



Facility Name & ID Number DANVILLE CARE CENTER

# 0032862 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	118	Skilled (SNF)	118	43,070	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	29,930	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	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			3,727	3,727	8
9	SNF/PED					9
10	ICF	28,153	4,105	1,448	33,706	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,153	4,105	5,175	37,433	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.28%

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 10/1/1987

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 10/1/1987 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 24 and days of care provided 3,727

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL  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 **DANVILLE CARE CENTER** # **0032862** 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
	<b>A. General Services</b>										
1	Dietary	193,671	17,343	10,640	221,654		221,654		221,654		1
2	Food Purchase		215,257		215,257		215,257	(455)	214,802		2
3	Housekeeping	155,936	42,183		198,119		198,119		198,119		3
4	Laundry	80,304	14,685		94,989		94,989		94,989		4
5	Heat and Other Utilities			190,758	190,758		190,758	1,418	192,176		5
6	Maintenance	72,219	32,141	26,458	130,818		130,818		130,818		6
7	Other (specify):*			8,843	8,843		8,843		8,843		7
8	<b>TOTAL General Services</b>	<b>502,130</b>	<b>321,609</b>	<b>236,699</b>	<b>1,060,438</b>		<b>1,060,438</b>	<b>963</b>	<b>1,061,401</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,664	7,664		7,664		7,664		9
10	Nursing and Medical Records	1,464,102	156,770	137,955	1,758,827		1,758,827	38,995	1,797,822		10
10a	Therapy	1,110	2,255	1,235	4,600		4,600		4,600		10a
11	Activities	46,518	2,328		48,846		48,846		48,846		11
12	Social Services	40,776		5,952	46,728		46,728		46,728		12
13	CNA Training										13
14	Program Transportation			12,062	12,062		12,062		12,062		14
15	Other (specify):* <b>nursing bene alloc</b>							7,017	7,017		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,552,506</b>	<b>161,353</b>	<b>164,868</b>	<b>1,878,727</b>		<b>1,878,727</b>	<b>46,012</b>	<b>1,924,739</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	69,861		96,888	166,749		166,749	(51,877)	114,872		17
18	Directors Fees										18
19	Professional Services			126,096	126,096		126,096	(88,640)	37,456		19
20	Dues, Fees, Subscriptions & Promotions			20,994	20,994		20,994	(6,154)	14,840		20
21	Clerical & General Office Expenses	96,799	23,258	373,085	493,142		493,142	(224,266)	268,876		21
22	Employee Benefits & Payroll Taxes			424,760	424,760		424,760	20,323	445,083		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,281	6,281		6,281	5,808	12,089		24
25	Other Admin. Staff Transportation			986	986		986	13,537	14,523		25
26	Insurance-Prop.Liab.Malpractice			129,027	129,027		129,027	7,493	136,520		26
27	Other (specify):* <b>admin bene alloc</b>							8,100	8,100		27
28	<b>TOTAL General Administration</b>	<b>166,660</b>	<b>23,258</b>	<b>1,178,117</b>	<b>1,368,035</b>		<b>1,368,035</b>	<b>(315,676)</b>	<b>1,052,359</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,221,296</b>	<b>506,220</b>	<b>1,579,684</b>	<b>4,307,200</b>		<b>4,307,200</b>	<b>(268,701)</b>	<b>4,038,499</b>		<b>29</b>

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	9,540
	REPAIRS & MAINTENANCE	1,100
		10,640
3	<b>HOUSEKEEPING</b>	
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	24,533
	ELECTRICITY	112,780
	WATER	51,031
	CABLE TV - LOBBY	2,414
		0
		190,758
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	11,892
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	7,493
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,533
	FIRE SERVICE	3,540
		0
		0
		0
		0
		26,458
7	<b>OTHER</b>	
	SCAVENGER	8,843
	SECURITY SERVICE	0
		0
		0
		8,843
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	0
		7,664

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	117,160
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	17,280
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,423
	PHARMACY CONSULTANT XVIII B 39-2	2,092
	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
		137,955
10a	<b>THERAPY</b>	
	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	199
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	1,036
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		1,235
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	5,952
		0
		5,952
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0



**DANVILLE CARE CENTER  
SCHEDULES  
12/31/2007**

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

TOTAL FOOD PURCHASE	215,257
LESS SALES TAX	<u>(455)</u>
NET FOOD	214,802

TOTAL PATIENT CENSUS	37,433
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	112,299

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

PATIENT MEALS	112,299
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	112,299

NET FOOD	214,802
DIVIDE TOTAL MEALS/YEAR	<u>112,299</u>

COST PER MEAL	1.91
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

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Facility Name & ID Number **DANVILLE CARE CENTER**

#0032862

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	
	<b>D. Ownership</b>											
30	Depreciation			53,990	53,990		53,990	172,922	226,912			30
31	Amortization of Pre-Op. & Org.							26,667	26,667			31
32	Interest			109,859	109,859		109,859	499,986	609,845			32
33	Real Estate Taxes			77,829	77,829		77,829		77,829			33
34	Rent-Facility & Grounds			524,386	524,386		524,386	(515,946)	8,440			34
35	Rent-Equipment & Vehicles			28,409	28,409		28,409		28,409			35
36	Other (specify):*							59	59			36
37	<b>TOTAL Ownership</b>			794,473	794,473		794,473	183,688	978,161			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		138,828	369,870	508,698		508,698		508,698			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):* <b>mktg</b>	14,341			14,341		14,341	(14,341)				43
44	<b>TOTAL Special Cost Centers</b>	14,341	138,828	479,370	632,539		632,539	(14,341)	618,198			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,235,637	645,048	2,853,527	5,734,212		5,734,212	(99,354)	5,634,858			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	16,733	30		9
10	Interest and Other Investment Income	(14)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(455)	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	(22,063)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(47,127)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(145,000)	21		24
25	Fund Raising, Advertising and Promotional	(3,081)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,073)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (204,080)		\$	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)	119,067		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 119,067		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (85,013)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

DANVILLE CARE CENTER

ID# 0032862

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	LEGAL FEES	(47,127)	19	2
3	MARKETING SALARY	(14,341)	43	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(61,468)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number DANVILLE CARE CENTER# 0032862

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	(455)	0	0	0	0	0	0	0	0	0	0	(455)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,418	0	0	0	0	0	0	0	0	1,418	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(455)</b>	<b>0</b>	<b>1,418</b>	<b>0</b>	<b>963</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	38,995	0	0	0	0	0	0	0	0	38,995	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	7,017	0	0	0	0	0	0	0	0	7,017	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>46,012</b>	<b>0</b>	<b>46,012</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	(96,888)	45,011	0	0	0	0	0	0	0	0	(51,877)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(47,127)	(44,892)	3,379	0	0	0	0	0	0	0	0	(88,640)	19
20	Fees, Subscriptions & Promotions	(6,154)	0	0	0	0	0	0	0	0	0	0	(6,154)	20
21	Clerical & General Office Expenses	(167,063)	(186,000)	128,797	0	0	0	0	0	0	0	0	(224,266)	21
22	Employee Benefits & Payroll Taxes	0	0	20,323	0	0	0	0	0	0	0	0	20,323	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	5,808	0	0	0	0	0	0	0	0	5,808	24
25	Other Admin. Staff Transportation	0	0	13,537	0	0	0	0	0	0	0	0	13,537	25
26	Insurance-Prop.Liab.Malpractice	0	0	7,493	0	0	0	0	0	0	0	0	7,493	26
27	Other (specify):* <b>marketing/bad de</b>	0	0	8,100	0	0	0	0	0	0	0	0	8,100	27
28	<b>TOTAL General Administration</b>	<b>(220,344)</b>	<b>(327,780)</b>	<b>232,448</b>	<b>0</b>	<b>(315,676)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(220,799)</b>	<b>(327,780)</b>	<b>279,878</b>	<b>0</b>	<b>(268,701)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number DANVILLE CARE CENTER# 0032862

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	16,733	152,672	3,517	0	0	0	0	0	0	0	0	172,922	30
31	Amortization of Pre-Op. & Org.	0	26,667	0	0	0	0	0	0	0	0	0	26,667	31
32	Interest	(14)	500,000	0	0	0	0	0	0	0	0	0	499,986	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(524,386)	8,440	0	0	0	0	0	0	0	0	(515,946)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	59	0	0	0	0	0	0	0	0	59	36
37	<b>TOTAL Ownership</b>	<b>16,719</b>	<b>154,953</b>	<b>12,016</b>	<b>0</b>	<b>183,688</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(14,341)	0	0	0	0	0	0	0	0	0	0	(14,341)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(14,341)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(14,341)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(218,421)</b>	<b>(172,827)</b>	<b>291,894</b>	<b>0</b>	<b>(99,354)</b>	<b>45</b>							

Facility Name & ID Number **DANVILLE CARE CENTER**

# **0032862**

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

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		CERTIFIED HEALTH MANAGEMENT	SKOKIE	BKKPG
					SKOKIE	REAL ESTATE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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 FEES	\$ 96,888	CETIFIED HEALTH MANAGEMETN		\$	\$ (96,888)	1
2	V	21 BOOKKEEPING	186,000				(186,000)	2
3	V	19 ADMIN CONSULTING FEES	44,892				(44,892)	3
4	V							4
5	V							5
6	V							6
7	V	34 RENT	524,386	DANVILLE CARE CENTER LLC			(524,386)	7
8	V	21 OFFICE EXPENSE						8
9	V	30 DEPRECIATION				152,672	152,672	9
10	V	31 AMORTIZATION				26,667	26,667	10
11	V	32 INTEREST				500,000	500,000	11
12	V							12
13	V							13
14	Total		\$ 852,166			\$ 679,339	\$ * (172,827)	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	3 HOUSEKEEPING	\$	CERTIFIED HEALTH MANAGEMENT		\$ 0	\$	15	
16	V	5 ELECTRIC/GAS		" " "		1,418		16	
17	V	6 MAINTENANCE		" " "		0		17	
18	V	10 NURSING/MEDICAL RECORDS		" " "		38,995		18	
19	V	15 NURSING BENEFITS		" " "		7,017		19	
20	V	17 ADMIN SALARIES		" " "		45,011		20	
21	V	19 PROFESSIONAL FEES		" " "		3,379		21	
22	V	20 FEES, SUBSCRIPTIONS		" " "		0		22	
23	V	21 OFFICE EXP		" " "		128,797		23	
24	V	22 EMPLOYEE BENEFITS		" " "		20,323		24	
25	V	24 TRAVEL/SEMINAR		" " "		5,808		25	
26	V	25 TRANSPORTATION		" " "		13,537		26	
27	V	26 INSURANCE		" " "		7,493		27	
28	V	27 ADMIN BENEFITS		" " "		8,100		28	
29	V	30 DEPRECIATION		" " "		3,517		29	
30	V	32 INTEREST		" " "		0		30	
31	V	34 OFFICE RENT		" " "		8,440		31	
32	V	36 EQUIPMENT RENTAL		" " "		59		32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$ 291,894	\$ *	291,894	39

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

Facility Name &amp; ID Number

DANVILLE CARE CENTER

#

0032862

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	BRADLEY ALTER		ADMINISTRATION		SEE ATTACHED SCHEDULE			ALLOC SALA	\$ 81,888	17-7	1
2	HOWARD GELLER		ADMINISTRATION		SEE ATTACHED SCHEDULE			ALLOC FEES	15,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 96,888		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 **DANVILLE CARE CENTER**

# **0032862** 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 CERTIFIED HEALTH MANAGEMENT  
 Street Address 3856 OAKTON SUITE 200  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number (847) 674-4700  
 Fax Number (847) 674-4733

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	3	HOUSEKEEPING	PER PATIENT DAY	4	\$ 0	\$	37,443	\$ 0	1
2	5	ELECTRIC/GAS	" " "	4	6,050		37,443	1,418	2
3	6	MAINTENANCE	" " "	4	0		37,443	0	3
4	10	NURSING/MEDICAL RECORDS	" " "	4	166,338	166,338	37,443	38,995	4
5	15	NURSING BENEFITS	" " "	4	29,933		37,443	7,017	5
6	17	ADMIN SALARIES	" " "	4	192,000	19,200	37,443	45,011	6
7	19	PROFESSIONAL FEES	" " "	4	14,414		37,443	3,379	7
8	20	FEES, SUBSCRIPTIONS	" " "	4	0		37,443	0	8
9	21	OFFICE EXP	" " "	4	549,397	481,726	37,443	128,797	9
10	22	EMPLOYEE BENEFITS	" " "	4	86,688		37,443	20,323	10
11	24	TRAVEL/SEMINAR	" " "	4	24,776		37,443	5,808	11
12	25	TRANSPORTATION	" " "	4	57,744		37,443	13,537	12
13	26	INSURANCE	" " "	4	31,963		37,443	7,493	13
14	27	ADMIN BENEFITS	" " "	4	34,551		37,443	8,100	14
15	30	DEPRECIATION	" " "	4	15,000		37,443	3,517	15
16	32	INTEREST	" " "	4	0		37,443	0	16
17	34	OFFICE RENT	" " "	4	36,000		37,443	8,440	17
18	36	EQUIPMENT RENTAL	" " "	4	250		37,443	59	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,245,104	\$ 667,264		\$ 291,894	25

Facility Name & ID Number **DANVILLE CARE CENTER**

# **0032862** 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 DANVILLE CARE CENTER LLC  
 Street Address 3856 OAKTON SUITE 200  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number (847) 674-4700  
 Fax Number (847) 674-4733

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT COSTS	1	1	\$ 152,672	\$ 1	\$ 152,672	1
2	31	AMORTIZATION		1	1	26,667	1	26,667	2
3	32	INTEREST		1	1	500,000	1	500,000	3
4	21	OFFICE EXPENSE		1	1		1		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					\$ 679,339	\$	\$ 679,339	25

Facility Name & ID Number

DANVILLE CARE CENTER

# 0032862

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	BANK FINANCIAL		X	WORKING CAPITAL							PRIME+	87,485	6					
7	INS FINANCING		X									7,207	7					
8	SHAREHOLDER LOAN	X		WORKING CAPITAL								15,167	8					
9	TOTAL Facility Related						\$	\$				109,859	9					
<b>B. Non-Facility Related*</b>																		
10	IRS, IDR, ETC		X	LATE FEES									10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$					14					
15	TOTALS (line 9+line14)						\$	\$				109,859	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 2006 report.		\$	<b>67,870</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>71,929</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>4,059</b>	<b>3</b>
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>73,770</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>77,829</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2002</b>	<b>60,866</b>	<b>8</b>
	<b>2003</b>	<b>60,485</b>	<b>9</b>
	<b>2004</b>	<b>65,072</b>	<b>10</b>
	<b>2005</b>	<b>66,537</b>	<b>11</b>
	<b>2006</b>	<b>71,929</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2006	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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 2006 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:** 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 DANVILLE CARE CENTER COUNTY VERMILLION

FACILITY IDPH LICENSE NUMBER 0032862

CONTACT PERSON REGARDING THIS REPORT DON FIETS

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

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 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>18-34-100-005-0060</u>	<u>NURSING HOME</u>	\$ <u>28,715.28</u>	\$ <u>28,715.28</u>
2. <u>18-33-200-016-0060</u>	<u>NURSING HOME</u>	\$ <u>43,213.52</u>	\$ <u>43,213.52</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>71,928.80</u>	\$ <u>71,928.80</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 DANVILLE CARE CENTER

# 0032862

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land. Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column (1-3). Row 1: Use, Square Feet, Year Acquired, Cost, 1. Row 2: 2. Row 3: 3 TOTALS

Facility Name &amp; ID Number DANVILLE CARE CENTER

# 0032862

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	200	1998		\$ 2,954,225	\$ 152,672		\$ 152,666	\$ (6)	\$ 1,526,666	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	LEASEHOLD IMPROVEMENTS		1989	34,167	1,083	30	1,139	56	20,206	9
10	LEASEHOLD IMPROVEMENTS		1990	17,344	551	30	578	27	9,912	10
11	LEASEHOLD IMPROVEMENTS		1991	45,376	1,441	30	1,513	72	24,496	11
12	LEASEHOLD IMPROVEMENTS		1992	12,043	382	30	401	19	6,111	12
13	LEASEHOLD IMPROVEMENTS		1993	9,213	236	30	307	71	4,142	13
14	LEASEHOLD IMPROVEMENTS		1994	8,304	213	39	213	(0)	2,885	14
15	NURSING STATION		1995	14,331	367	39	367	0	4,512	15
16	DOOR/LIGHT FIXTURES		1995	17,592	451	39	451	0	5,513	16
17	FIRE ALARM & ELECTRICAL WORK		1995	2,420	62	39	62	0	762	17
18	SHOWER/BATH CONST.		1995	4,704	121	39	121	(0)	1,487	18
19	NURSECALL REPAIR		1996	1,655	42	39	42	0	508	19
20	SMOKE DETECTORS/LIGHT FIXTURES/DOOR		1996	5,894	151	39	151	0	1,778	20
21	RESURFACE PARKING AREA		1996	12,910	861	15	861	(0)	9,891	21
22	ROOF REPAIR		1966	12,742	327	39	327	(0)	3,638	22
23	WARDROBE UNITS		1996	8,361	214	39	214	0	2,363	23
24	FLOORING		1996	2,444	63	39	63	(0)	695	24
25	CARPET/WALLPAPER/BUMPER GUARDS/COVE BASE		1997	19,014	488	39	488	(0)	5,162	25
26	PARKING LOT REPAIR		1997	1,500	100	15	100		1,050	26
27	PAVILION CONST.		1997	8,297	213	39	213	(0)	2,270	27
28	THERAPY ROOM ADDITION		1998	320,230	8,211	39	8,211	0	74,242	28
29	NORTH WING RENOVATION		1998	65,143	1,670	39	1,670	0	15,100	29
30	BUMPER GUARDS		1998	9,285	238	39	238	0	2,371	30
31	CEILING REPAIR/DRYWALL/TILE		1999	17,083	438	39	438	0	3,546	31
32	NURSE CALL/FIRE ALARM SYSTEM		1999	5,616	144	39	144		1,232	32
33	ROOF REPAIR/AIR EXHAUSTS		1999	7,095	182	39	182	(0)	1,560	33
34	LANDSCAPING		1999	12,535	836	15	836	(0)	7,105	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 &amp; ID Number DANVILLE CARE CENTER

# 0032862

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	AIR CONDITIONER	2000	\$ 3,436	\$	7	\$ 491	\$ 491	\$ 3,214	37
38	CARPET/COVE BASE/WALLPAPER	2000	9,734		7	1,391	1,391	9,076	38
39	BATHROOM REPAIR/REMODEL	2000	11,104	404	27.5	404	(0)	3,138	39
40	HOT TUB ROOM REPAIR/REMODEL	2000	6,700	244	27.5	244	(0)	1,890	40
41	ALARMA SYSTEM/DOORS/CAMERAS	2000	15,171	552	27.5	552	(0)	4,282	41
42	NORTH WING RENOVATION	2000	4,809	175	27.5	175	(0)	1,353	42
43	WATER HEATER VALVE	2000	1,026	37	27.5	37	0	291	43
44	SECURITY DOOR	2001	693	25	27.5	25	0	162	44
45	WATER HEATER	2001	684	25	27.5	25	(0)	161	45
46	ROOF REPAIRS	2002	10,000	364	27.5	364	(0)	1,865	46
47	CONCRETE REPAIRS	2002	1,592	58	27.5	58	(0)	298	47
48	ROOF	2003	23,000	836	27.5	836	0	3,727	48
49	BEDROOM CEILING/WALLS	2003	3,300	120	27.5	120		535	49
50	BLINDS	2003	3,118	359	5	624	265	3,120	50
51	VENT TO ROOF	2003	5,700	207	27.5	207	0	923	51
52	INSTALL PULL STATIONS	2003	1,033	38	27.5	38	(0)	169	52
53	ELECTRIC DOOR HOLDER/CLOSER	2003	852	31	27.5	31	(0)	138	53
54	GAS/ELECT ROOF TOP UNIT	2003	6,542	238	27.5	238	(0)	1,061	54
55	WATER HEATER REPAIR	2003	1,971	72	27.5	72	(0)	321	55
56	REPLACE DOORS/EXIT DEVICES	2003	13,040	474	27.5	474	0	2,113	56
57	NURSE CALL SYSTEM	2003	9,000	327	27.5	327	0	1,458	57
58	HEAT/COOL ROOF TOP UNIT	2003	5,287	192	27.5	192	0	856	58
59	DURO LAST ROOFING SYSTEM	2003	41,750	1,518	27.5	1,518	0	6,768	59
60	REPAIR CEILING/DOORS	2003	8,000	291	27.5	291	(0)	1,297	60
61	NURSE CALL SYSTEM/PULL STATIONS	2004	7,368	268	27.5	268	(0)	938	61
62	CEILING PANEL REPLACEMENT	2004	999	36	27.5	36	0	126	62
63	HANDRAILS	2004	1,406	51	27.5	51	0	179	63
64	SKYLITE	2004	2,400	87	27.5	87	0	305	64
65	WALL A/C UNITS	2004	10,249	373	27.5	373	(0)	1,305	65
66	ALARM SYSTEM	2004	1,995	73	27.5	73	(0)	255	66
67	WALLPAPER/PAINTING/COVE REPLACEMENT	2004	26,302	956	27.5	956	0	3,346	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,867,784	\$ 180,188		\$ 182,572	\$ 2,384	\$ 1,793,871	70

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

Facility Name &amp; ID Number DANVILLE CARE CENTER

# 0032862

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,867,784	\$ 180,188		\$ 182,572	\$ 2,384	\$ 1,793,871	1
2	WALL AC UNITS/WALLPAPERING	2005	27,054	5,194	5	5,411	217	13,527	2
3	SHEET VINYL BATHROOM/ROTUNDA	2005	5,456	198	27.5	198	0	495	3
4	ROOF REPLACEMENT-PARTIAL	2005	29,083	1,058	27.5	1,058	(0)	2,645	4
5	HANDRAILS IN HALLWAYS	2005	15,871	577	27.5	577	0	1,443	5
6	REMOVE OLD/INSTALL NEW CERAMIC TILE	2005	9,460	344	27.5	344		860	6
7	BACKFLOW PREVENTER	2005	9,410	342	27.5	342	0	855	7
8	SIDEWALKS	2006	6,658	444	15	444	(0)	666	8
9	DOOR REPLACEMENT	2006	12,000	436	27.5	436	0	654	9
10	ROOF REPAIRS	2006	5,000	182	27.5	182	(0)	273	10
11	CONCRETE REPLACEMENT NORTH BLDG	2006	1,900	69	27.5	69	0	104	11
12	HANDRAILS IN HALLWAYS	2006	6,103	222	27.5	222	(0)	333	12
13	THRU WALL AC UNITS	2006	1,631	59	27.5	59	0	89	13
14	GENERATOR REPAIR/UPGRADE	2006	2,550	93	27.5	93	(0)	139	14
15	ROOFTOP A/C UNIT	2006	6,908	251	27.5	251	0	377	15
16	HOT/COLD WATER LINE/MIXING VALVE	2006	10,702	389	27.5	389	0	584	16
17	ENTRY DOORS - STEEL	2007	6,180	154	39	309	155	309	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,023,750	\$ 190,200		\$ 192,957	\$ 2,757	\$ 1,817,225	34

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

Facility Name & ID Number **DANVILLE CARE CENTER**

# **0032862**

Report Period Beginning:

**01/01/2007**

Ending:

**12/31/2007**

**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	\$ 370,381	\$ 12,812	\$ 28,577	\$ 15,765	5-7	\$ 341,791	71
72	Current Year Purchases	13,244	1,893	544	(1,349)	5	544	72
73	Fully Depreciated Assets	267,843					267,843	73
74			3,517	3,517				74
75	<b>TOTALS</b>	\$ 651,468	\$ 18,222	\$ 32,638	\$ 14,416		\$ 610,178	75

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	maint dept	1995 dodge van	1994	\$ 19,595	\$	\$	\$		\$ 19,595	76
77	patient transp	1996 for wagon	2000	21,907					21,907	77
78	tie downs for above van		2007	8,783	1,757	1,317	(440)	5	1,317	78
79										79
80	<b>TOTALS</b>			\$ 50,285	\$ 1,757	\$ 1,317	\$ (440)		\$ 42,819	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)	\$ 4,725,503	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 210,179	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 226,912	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 16,733	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,470,222	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	<b>TOTALS</b>	\$	\$	\$	91

**G. Construction-in-Progress**

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

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

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

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

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

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

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

16. Rental Amount for movable equipment: \$ **28,409** Description: **SEE SCHEDULE ATTACHED**

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2008 \$ \_\_\_\_\_

13. \_\_\_\_\_/2009 \$ \_\_\_\_\_

14. \_\_\_\_\_/2010 \$ \_\_\_\_\_

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 100,927	\$		\$ 100,927	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			62,509			62,509	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			206,434			206,434	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				134,738		134,738	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): labs/xrays						4,090		4,090	13
14	<b>TOTAL</b>			\$		\$ 369,870	\$ 138,828		\$ 508,698	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 &amp; ID Number DANVILLE CARE CENTER

# 0032862

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>75,778</u> )	539,549		3
4	Supply Inventory (priced at _____ )			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,229		6
7	Other Prepaid Expenses	268,515		7
8	Accounts Receivable (owners or related parties)	198,039		8
9	Other(specify): <u>r/e tax escrow</u>	128,118		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,192,450	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,073,876		15
16	Equipment, at Historical Cost	664,706		16
17	Accumulated Depreciation (book methods)	(925,640)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 812,942	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,005,392	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 986,648	\$	26
27	Officer's Accounts Payable	932,090		27
28	Accounts Payable-Patient Deposits	39,050		28
29	Short-Term Notes Payable	789,972		29
30	Accrued Salaries Payable	158,195		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,905		31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,770		32
33	Accrued Interest Payable	14,134		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	_____			36
37	_____			37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 3,002,764	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	288,637		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	_____			43
44	_____			44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 288,637	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 3,291,401	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (1,286,009)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,005,392	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(701,156)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(701,156)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(584,853)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(584,853)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,286,009)</b>	<b>24</b> *

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,693,696	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,693,696	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	418,068	6
7	Oxygen	32,670	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 450,738	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	23,709	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 23,709	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	14	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 14	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,168,157	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,060,438	31
32	Health Care	1,878,727	32
33	General Administration	1,368,035	33
	<b>B. Capital Expense</b>		
34	Ownership	794,473	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	523,039	35
36	Provider Participation Fee	109,500	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>	18,798	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,753,010	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(584,853)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (584,853)	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 DANVILLE CARE CENTER

# 0032862

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	1,122	1,202	\$ 35,396	\$ 29.45	1
2	Assistant Director of Nursing	908	908	24,271	26.73	2
3	Registered Nurses	18,331	18,590	487,219	26.21	3
4	Licensed Practical Nurses	7,587	7,885	205,419	26.05	4
5	CNAs & Orderlies	68,569	69,771	673,534	9.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			1,110		8
9	Activity Director	1,723	1,839	17,605	9.57	9
10	Activity Assistants	3,117	3,798	28,913	7.61	10
11	Social Service Workers	4,540	4,580	40,776	8.90	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,080	31,394	15.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,126	12,582	99,493	7.91	15
16	Dishwashers	7,972	8,025	62,784	7.82	16
17	Maintenance Workers	5,892	6,229	72,219	11.59	17
18	Housekeepers	16,594	17,332	155,936	9.00	18
19	Laundry	9,283	10,072	80,304	7.97	19
20	Administrator	744	880	23,269	26.44	20
21	Assistant Administrator	1,952	2,080	46,592	22.40	21
22	Other Administrative					22
23	Office Manager	3,534	3,960	52,137	13.17	23
24	Clerical	4,332	4,593	44,662	9.72	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 <u>care plan</u>	1,803	1,947	38,263	19.65	32
33	Other(specify) <u>marketing</u>	712	880	14,341	16.30	33
34	TOTAL (lines 1 - 33)	171,825	179,233	\$ 2,235,637 *	\$ 12.47	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	\$ 9,540	1-3	35
36	Medical Director	O	0	9-3	36
37	Medical Records Consultant	N	1,423	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,092	10-3	39
40	Physical Therapy Consultant	L	199	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		1,036	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	5,952	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 20,242		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	691	\$ 33,405	10-3	50
51	Licensed Practical Nurses	1,950	83,755	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	2,641	\$ 117,160		53





Facility Name &amp; ID Number DANVILLE CARE CENTER

# 0032862

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? \_\_\_\_\_ 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. \$ 109,500  
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? 100% of line  
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