

Facility Name & ID Number COMMUNITY CARE

0048355 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	145	Skilled (SNF)	145	52,925	1
2		Skilled Pediatric (SNF/PED)			2
3	59	Intermediate (ICF)	59	21,535	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,460	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	448		6,267	6,715	8
9	SNF/PED					9
10	ICF	60,814	116	436	61,366	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,262	116	6,703	68,081	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.43%

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 11/01/06

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/01/06 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 30 and days of care provided 6,267

Medicare Intermediary ADMINISTAR OF ILLINOIS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **COMMUNITY CARE** # **0048355** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	339,776	40,088	10,800	390,664		390,664		390,664		1
2	Food Purchase		290,660		290,660		290,660	(1,774)	288,886		2
3	Housekeeping	215,650	32,887		248,537		248,537		248,537		3
4	Laundry	116,357	20,159	6,714	143,230		143,230	1,547	144,777		4
5	Heat and Other Utilities			195,942	195,942		195,942	439	196,381		5
6	Maintenance	96,612	28,606	76,740	201,958		201,958	3,743	205,701		6
7	Other (specify):* Security	81,713		21,375	103,088		103,088	90	103,178		7
8	TOTAL General Services	850,108	412,400	311,571	1,574,079		1,574,079	4,045	1,578,124		8
	B. Health Care and Programs										
9	Medical Director			6,500	6,500		6,500		6,500		9
10	Nursing and Medical Records	2,106,700	87,006	15,619	2,209,325		2,209,325		2,209,325		10
10a	Therapy	13,585			13,585		13,585		13,585		10a
11	Activities		10,720	1,073	11,793		11,793		11,793		11
12	Social Services	232,360		1,100	233,460		233,460		233,460		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,352,645	97,726	24,292	2,474,663		2,474,663		2,474,663		16
	C. General Administration										
17	Administrative	72,173		161,066	233,239		233,239	(86,509)	146,730		17
18	Directors Fees										18
19	Professional Services			66,841	66,841		66,841	9,663	76,504		19
20	Dues, Fees, Subscriptions & Promotions			105,891	105,891		105,891	(83,158)	22,733		20
21	Clerical & General Office Expenses	128,856	26,972	48,812	204,640		204,640	(23,743)	180,897		21
22	Employee Benefits & Payroll Taxes			450,629	450,629		450,629		450,629		22
23	Inservice Training & Education							52	52		23
24	Travel and Seminar			670	670		670		670		24
25	Other Admin. Staff Transportation			8,445	8,445		8,445	624	9,069		25
26	Insurance-Prop.Liab.Malpractice			110,499	110,499		110,499	637	111,136		26
27	Other (specify):*			366,718	366,718		366,718	(361,149)	5,569		27
28	TOTAL General Administration	201,029	26,972	1,319,571	1,547,572		1,547,572	(543,583)	1,003,989		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,403,782	537,098	1,655,434	5,596,314		5,596,314	(539,538)	5,056,776		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	10,800
	REPAIRS & MAINTENANCE	0
		0
		10,800
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	6,714
		0
		6,714
5	HEAT & OTHER UTILITIES	
	GAS HEAT	73,103
	ELECTRICITY	76,093
	WATER	43,996
	CABLE TV - LOBBY	2,750
		0
		195,942
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,635
	PAINTING & DECORATING	2,355
	BUILDING REPAIRS	13,456
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	27,361
	ELEVATOR MAINTENANCE & REPAIR	13,227
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	5,470
	FIRE SERVICE	11,236
		0
		0
		0
		0
		76,740
7	OTHER	
	SCAVENGER	12,375
	SECURITY SERVICE	9,000
		0
		0
		21,375
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,500
		6,500

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	2,235
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	3,886
	PHARMACY CONSULTANT XVIII B 39-2	5,898
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL	3,600
		0
		15,619
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	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	1,073
		0
		1,073
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	1,100
	SOCIAL WORKER XVIII B 45-2	0
		0
		1,100
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	161,066
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	22,349
	ADMINISTRATIVE CONSULTANTS XIX C	13,341
	PROFESSIONAL FEES XIX C	31,151
		0
		66,841
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	3,404
	EMPLOYEE WANT ADS XIX F	589
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	11,628
	LICENSES & PERMITS XIX F	5,892
	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	1,715
	PATIENT BACKGROUND CHECKS XIX F	0
	STAFF DEVELOPMENT	82663
		105,891
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,962
	EQUIPMENT REPAIR & MAINTENANCE	4,358
	OUTSIDE CLERICAL SERVICES	28,500
	PENALTIES / OVERDRAFT CHARGES VI 18	290
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	13,702
	MESSENGER SERVICE	0
		0
		48,812

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	258,327
	UNEMPLOYMENT COMPENSATION XIX D	61,466
	WORKERS COMPENSATION INSURANC XIX D	92,749
	HOSPITALIZATION INSURANCE XIX D	27,447
	EMPLOYEE BENEFITS - OTHER XIX D	743
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	1,869
	CHICAGO HEAD TAX XIX D	8,028
		0
		450,629
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	670
	TRAVEL XIX G	0
		0
		670
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	8,445
		8,445
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	110,499
		0
		110,499
27	OTHER	
	BAD DEBTS VI 24	366,718
		0
		366,718

GRAND TOTAL COLUMN 3 OTHER

1,655,434

**COMMUNITY CARE
SCHEDULES
12/31/2007**

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

TOTAL FOOD PURCHASE	290,660
LESS SALES TAX	<u>(1,774)</u>
NET FOOD	288,886

TOTAL PATIENT CENSUS	68,081
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	204,243

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	204,243
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	204,243

NET FOOD	288,886
DIVIDE TOTAL MEALS/YEAR	<u>204,243</u>

COST PER MEAL	1.41
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

=====

Facility Name & ID Number

COMMUNITY CARE

#0048355

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			4,511	4,511		4,511	(900)	3,611			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,206	33,206		33,206	(10,709)	22,497			32
33	Real Estate Taxes			243,783	243,783		243,783	1,975	245,758			33
34	Rent-Facility & Grounds			1,544,051	1,544,051		1,544,051		1,544,051			34
35	Rent-Equipment & Vehicles			60,978	60,978		60,978	(7,016)	53,962			35
36	Other (specify):* IME			15,912	15,912		15,912	(15,912)				36
37	TOTAL Ownership			1,902,441	1,902,441		1,902,441	(32,562)	1,869,879			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		134,437	329,270	463,707		463,707		463,707			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,690	111,690		111,690		111,690			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		134,437	440,960	575,397		575,397		575,397			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,403,782	671,535	3,998,835	8,074,152		8,074,152	(572,100)	7,502,052			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 **COMMUNITY CARE**

0048355

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	BHF 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	(2,635)	30		9
10	Interest and Other Investment Income	(13,361)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,774)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(290)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(366,718)	27		24
25	Fund Raising, Advertising and Promotional	(3,404)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(116,079)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (504,261)		\$	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)	(67,839)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (67,839)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (572,100)		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

COMMUNITY CARE

ID# 0048355

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	BANK CHARGES	\$ (1,962)	21	1
2	MARKETING SALARY	(21,000)	21	2
3	MARKETING AUTO LEASE	(10,454)	35	3
4	STAFF DEVELOPMENT	(82,663)	20	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	(116,079)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COMMUNITY CARE# 0048355

Report Period Beginning:

01/01/2007

Ending:

12/31/2007**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	(1,774)	0	0	0	0	0	0	0	0	0	0	(1,774)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	1,547	0	0	0	0	0	0	0	0	1,547	4
5	Heat and Other Utilities	0	0	0	439	0	0	0	0	0	0	0	439	5
6	Maintenance	0	0	2,059	1,684	0	0	0	0	0	0	0	3,743	6
7	Other (specify):*	0	0	41	49	0	0	0	0	0	0	0	90	7
8	TOTAL General Services	(1,774)	0	3,647	2,172	0	4,045	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	(96,392)	9,883	0	0	0	0	0	0	0	0	(86,509)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	9,582	81	0	0	0	0	0	0	0	9,663	19
20	Fees, Subscriptions & Promotions	(86,067)	0	2,909	0	0	0	0	0	0	0	0	(83,158)	20
21	Clerical & General Office Expenses	(23,252)	0	(562)	71	0	0	0	0	0	0	0	(23,743)	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	52	0	0	0	0	0	0	0	0	52	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	624	0	0	0	0	0	0	0	0	624	25
26	Insurance-Prop.Liab.Malpractice	0	0	539	98	0	0	0	0	0	0	0	637	26
27	Other (specify):*	(366,718)	0	5,569	0	0	0	0	0	0	0	0	(361,149)	27
28	TOTAL General Administration	(476,037)	(96,392)	28,596	250	0	(543,583)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(477,811)	(96,392)	32,243	2,422	0	(539,538)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COMMUNITY CARE# 0048355

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(2,635)	0	325	1,410	0	0	0	0	0	0	0	(900)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,361)	0	0	2,652	0	0	0	0	0	0	0	(10,709)	32
33	Real Estate Taxes	0	0	0	1,975	0	0	0	0	0	0	0	1,975	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(10,454)	0	2,969	469	0	0	0	0	0	0	0	(7,016)	35
36	Other (specify):*	0	0	0	(15,912)	0	0	0	0	0	0	0	(15,912)	36
37	TOTAL Ownership	(26,450)	0	3,294	(9,406)	0	(32,562)	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)	(504,261)	(96,392)	35,537	(6,984)	0	(572,100)	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
				6865 Financial Inc.	LINCOLNWOOD	MGMT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		EKS MGMT	LINCOLNWOOD	BOOKKEEPING
				IME REALTY	LINCINWOOD	HOME OFFICE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 MANAGEMENT FEE	\$ 161,066	6865 FINANCIAL INC		\$	(161,066)	1
2	V	17 SALARY- M ESFORMES				21,798	21,798	2
3	V	17 SALARY- P ESFORMES				21,798	21,798	3
4	V	17 SALARY- D. WEISS				3,303	3,303	4
5	V	17 SALARY- A. WEINFELD				17,775	17,775	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 161,066			\$ 64,674	\$ * (96,392)	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	21 OUTSIDE CLERICAL	\$ 28,500	EKS MANAGEMENT		\$	\$(28,500)
16	V	4 HOUSEKEEPING SALARIES				1,547	1,547
17	V	6 PAINTERS' SALARIES				2,059	2,059
18	V	7 SCAVENGER				41	41
19	V	17 CFO SALARY - A. WEINFELD				9,883	9,883
20	V	19 PROFESSIONAL FEES				9,582	9,582
21	V	20 WANT ADS / BACKGR CKS				2,909	2,909
22	V	21 OFFICE EXPENSE				27,938	27,938
23	V	23 SEMINARS				52	52
24	V	25 TRANSPORTATION				624	624
25	V	26 INSURANCE				539	539
26	V	27 EMPLOYEE BENEFITS				5,569	5,569
27	V	30 DEPRECIATION S.L				325	325
28	V	35 EQUIPMENT RENT				2,969	2,969
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 28,500			\$ 64,037	\$ * 35,537

* 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	36 OFFICE RENT	\$ 15,912	IME REALTY		\$	(15,912)
16	V	5 UTILITIES				439	439
17	V	6 PAINTERS FEES				523	523
18	V	6 REPAIRS / MAINT				1,161	1,161
19	V	7 ALARM SERVICE				49	49
20	V	19 PROFESSIONAL FEES				81	81
21	V	21 OFFICE EXPENSE				71	71
22	V	26 INSURANCE				98	98
23	V	30 DEPRECIATION S/L				1,410	1,410
24	V	32 INTEREST				2,652	2,652
25	V	33 R/E TAX				1,975	1,975
26	V	35 STORAGE FEES				469	469
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		\$ 15,912			\$ 8,928	\$ * (6,984)

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

Facility Name & ID Number

COMMUNITY CARE

0048355

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	MORRIS ESFORMES		Administrative			List		Comp fr	\$ 21,798	17-7	1
2						Attached		6865 Fin			2
3								ADM CONS	13,341	19-3	3
4	PHILIP ESFORMES		Administrative	96.00		List		Comp fr	21,798	17-7	4
5						Attached		6865 Fin			5
6	DANIEL WEISS		Administrative			List		Comp fr	3,303	17-7	6
7						Attached		6865 Fin			7
8	AVRUM WEINFELD		Administrative	2.00		List		Comp fr	17,775	17-7	8
9						Attached		6865 Fin			9
10								Salary fr EKS	9,883	17-7	10
11											11
12	FLORA WEISS		Clerical					Comp fr EKS	1,327	21-7	12
13								TOTAL	\$ 89,225		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 COMMUNITY CARE

0048355 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

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 6865 FINANCIAL INC
 Street Address 6865 N. LINCOLN AVE.
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-5795
 Fax Number (847) 674-5794

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	17	SALARY- M ESFORMES	PATIENT DAYS	515,342	10	\$ 165,000	\$ 165,000	68,081	\$ 21,798	1
2	17	SALARY- P ESFORMES	PATIENT DAYS	515,342	10	165,000	165,000	68,081	21,798	2
3	17	SALARY- D. WEISS	PATIENT DAYS	515,342	10	25,000	165,000	68,081	3,303	3
4	17	SALARY- A. WEINFELD	PATIENT DAYS	515,342	10	134,551	165,000	68,081	17,775	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					\$ 489,551	\$ 660,000		\$ 64,674	25

Facility Name & ID Number COMMUNITY CARE

0048355

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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 EKS MANAGEMENT
 Street Address 6865 N LINCOLN AVE.
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-1946
 Fax Number (847) 674-1962

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	4	HOUSEKEEPING SALARIES	PATIENT DAYS	857,979	14	\$ 19,500	\$ 68,081	\$ 1,547	1
2	6	PAINTERS' SALARIES	PATIENT DAYS	857,979	14	25,953	68,081	2,059	2
3	7	SCAVENGER	PATIENT DAYS	857,979	14	512	68,081	41	3
4	17	CFO SALARY - A. WEINFELD	PATIENT DAYS	857,979	14	124,552	68,081	9,883	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	857,979	14	120,756	68,081	9,582	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	857,979	14	36,665	68,081	2,909	6
7	21	OFFICE EXPENSE	PATIENT DAYS	857,979	14	352,089	68,081	27,938	7
8	23	SEMINARS	PATIENT DAYS	857,979	14	659	68,081	52	8
9	25	TRANSPORTATION	PATIENT DAYS	857,979	14	7,865	68,081	624	9
10	26	INSURANCE	PATIENT DAYS	857,979	14	6,798	68,081	539	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	857,979	14	70,186	68,081	5,569	11
12	30	DEPRECIATION S.L	PATIENT DAYS	857,979	14	4,096	68,081	325	12
13	35	EQUIPMENT RENT	PATIENT DAYS	857,979	14	37,419	68,081	2,969	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					\$ 807,050	\$ 416,692	\$ 64,037	25

Facility Name & ID Number COMMUNITY CARE

0048355

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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 IME REALTY CORP
 Street Address 6865 N. LINCOLN AVE.
 City / State / Zip Code LINCOLNWOOD , IL. 60712
 Phone Number (847) 674 - 1946
 Fax Number (847) 674 -1962

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	INCOME	187,059	15	\$ 5,162	\$ 15,912	\$ 439	1
2	6	PAINTERS FEES	INCOME	187,059	15	6,152	15,912	523	2
3	6	REPAIRS / MAINT	INCOME	187,059	15	13,651	15,912	1,161	3
4	7	ALARM SERVICE	INCOME	187,059	15	575	15,912	49	4
5	19	PROFESSIONAL FEES	INCOME	187,059	15	952	15,912	81	5
6	21	OFFICE EXPENSE	INCOME	187,059	15	831	15,912	71	6
7	26	INSURANCE	INCOME	187,059	15	1,150	15,912	98	7
8	30	DEPRECIATION S/L	INCOME	187,059	15	16,570	15,912	1,410	8
9	32	INTEREST	INCOME	187,059	15	31,178	15,912	2,652	9
10	33	R/E TAX	INCOME	187,059	15	23,213	15,912	1,975	10
11	35	STORAGE FEES	INCOME	187,059	15	5,519	15,912	469	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					\$ 104,953	\$	\$ 8,928	25

Facility Name & ID Number COMMUNITY CARE

0048355

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	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																				
2																				
3																				
4																				
5																				
Working Capital																				
6	LASALLE BANK		X	WORKING CAPITAL	INTEREST	REVOLV			REVOLV	PRIME +	31,312									
7	THE PRIVATE BANK		X	WORKING CAPITAL	INTEREST	REVOLV		580,050	REVOLV	PRIME +	1,894									
8																				
9	TOTAL Facility Related						\$	580,050			\$ 33,206									
B. Non-Facility Related*																				
10	IRS, IDR, ETC		X	LATE FEES																
11																				
12																				
13																				
14	TOTAL Non-Facility Related						\$				\$									
15	TOTALS (line 9+line14)						\$	580,050			\$ 33,206									

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 2006 report.		\$	43,000	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.)		\$	41,065	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,935)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	245,718	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.		\$	243,783	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	_____	8
	2003	_____	9
	2004	_____	10
	2005	255,820	11
	2006	245,718	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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 ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2006 TAX BILL.

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COMMUNITY CARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0048355

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 2006 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 2006.

(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>20-03-300-021-000</u>	<u>NURSING HOME</u>	\$ <u>5,451.57</u>	\$ <u>5,451.57</u>
2. <u>20-03-300-022-000</u>	<u>NURSING HOME</u>	\$ <u>58,570.24</u>	\$ <u>58,570.24</u>
3. <u>20-03-300-023-000</u>	<u>NURSING HOME</u>	\$ <u>59,518.71</u>	\$ <u>59,518.71</u>
4. <u>20-03-300-024-000</u>	<u>NURSING HOME</u>	\$ <u>58,823.46</u>	\$ <u>58,823.46</u>
5. <u>20-03-300-025-000</u>	<u>NURSING HOME</u>	\$ <u>57,880.87</u>	\$ <u>57,880.87</u>
6. <u>20-03-300-026-000</u>	<u>NURSING HOME</u>	\$ <u>5,473.41</u>	\$ <u>5,473.41</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>245,718.26</u>	\$ <u>245,718.26</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 COMMUNITY CARE

0048355 Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number **COMMUNITY CARE**

0048355

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	204				\$	\$		\$	\$	\$	4
5											5
6											6
7	RELATED PARTY				46,940	1,354		1,354			7
8	OFFICE										8
	Improvement Type**										
9	WATER BOILER		2007		91,500	970	27.5	970		970	9
10	GENERATOR		2007		17,887	27	27.5	27		27	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

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	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)		\$ 156,327	\$ 2,351		\$ 2,351	\$	\$ 997	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases	<u>17,572</u>	<u>3,514</u>	<u>879</u>	<u>(2,635)</u>		<u>879</u>	72
73	Fully Depreciated Assets							73
74	<u>RELATED PARTY</u>		<u>381</u>	<u>381</u>				74
75	TOTALS	\$ <u>17,572</u>	\$ <u>3,895</u>	\$ <u>1,260</u>	\$ <u>(2,635)</u>		\$ <u>879</u>	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 173,899	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 6,246	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 3,611	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,635)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,876	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: **GRANITE COMMUNITY CARE LLC**

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:	204	11/01/06	\$ 1,544,051	5.5	5	3
4	Additions						4
5							5
6							6
7	TOTAL	204		\$ 1,544,051			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: \$ **33,255** 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			\$	\$ 27,723	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 27,723	21

10. Effective dates of current rental agreement:

Beginning 11/01/06

Ending 04/30/12

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

Fiscal Year Ending Annual Rent

12. /2008 \$ 1,547,911

13. /2009 \$ 1,567,212

14. /2010 \$ 1,567,212

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	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	\$		\$ 144,292	\$		\$ 144,292	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,607			1,607	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			183,371			183,371	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				119,735		119,735	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): supplies,lab,rentals,fees	39-2					14,702		14,702	13
14	TOTAL			\$		\$ 329,270	\$ 134,437		\$ 463,707	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 COMMUNITY CARE

0048355

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 103,456	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,929,419		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	120,241		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>REAL ESTATE ESCROW</u>	263,188		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,416,304	\$	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	109,387		15
16	Equipment, at Historical Cost	17,572		16
17	Accumulated Depreciation (book methods)	(4,511)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	469,313		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>ADVANCE RENT</u>	14,450		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 606,211	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,022,515	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 581,573	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	580,050		29
30	Accrued Salaries Payable	114,336		30
31	Accrued Taxes Payable (excluding real estate taxes)	50,026		31
32	Accrued Real Estate Taxes(Sch.IX-B)	245,718		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)	\$ 1,571,703	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,571,703	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,450,812	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,022,515	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,040,789	1
2	Restatements (describe):		2
3	ROUNDING	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,040,787	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	410,025	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)	\$ 410,025	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,450,812	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	\$ 8,274,827	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,274,827	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	195,989	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 195,989	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)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,361	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,361	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)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,484,177	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,574,079	31
32	Health Care	2,474,663	32
33	General Administration	1,547,572	33
	B. Capital Expense		
34	Ownership	1,902,441	34
	C. Ancillary Expense		
35	Special Cost Centers	463,707	35
36	Provider Participation Fee	111,690	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,074,152	40
41	Income before Income Taxes (line 30 minus line 40)**	410,025	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 410,025	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number COMMUNITY CARE

0048355

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	4,277	4,494	\$ 100,181	\$ 22.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,270	10,623	224,219	21.11	3
4	Licensed Practical Nurses	36,819	37,969	741,105	19.52	4
5	CNAs & Orderlies	97,095	107,145	930,376	8.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,080	1,174	13,585	11.57	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	18,472	20,583	232,360	11.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	34,480	37,941	339,776	8.96	15
16	Dishwashers					16
17	Maintenance Workers	8,688	9,014	96,612	10.72	17
18	Housekeepers	27,169	29,049	215,650	7.42	18
19	Laundry	11,060	12,566	116,357	9.26	19
20	Administrator	2,132	3,287	72,173	21.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,482	15,030	128,856	8.57	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	3,232	3,418	57,815	16.91	31
32	Other Health C: <u>Quality Assurance</u>	2,203	2,321	53,004	22.84	32
33	Other(specify) <u>Security</u>	9,404	9,972	81,713	8.19	33
34	TOTAL (lines 1 - 33)	280,863	304,586	\$ 3,403,782 *	\$ 11.18	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	\$ 10,800	1-3	35
36	Medical Director	O	6,500	9-3	36
37	Medical Records Consultant	N	3,886	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,898	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	1,073	11-3	44
45	Social Service Consultant	E	1,100	12-3	45
46	Other(specify) <u>DENTAL</u>	S	3,600	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 32,857		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	
DENISE MARTIN	ADMINISTRATOR	0	\$ 72,173	Workers' Compensation Insurance	\$ 92,749	IDPH License Fee	\$ 1,129	
	ASST ADMIN		0	Unemployment Compensation Insurance	61,466	Advertising: Employee Recruitment	589	
	OTHER ADMIN		0	FICA Taxes	258,327	Health Care Worker Background Check	1,715	
				Employee Health Insurance	27,447	(Indicate # of checks performed _____)		
				Employee Meals	0	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	743	MARKETING/ADV/PROMO	3,404	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	16,391	
				PENSION/PROFIT SHARING PLANS	1,869	MGMT CO ALLOC	2,909	
				CHICAGO HEAD TAX	8,028	TRUST/FRANCHISE/CONTRIB/ETC	0	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(3,404)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 72,173	TOTAL (agree to Schedule V, line 22, col.8)	\$ 450,629	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 22,733	
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
6865 FINANCIAL INS - MANAGEMENT FEE			\$ 161,066			\$	Out-of-State Travel	\$
							In-State Travel	0
							Seminar Expense	670
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 161,066	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 670
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			66,841					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 66,841					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number COMMUNITY CARE

0048355

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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 \$11,628
- (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. \$ 702 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. \$ 111,690
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 \$5,000, 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