

Facility Name & ID Number SPRINGFIELD TERRACE

0032961 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	65	Intermediate (ICF)	65	23,725	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,725	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					8
9	SNF/PED					9
10	ICF	14,229	387	318	14,934	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,229	387	318	14,934	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.95%

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 11/06/87

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/06/87 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 **SPRINGFIELD TERRACE** # **0032961** 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	72,203	6,866	3,675	82,744		82,744	0	82,744		1
2	Food Purchase		75,822		75,822	0	75,822	(264)	75,558		2
3	Housekeeping	39,951	9,159	0	49,110		49,110	0	49,110		3
4	Laundry	19,204	3,046	0	22,250	0	22,250	0	22,250		4
5	Heat and Other Utilities			46,249	46,249		46,249	1,095	47,344		5
6	Maintenance	18,682		30,732	49,414		49,414	(3,741)	45,673		6
7	Other (specify):*			4,099	4,099		4,099	53	4,152		7
8	TOTAL General Services	150,040	94,893	84,755	329,688	0	329,688	(2,857)	326,831		8
	B. Health Care and Programs										
9	Medical Director	0		13,800	13,800		13,800	0	13,800		9
10	Nursing and Medical Records	475,061	10,977	8,541	494,579		494,579	5,889	500,468		10
10a	Therapy	0		4,055	4,055		4,055	0	4,055		10a
11	Activities	24,892	1,000	3,240	29,132		29,132	(3,240)	25,892		11
12	Social Services	37,035	650	0	37,685		37,685	0	37,685		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	536,988	12,627	29,636	579,251	0	579,251	2,649	581,900		16
	C. General Administration										
17	Administrative	85,807		3,000	88,807		88,807	3,794	92,601		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			113,486	113,486		113,486	(60,474)	53,012		19
20	Dues, Fees, Subscriptions & Promotions			8,630	8,630		8,630	(326)	8,304		20
21	Clerical & General Office Expenses	31,294	2,809	43,532	77,635		77,635	(3,034)	74,601		21
22	Employee Benefits & Payroll Taxes			144,847	144,847	0	144,847	0	144,847		22
23	Inservice Training & Education			0	0		0	156	156		23
24	Travel and Seminar			3,191	3,191		3,191	7,248	10,439		24
25	Other Admin. Staff Transportation			12,887	12,887		12,887	3,345	16,232		25
26	Insurance-Prop.Liab.Malpractice			7,791	7,791		7,791	142	7,933		26
27	Other (specify):*			367	367		367	11,839	12,206		27
28	TOTAL General Administration	117,101	2,809	337,731	457,641	0	457,641	(37,310)	420,331		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	804,129	110,329	452,122	1,366,580	0	1,366,580	(37,518)	1,329,062		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	3,675
	REPAIRS & MAINTENANCE	0
		0
		3,675
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	9,020
	ELECTRICITY	26,854
	WATER	9,555
	CABLE TV - LOBBY	820
		0
		46,249
6	MAINTENANCE	
	GROUNDS MAINTENANCE	350
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE CONSULTANT	9,984
	EQUIPMENT MAINTENANCE & REPAIR	14,061
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	862
	FIRE SERVICE	5,475
		0
		0
		0
		0
		30,732
7	OTHER	
	SCAVENGER	3,408
	SECURITY SERVICE	691
		0
		0
		4,099
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	13,800
		13,800

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	1,461
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	6,240
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	840
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		8,541
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	1,370
	SPEECH THERAPY SERVICES	271
	OCCUPATIONAL THERAPY SERVICES	2,028
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	386
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		4,055
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,240
		0
		3,240
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
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	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	3,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	7,791
	ADMINISTRATIVE CONSULTANTS XIX C	22,480
	PROFESSIONAL FEES XIX C	27,315
	BOOKKEEPING/ ADMINISTRATIVE SERVICE	55,900
20	FEES,SUBSCRIPTIONS,PROMOTIONS	113,486
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	18
	EMPLOYEE WANT ADS XIX F	894
	CONTRIBUTIONS VI 20 XIX F	360
	DUES & SUBSCRIPTIONS XIX F	4,056
	LICENSES & PERMITS XIX F	1,512
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,260
	PATIENT BACKGROUND CHECKS XIX F	530
		8,630
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,201
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	35,535
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	6,746
	MESSENGER SERVICE	50
		0
		43,532

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	63,073
	UNEMPLOYMENT COMPENSATION XIX D	54,827
	WORKERS COMPENSATION INSURANC XIX D	23,850
	HOSPITALIZATION INSURANCE XIX D	1,961
	EMPLOYEE BENEFITS - OTHER XIX D	1,136
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		144,847
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	2,115
	TRAVEL XIX G	1,076
		3,191
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	12,887
		12,887
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	7,791
		7,791
27	OTHER	
	BAD DEBTS VI 24	367
		367

GRAND TOTAL COLUMN 3 OTHER

452,122

SPRINGFIELD TERRACE
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	75,822	PATIENT MEALS	44802
LESS SALES TAX	(264)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	75,558	TOTAL MEALS/YEAR	44802
TOTAL PATIENT CENSUS	14,934	NET FOOD	75558
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	44802

TOTAL PATIENT MEALS	44802	COST PER MEAL	1.69
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number

SPRINGFIELD TERRACE

#0032961

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			2,542	2,542		2,542	22,091	24,633			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			13,308	13,308		13,308	57,989	71,297			32
33	Real Estate Taxes			15,270	15,270		15,270	0	15,270			33
34	Rent-Facility & Grounds			78,629	78,629		78,629	(70,635)	7,994			34
35	Rent-Equipment & Vehicles			8,543	8,543		8,543	2,145	10,688			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			118,292	118,292	0	118,292	11,590	129,882			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			35,588	35,588		35,588	0	35,588			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	35,588	35,588	0	35,588	0	35,588			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	804,129	110,329	606,002	1,520,460	0	1,520,460	(25,928)	1,494,532			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 **SPRINGFIELD TERRACE**

0032961

Report Period Beginning:

01/01/2006

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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,116	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(264)	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	(35,535)	21		18
19	Entertainment	0	20		19
20	Contributions	(360)	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	(367)	27		24
25	Fund Raising, Advertising and Promotional	(18)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	0			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,428)		\$ 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)	7,500		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 7,500		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (25,928)		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

SPRINGFIELD TERRACE

ID# 0032961

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$	6 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			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SPRINGFIELD TERRACE# 0032961

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	(264)	0	0	0	0	0	0	0	0	0	0	(264)	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	1,095	0	0	0	0	0	0	0	0	0	1,095	5
6	Maintenance	0	(3,741)	0	0	0	0	0	0	0	0	0	(3,741)	6
7	Other (specify):*	0	53	0	0	0	0	0	0	0	0	0	53	7
8	TOTAL General Services	(264)	(2,593)	0	0	0	0	0	0	0	0	0	(2,857)	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	5,889	0	0	0	0	0	0	0	0	0	5,889	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	(3,240)	0	0	0	0	0	0	0	0	0	(3,240)	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	2,649	0	0	0	0	0	0	0	0	0	2,649	16
	C. General Administration													
17	Administrative	0	3,794	0	0	0	0	0	0	0	0	0	3,794	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(60,474)	0	0	0	0	0	0	0	0	0	(60,474)	19
20	Fees, Subscriptions & Promotions	(378)	0	52	0	0	0	0	0	0	0	0	(326)	20
21	Clerical & General Office Expenses	(35,535)	0	32,501	0	0	0	0	0	0	0	0	(3,034)	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	156	0	0	0	0	0	0	0	0	156	23
24	Travel and Seminar	0	0	7,248	0	0	0	0	0	0	0	0	7,248	24
25	Other Admin. Staff Transportation	0	0	3,345	0	0	0	0	0	0	0	0	3,345	25
26	Insurance-Prop.Liab.Malpractice	0	0	142	0	0	0	0	0	0	0	0	142	26
27	Other (specify):*	(367)	0	12,206	0	0	0	0	0	0	0	0	11,839	27
28	TOTAL General Administration	(36,280)	(56,680)	55,650	0	(37,310)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(36,544)	(56,624)	55,650	0	(37,518)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SPRINGFIELD TERRACE# 0032961

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	3,116	0	266	18,709	0	0	0	0	0	0	0	22,091	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	1,414	56,575	0	0	0	0	0	0	0	57,989	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	7,994	(78,629)	0	0	0	0	0	0	0	(70,635)	34
35	Rent-Equipment & Vehicles	0	0	2,145	0	0	0	0	0	0	0	0	2,145	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	3,116	0	11,819	(3,345)	0	11,590	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)	(33,428)	(56,624)	67,469	(3,345)	0	(25,928)	45						

Facility Name & ID Number

SPRINGFIELD TERRACE

0032961

Report Period Beginning:

01/01/2006

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
		ARC OF JACKSONVILLE	JACKSONVILLE	MAVIN	SKOKIE, IL	CONSULTING,
SEE ATTACHED SCHEDULE		LITCHFIELD TERRACE	LITCHFIELD	ENTERPRISES, LTD		BOOKKEEPING
		PARKVIEW TERRACE	EAST MOLINE	IDEA ASSOCIATES	SKOKIE, IL	REAL ESTATE
		GOLDEN MOMENTS	JACKSONVILLE			
		VANDALIA TERRACE	VANDALIA			

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	6 MAINTENANCE CONSULTANT	\$ 9,984	MAVIN ENTERPRISES, LTD		\$	\$ (9,984)	1
2	V	10 PSYCHO-SOCIAL CONSULTANT	3,240				(3,240)	2
3	V	11 ACTIVITIES CONSULTANT	3,240				(3,240)	3
4	V	19 ADMIN./BKPP. FEES	55,900				(55,900)	4
5	V	19 ADMIN./CONSULT. FEES	6,480				(6,480)	5
6	V							6
7	V	5 ELECTRICITY/GAS				1,095	1,095	7
8	V	6 MAINTENANCE SALARIES				5,940	5,940	8
9	V	6 MAINTENANCE & REPAIR				303	303	9
10	V	7 SCAVENDER				53	53	10
11	V	10 PSYCHO-SOCIAL & NURSING CONSULT.				9,129	9,129	11
12	V	17 ADMINISTRATIVE SALARIES				3,794	3,794	12
13	V	19 PROFESSIONAL FEES				1,906	1,906	13
14	Total		\$ 78,844			\$ 22,220	\$ * (56,624)	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	20 ADVERTISING	\$	MAVIN ENTERPRISES, LTD		\$ 52	\$	52	15
16	V	21 TOTAL OFFICE				32,501		32,501	16
17	V	23 SEMINARS				156		156	17
18	V	24 TRAVEL				7,248		7,248	18
19	V	25 TRANSPORTATION				3,345		3,345	19
20	V	26 INSURANCE				142		142	20
21	V	27 EMPLOYEE BENEFITS				12,206		12,206	21
22	V	30 DEPRECIATION (SL)				266		266	22
23	V	32 INTEREST				1,414		1,414	23
24	V	34 OFFICE RENT				7,994		7,994	24
25	V	35 EQUIPMENT RENT				2,145		2,145	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		\$			\$ 67,469	\$ *	67,469	39

* 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	\$ 78,629	IDEA ASSOCIATED		\$	(78,629) 15
16	V	30 DEPRECIATION				18,709	18,709 16
17	V	32 INTEREST				56,575	56,575 17
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 78,629			\$ 75,284	\$ * (3,345) 39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

Facility Name & ID Number

SPRINGFIELD TERRACE

#

0032961

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									\$		1
2											2
3											3
4											4
5											5
6											6
7			SEE ATTACHED LIST								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 **SPRINGFIELD TERRACE**

0032961

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 MAVIN ENTERPRISES, LTD
 Street Address 3845 OAKTON
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847)-679-0100
 Fax Number (847)-679-0647

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	ELECTRICITY/GAS	PATIENT DAYS	126,554	6	\$ 9,240	\$ 15,004	\$ 1,095	1	
2	6	MAINTENANCE SALARIES	PATIENT DAYS	126,554	6	50,100	50,100	15,004	5,940	2
3	6	MAINTENANCE & REPAIR	PATIENT DAYS	126,554	6	2,556	15,004		303	3
4	7	SCAVENDER	PATIENT DAYS	126,554	6	448	15,004		53	4
5	10	PSYCHO-SOCIAL & NURSING	PATIENT DAYS	126,554	6	77,000	15,004		9,129	5
6	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	126,554	6	32,000	32,000	15,004	3,794	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	126,554	6	16,074	15,004		1,906	7
8	20	ADVERTISING	PATIENT DAYS	126,554	6	438	15,004		52	8
9	21	TOTAL OFFICE	PATIENT DAYS	126,554	6	274,137	224,827	15,004	32,501	9
10	23	SEMINARS	PATIENT DAYS	126,554	6	1,320	15,004		156	10
11	24	TRAVEL	PATIENT DAYS	126,554	6	61,135	15,004		7,248	11
12	25	TRANSPORTATION	PATIENT DAYS	126,554	6	28,213	15,004		3,345	12
13	26	INSURANCE	PATIENT DAYS	126,554	6	1,200	15,004		142	13
14	27	EMPLOYEE BENEFITS	PATIENT DAYS	126,554	6	102,955	15,004		12,206	14
15	30	DEPRECIATION (SL)	PATIENT DAYS	126,554	6	2,239	15,004		266	15
16	32	INTEREST	PATIENT DAYS	126,554	6	11,923	15,004		1,414	16
17	34	OFFICE RENT	PATIENT DAYS	126,554	6	67,423	15,004		7,994	17
18	35	EQUIPMENT RENT	PATIENT DAYS	126,554	6	18,096	15,004		2,145	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 756,497	\$ 306,927	\$ 89,689		25

Facility Name & ID Number

SPRINGFIELD TERRACE

0032961

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	RELATED PARTY						\$	\$			\$	1						
2	IDEA ASSOCIATES											2						
3	BANK FINANCIAL		X	MORTGAGE	\$6,755.00	01/04	874,500	820,196		6.5000	56,575	3						
4												4						
5	MGMT ALLOCATION										1,414	5						
	Working Capital																	
6	BANK FINANCIAL	X		LINE OF CREDIT	DEMAND	11/97	150,000	263,022		PRIME+	13,308	6						
7												7						
8												8						
9	TOTAL Facility Related				\$6,755.00		\$ 1,024,500	\$ 1,083,218			\$ 71,297	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14						
15	TOTALS (line 9+line14)						\$ 1,024,500	\$ 1,083,218			\$ 71,297	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.		\$	14,515	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.)		\$	14,818	2
3. Under or (over) accrual (line 2 minus line 1).		\$	303	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	14,967	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.		\$	15,270	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	13,434	8
	2002	13,676	9
	2003	13,692	10
	2004	14,372	11
	2005	14,818	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 SPRINGFIELD TERRACE COUNTY SANGAMON

FACILITY IDPH LICENSE NUMBER 0032961

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>14-35-0-157-019</u>	<u>NURSING HOME</u>	\$ <u>14,818.46</u>	\$ <u>14,818.46</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>14,818.46</u>	\$ <u>14,818.46</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 SPRINGFIELD TERRACE

0032961

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	FACILITY		1987	\$ 22,340	1
2					2
3	TOTALS			\$ 22,340	3

Facility Name & ID Number **SPRINGFIELD TERRACE**# **0032961**

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	65	1987		\$ 589,342	\$ 18,709	31.5	\$ 18,709	\$	\$ 302,963	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	VARIOUS		1991	3,905	124	20	196	72	2,916	9
10	VARIOUS		1992	8,184	260	20	409	149	5,568	10
11	VARIOUS		1993	750	19	20	38	19	459	11
12	VARIOUS		1994	540	13	20	27	14	338	12
13	DOOR		1997	1,086	27	20	54	27	509	13
14	SPRINKLER		1997	3,790	97	20	189	92	1,780	14
15	DECORATING		1997	2,281	58	20	114	56	1,083	15
16	EXHAUST SYTEM		1997	1,250	32	20	62	30	605	16
17	TILE		1997	1,944	49	20	97	48	970	17
18	TILE		1997	638	16	20	32	16	299	18
19	DOORS		1997	1,327	35	20	66	31	605	19
20	SPRINKLER		1997	705	18	20	35	17	324	20
21	SPRINKLER		1997	1,532	40	20	77	37	710	21
22	REWIRE & REPLACE SECURITY		1997	3,000	77	20	150	73	1,363	22
23	SPRINKLER		1998	2,138	56	20	107	51	909	23
24	DOORS		1998	1,896	49	20	95	46	807	24
25	SECURITY SYSTEM		1998	1,149	30	20	57	27	513	25
26	FLOOR TILE, LIGHTS		1999	1,468	38	20	73	35	584	26
27	SHINGLE ROOF		2000	26,800	974	27.5	974		6,640	27
28	NEW AIR CONDITIONERS		2000	2,255	82	27.5	82		559	28
29	FRONT DOOR WITH LOCK		2000	1,245	46	27.5	46		313	29
30	REPLACE 3 TON CONDENSING UNIT FOR LUNCH ROOM		2001	3,494	127	27.5	127		699	30
31	GUTTERS AND DOWNSPOUTS		2001	2,654	97	27.5	97		533	31
32										32
33										33
34										34
35										35
36										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 **SPRINGFIELD TERRACE**

0032961

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	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)	\$	\$		\$	\$	\$	70
			663,373		21,073	21,913	840	332,049

**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	\$ 24,830	\$ 178	\$ 2,454	\$ 2,276	5-10	\$ 20,530	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets	48,223			0		48,223	73
74	MGMT ALLOCATION		266	266	0			74
75	TOTALS	\$ 73,053	\$ 444	\$ 2,720	\$ 2,276		\$ 68,753	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	FACILITY	1998 CHEVROLET VAN	1999	\$ 5,429	\$	\$	\$ 0	5 YRS	\$ 5,429	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 5,429	\$ 0	\$ 0	\$ 0		\$ 5,429	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)	\$ 764,195	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,517	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 24,633	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,116	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 406,231	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 8,543 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	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			N/A				8
9	Pharmacy	39-2	# 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			\$		\$	\$		\$	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 **SPRINGFIELD TERRACE**# **0032961**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	\$ (16,817)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	384,102		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,040		6
7	Other Prepaid Expenses	14,631		7
8	Accounts Receivable (owners or related parties)	59,665		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 476,621	\$ 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	74,031		15
16	Equipment, at Historical Cost	78,481		16
17	Accumulated Depreciation (book methods)	(99,526)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,350		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction Escrow Acct	10,378		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 64,714	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 541,335	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 440,092	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,933		28
29	Short-Term Notes Payable	1,276,997		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	163,060		31
32	Accrued Real Estate Taxes(Sch.IX-B)	14,967		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,940,049	\$ 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)	\$ 1,940,049	\$ 0	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,398,714)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 541,335	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (963,448)	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	(35,871)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (999,319)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(399,395)	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)	\$ (399,395)	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)	\$ (1,398,714)	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	\$ 1,121,065	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,121,065	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***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 0	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,121,065	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	329,688	31
32	Health Care	579,251	32
33	General Administration	457,641	33
B. Capital Expense			
34	Ownership	118,292	34
C. Ancillary Expense			
35	Special Cost Centers	0	35
36	Provider Participation Fee	35,588	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,520,460	40
41	Income before Income Taxes (line 30 minus line 40)**	(399,395)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (399,395)	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.

*** 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 **SPRINGFIELD TERRACE**

0032961

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,811	1,857	\$ 46,045	\$ 24.80	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,458	1,469	31,123	21.19	3
4	Licensed Practical Nurses	8,975	9,462	165,702	17.51	4
5	CNAs & Orderlies	23,067	24,280	206,927	8.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,443	2,639	24,892	9.43	10
11	Social Service Workers	2,926	2,987	37,035	12.40	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,216	9,514	72,203	7.59	15
16	Dishwashers					16
17	Maintenance Workers	1,868	1,989	18,682	9.39	17
18	Housekeepers	5,362	5,659	39,951	7.06	18
19	Laundry	2,507	2,641	19,204	7.27	19
20	Administrator	3,055	3,289	85,807	26.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,359	4,390	31,294	7.13	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) <u>SEE ATTACHED</u>	1,451	1,497	25,264	16.88	33
34	TOTAL (lines 1 - 33)	68,498	71,673	\$ 804,129 *	\$ 11.22	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	\$ 3,675	1-3	35
36	Medical Director	O	13,800	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	840	10-3	39
40	Physical Therapy Consultant	L	386	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	3,240	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47	<u>PSYCHO-SOCIAL CONSULTANT</u>			10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 21,941		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	47	1,461	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	47	\$ 1,461		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	
GLENN MILLER	ADMINISTRATOR	0.00%	\$ 10,211	Workers' Compensation Insurance	\$ 23,850	IDPH License Fee	\$	
SHELLEY REISS	ADMINISTRATOR	0.00%	43,761	Unemployment Compensation Insurance	54,827	Advertising: Employee Recruitment	894	
CHRIS ROBIB	ADMINISTRATOR	0.00%	31,835	FICA Taxes	63,073	Health Care Worker Background Check	1,260	
				Employee Health Insurance	1,961	(Indicate # of checks performed <u>126</u>)		
				Employee Meals	0	Patient Background Checks	53	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	360	
				EMPLOYEE BENEFITS - OTHER	1,136	MARKETING/ADV/PROMO	18	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	5,568	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	52	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(360)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(18)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 85,807	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 144,847		\$ 8,304		
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
MELVIN SIEGEL	MANAGEMENT FEES		\$ 3,000				Out-of-State Travel	\$
							In-State Travel	
								1,076
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 3,000				MGMT CO ALLOC	7,248
							Seminar Expense	2,115
C. Professional Services								
Vendor/Payee	Type	Amount						
NURSING CARE SYSTEM,INC	DATA PROCESSING	\$ 3,720					Entertainment Expense ()	
ALPHA DATA SERVICE	DATA PROCESSING	2,652					(agree to Sch. V, line 24, col. 8)	
LTC SOLUTION INC.	DATA PROCESSING	1,419					TOTAL	
GARY A. WEINTRAUB, P.C.	LEGAL FEES	5,150					\$ 10,439	
KRUPNICK BOKOR KAGDA	ACCOUNTING FEES	16,100						
PERSONNEL PLANNERS,INC	UC CONSULTANT	1,069						
BANK FINANCIAL	LINE OF CREDIT AUDIT	4,996						
MAVIN ENTERPRISES, LTD	BOOKKEEPING/ADMIN	55,900						
MAVIN ENTERPRISES, LTD	ADMIN. CONSULTANT	6,480						
MARY MARGAR. DAL POZZO	ADMIN. CONSULTANT	16,000						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 113,486	TOTAL				

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SPRINGFIELD TERRACE# 0032961Report Period Beginning: 01/01/2006Ending: 12/31/2006**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE \$3783
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO _____ 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. \$ 35,588
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