EMPLOYEE PHYSICAL EXAMS	1,750	LICENSES/DUES/SUBSCRIPTIONS	7,039	
				PENSION/PROFIT SHARING PLANS	19,218	MGMT CO ALLOC		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(1,959)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(5,728)	
						Yellow page advertising	(624)	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 347,448	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 7,189	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
PREMIER MANAGEMENT - MANAGEMENT FEES			\$ 130,684				Out-of-State Travel	\$
							In-State Travel	23,745
							Seminar Expense	285
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 24,030
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL				
C. Professional Services								
Vendor/Payee	Type		Amount					
KEANE CARE	DATA PROCESSING		\$ 1,366					
OMNICARE OF NORTHERN	DATA PROCESSING		3,120					
KRUPNICK,BOKOR,KAGDA	ACCOUNTING		8,313					
THOMASHOW BROWN & PAIALI	ACCOUNTING		7,124					
LARRY SCHWARTZ	ACCOUNTING		375					
JOHN FITZGERALD	LEGAL FEES		6,833					
US HOUSING	INSPECTION		577					
ANTHONY'S MOBI	PERSONEL FINGERPRINTING		270					
JOAN WILLEY	ADMIN. CONSULTANT		3,000					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	2001	\$ 1,246	3 YRS	\$ 415	\$ 208	\$	\$	\$	\$	\$	\$								
2	PAINT/DECORATING	2004	1,500	3 YRS		250	500	500	250											
3	PAINT/DECORATING	2005	591	3 YRS			99	197	197	98										
4	PAINT/DECORATING	2006	413	3 YRS				69	138	138	68									
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$ 3,750		\$ 415	\$ 458	\$ 599	\$ 766	\$ 585	\$ 236	\$ 68	\$								

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2

0031393

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$5528
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 60,773
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