



Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE

# 0045492 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	103	Intermediate (ICF)	103	37,595	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	103	TOTALS	103	37,595	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			677	677	8
9	SNF/PED					9
10	ICF	19,464	647		20,111	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,464	647	677	20,788	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.29%

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 10/01/01

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 10/01/01 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided 677

Medicare Intermediary ADMINISTAR

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 **EAST PEORIA GARDENS HEALTHCARE** # **0045492** 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	127,834	7,683	5,004	140,521		140,521		140,521		1
2	Food Purchase		114,416		114,416		114,416	(370)	114,046		2
3	Housekeeping	90,528	15,954		106,482		106,482		106,482		3
4	Laundry	37,871	10,132		48,003		48,003		48,003		4
5	Heat and Other Utilities			98,008	98,008		98,008	5	98,013		5
6	Maintenance	33,495	24,621	15,567	73,683		73,683	3,041	76,724		6
7	Other (specify):*			11,567	11,567		11,567	26	11,593		7
8	<b>TOTAL General Services</b>	<b>289,728</b>	<b>172,806</b>	<b>130,146</b>	<b>592,680</b>		<b>592,680</b>	<b>2,702</b>	<b>595,382</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			11,000	11,000		11,000		11,000		9
10	Nursing and Medical Records	940,164	45,856	1,825	987,845		987,845	18,960	1,006,805		10
10a	Therapy	20,097	1,029	58,931	80,057		80,057	8,507	88,564		10a
11	Activities	27,299	15,795		43,094		43,094		43,094		11
12	Social Services			2,106	2,106		2,106		2,106		12
13	CNA Training										13
14	Program Transportation			456	456		456		456		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>987,560</b>	<b>62,680</b>	<b>74,318</b>	<b>1,124,558</b>		<b>1,124,558</b>	<b>27,467</b>	<b>1,152,025</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	81,541		60,000	141,541		141,541	(20,025)	121,516		17
18	Directors Fees										18
19	Professional Services			175,870	175,870		175,870	(78,295)	97,575		19
20	Dues, Fees, Subscriptions & Promotions			26,144	26,144		26,144	(8,503)	17,641		20
21	Clerical & General Office Expenses	117,419	12,704	160,402	290,525		290,525	(169,495)	121,030		21
22	Employee Benefits & Payroll Taxes			208,683	208,683		208,683		208,683		22
23	Inservice Training & Education			3,080	3,080		3,080	655	3,735		23
24	Travel and Seminar							969	969		24
25	Other Admin. Staff Transportation			38,930	38,930		38,930	3,786	42,716		25
26	Insurance-Prop.Liab.Malpractice			56,980	56,980		56,980	817	57,797		26
27	Other (specify):*							27,024	27,024		27
28	<b>TOTAL General Administration</b>	<b>198,960</b>	<b>12,704</b>	<b>730,089</b>	<b>941,753</b>		<b>941,753</b>	<b>(243,067)</b>	<b>698,686</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,476,248</b>	<b>248,190</b>	<b>934,553</b>	<b>2,658,991</b>		<b>2,658,991</b>	<b>(212,898)</b>	<b>2,446,093</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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	4,986
	REPAIRS & MAINTENANCE	18
		0
		5,004
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	34,083
	ELECTRICITY	30,634
	WATER	25,447
	CABLE TV - LOBBY	7,844
		0
		98,008
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	5,655
	PAINTING & DECORATING	482
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	3,343
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,298
	FIRE SERVICE	3,789
		0
		0
		0
		0
		15,567
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	11,567
	SECURITY SERVICE	0
		0
		0
		11,567
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	11,000
		11,000

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	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	625
	PHARMACY CONSULTANT XVIII B 39-2	1,200
	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
		1,825
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	828
	SPEECH THERAPY SERVICES	1,121
	OCCUPATIONAL THERAPY SERVICES	536
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	5,400
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	5,400
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	<b>THERAPY CONTRACT SERVICES</b>	45,646
		58,931
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,106
		0
		2,106
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	456
		456
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	60,000
		60,000
	<b>DIRECTORS FEES</b>	
<b>18</b>	DIRECTORS FEES	0
		0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	30,021
	ADMINISTRATIVE CONSULTANTS XIX C	60,000
	PROFESSIONAL FEES XIX C	85,849
		0
		175,870
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	9,809
	EMPLOYEE WANT ADS XIX F	15,329
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	476
	LICENSES & PERMITS XIX F	500
	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	30
	PATIENT BACKGROUND CHECKS XIX F	0
		26,144
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	1,108
	OUTSIDE CLERICAL SERVICES	60,000
	PENALTIES / OVERDRAFT CHARGES VI 18	87,143
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	109
	TELEPHONE	9,267
	MESSENGER SERVICE	2,775
		0
		160,402

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	111,465
	UNEMPLOYMENT COMPENSATION XIX D	44,721
	WORKERS COMPENSATION INSURANC XIX D	50,315
	HOSPITALIZATION INSURANCE XIX D	1,621
	EMPLOYEE BENEFITS - OTHER XIX D	425
	EMPLOYEE PHYSICAL EXAMS XIX D	136
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		208,683
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	3,080
		3,080
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	38,930
		38,930
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	56,980
		56,980
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

934,553

**EAST PEORIA GARDENS HEALTHCARE  
SCHEDULES  
12/31/2007**

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

TOTAL FOOD PURCHASE	114,416
LESS SALES TAX	<u>(370)</u>
NET FOOD	114,046

TOTAL PATIENT CENSUS	20,788
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	62,364

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

PATIENT MEALS	62,364
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	62,364

NET FOOD	114,046
DIVIDE TOTAL MEALS/YEAR	<u>62,364</u>

COST PER MEAL	1.83
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

=====

Facility Name & ID Number **EAST PEORIA GARDENS HEALTHCARE**

#0045492

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			25,100	25,100		25,100	20,870	45,970			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			136,372	136,372		136,372	148,447	284,819			32
33	Real Estate Taxes			29,511	29,511		29,511	2,621	32,132			33
34	Rent-Facility & Grounds			169,182	169,182		169,182	(184,691)	(15,509)			34
35	Rent-Equipment & Vehicles			67,070	67,070		67,070	(37,228)	29,842			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			427,235	427,235		427,235	(49,981)	377,254			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		37,775	24,215	61,990		61,990	2,541	64,531			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,393	56,393		56,393		56,393			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		37,775	80,608	118,383		118,383	2,541	120,924			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,476,248	285,965	1,442,396	3,204,609		3,204,609	(260,338)	2,944,271			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	(5,718)	30		9
10	Interest and Other Investment Income	(993)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(370)	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	(87,143)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,366)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(9,809)	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	(61,442)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (167,841)</b>		<b>\$</b>	<b>30</b>

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)	(92,497)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (92,497)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (260,338)</b>		<b>37</b>

\*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>			<b>\$</b>		<b>47</b>

ID# 0045492

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (61,442)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(61,442)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE# 0045492

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	(370)	0	0	0	0	0	0	0	0	0	0	(370)	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	0	5	0	0	0	0	0	0	0	5	5
6	Maintenance	0	0	0	3,041	0	0	0	0	0	0	0	3,041	6
7	Other (specify):*	0	0	0	26	0	0	0	0	0	0	0	26	7
8	<b>TOTAL General Services</b>	<b>(370)</b>	<b>0</b>	<b>0</b>	<b>3,072</b>	<b>0</b>	<b>2,702</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	0	18,960	0	0	0	0	0	0	0	18,960	10
10a	Therapy	0	6,185	0	2,322	0	0	0	0	0	0	0	8,507	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>6,185</b>	<b>0</b>	<b>21,282</b>	<b>0</b>	<b>27,467</b>	<b>16</b>						
	<b>C. General Administration</b>													
17	Administrative	0	0	(60,000)	39,975	0	0	0	0	0	0	0	(20,025)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,366)	0	(79,176)	3,247	0	0	0	0	0	0	0	(78,295)	19
20	Fees, Subscriptions & Promotions	(9,809)	0	0	1,306	0	0	0	0	0	0	0	(8,503)	20
21	Clerical & General Office Expenses	(148,585)	0	(60,000)	39,090	0	0	0	0	0	0	0	(169,495)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	655	0	0	0	0	0	0	0	655	23
24	Travel and Seminar	0	0	0	969	0	0	0	0	0	0	0	969	24
25	Other Admin. Staff Transportation	0	0	0	3,786	0	0	0	0	0	0	0	3,786	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	817	0	0	0	0	0	0	0	817	26
27	Other (specify):*	0	0	0	27,024	0	0	0	0	0	0	0	27,024	27
28	<b>TOTAL General Administration</b>	<b>(160,760)</b>	<b>0</b>	<b>(199,176)</b>	<b>116,869</b>	<b>0</b>	<b>(243,067)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(161,130)</b>	<b>6,185</b>	<b>(199,176)</b>	<b>141,223</b>	<b>0</b>	<b>(212,898)</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE # 0045492 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 TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(5,718)	20,844	0	5,744	0	0	0	0	0	0	0	20,870	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(993)	130,675	0	18,765	0	0	0	0	0	0	0	148,447	32
33	Real Estate Taxes	0	0	0	2,621	0	0	0	0	0	0	0	2,621	33
34	Rent-Facility & Grounds	0	(184,691)	0	0	0	0	0	0	0	0	0	(184,691)	34
35	Rent-Equipment & Vehicles	0	(41,080)	0	3,852	0	0	0	0	0	0	0	(37,228)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(6,711)</b>	<b>(74,252)</b>	<b>0</b>	<b>30,982</b>	<b>0</b>	<b>(49,981)</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	2,541	0	0	0	0	0	0	0	0	0	2,541	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>2,541</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>2,541</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(167,841)</b>	<b>(65,526)</b>	<b>(199,176)</b>	<b>172,205</b>	<b>0</b>	<b>(260,338)</b>	<b>45</b>						

**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
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CAREPLUS MGMT	SKOKIE	MGMT/BKBP
				EAST PEORIA GARDENS LLC		REAL ESTATE
					SKOKIE	
				CAREPLUS REHABILITATIVE SERVICES		REHAB SVC
					SKOKIE	

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	30 DEPRECIATION	\$	EAST PEORIA GARDENS REALTY LLC	100.00%	\$ 13,141	\$ 13,141	1
2	V	32 INTEREST		" " "		119,379	119,379	2
3	V	34 RENT	184,691	" " "			(184,691)	3
4	V							4
5	V							5
6	V	10A THERAPY SERVICES	58,930	CAREPLUS REHABILITATIVE SERVICES			(58,930)	6
7	V	39 THERAPY SERVICES	24,214	" " "			(24,214)	7
8	V	10A THERAPY SERVICES		" " "		65,115	65,115	8
9	V	39 THERAPY SERVICES		" " "		26,755	26,755	9
10	V	35 EQUIPMENT RENT	41,080	" " "			(41,080)	10
11	V	30 DEPRECIATION		" " "		7,703	7,703	11
12	V	32 EQUIPMENT LOAN INTEREST		" " "		11,296	11,296	12
13	V							13
14	Total		\$ 308,915			\$ 243,389	\$ * (65,526)	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	17 MANAGEMENT FEES	\$ 60,000	CAREPLUS MANAGEMENT INC	100.00%	\$	\$ (60,000)
16	V	19 ADMINISTRATIVE CONSULTANT	60,000				(60,000)
17	V	19 DATA PROCESSING FEES	19,176				(19,176)
18	V	21 CLERICAL FEES	60,000				(60,000)
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 199,176			\$ 0	\$ * (199,176)

\* 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	5 UTILITIES	\$	CAREPLUS MANAGEMENT INC	100.00%	\$ 5	\$ 5
16	V	6 MAINT & REPAIRS				546	546
17	V	6 MAINTENANCE SALARIES				2,495	2,495
18	V	7 SECURITY				26	26
19	V	10 NURSING SALARIES				18,960	18,960
20	V	10a THERAPY SALARIES				1,764	1,764
21	V	10a REHAB SUPPLIES				558	558
22	V	17 ADMIN SALARIES				39,975	39,975
23	V	19 PROFESSIONAL FEES				3,247	3,247
24	V	20 ADVERTISING				1,306	1,306
25	V	21 OFFICE EXPENSE				9,996	9,996
26	V	21 OFFICE SALARIES				29,094	29,094
27	V	23 SEMINARS				655	655
28	V	24 TRAVEL				969	969
29	V	25 TRANSPORATION				3,786	3,786
30	V	26 INSURANCE				817	817
31	V	27 EMPLOYEE BENEFITS				27,024	27,024
32	V	30 DEPRECIATION				5,744	5,744
33	V	32 INTEREST				16,845	16,845
34	V	32 INTEREST TAG 18				1,780	1,780
35	V	32 INTEREST CP REHAB EQUIP				140	140
36	V	33 REAL ESTATE TAX TAG 18				2,621	2,621
37	V	35 EQUIPMENT RENT				3,852	3,852
38	V						
39	Total		\$			\$ 172,205	\$ * 172,205

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

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE # 0045492 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	SHERWIN I RAY	ADMIN CONSULT			SEE ATTACHED	2.8		SALARY	\$ 7,695	17-7	1
2	JAKOB BAKST	DIR OPERATIONS			SCHEDULES	2.8		SALARY	7,695	17-7	2
3	ROSLYN INDICH	CONTROLLER A/P				2.8		SALARY	2,305	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 17,695		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 &amp; ID Number EAST PEORIA GARDENS HEALTHCARE

# 0045492

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 CAREPLUS MANAGEMENT INC  
 Street Address 8320 SKOKIE BLVD  
 City / State / Zip Code SKOKIE, IL 60077  
 Phone Number ( 847)329-1555  
 Fax Number ( 847) 329-9555

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	PATIENT DAYS	445,767	11	\$ 100	20,788	\$ 5	1
2	6	MAINT & REPAIRS	PATIENT DAYS	445,767	11	11,715	20,788	546	2
3	6	MAINTENANCE SALARIES	PATIENT DAYS	445,767	11	53,507	20,788	2,495	3
4	7	SECURITY	PATIENT DAYS	445,767	11	548	20,788	26	4
5	10	NURSING SALARIES	PATIENT DAYS	445,767	11	406,577	20,788	18,960	5
6	10a	THERAPY SALARIES	PATIENT DAYS	445,767	11	37,834	20,788	1,764	6
7	10a	REHAB SUPPLIES	PATIENT DAYS	445,767	11	11,963	20,788	558	7
8	17	ADMIN SALARIES	PATIENT DAYS	445,767	11	857,197	20,788	39,975	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	445,767	11	69,630	20,788	3,247	9
10	20	ADVERTISING	PATIENT DAYS	445,767	11	28,013	20,788	1,306	10
11	21	OFFICE EXPENSE	PATIENT DAYS	445,767	11	214,347	20,788	9,996	11
12	21	OFFICE SALARIES	PATIENT DAYS	445,767	11	623,871	20,788	29,094	12
13	23	SEMINARS	PATIENT DAYS	445,767	11	14,052	20,788	655	13
14	24	TRAVEL	PATIENT DAYS	445,767	11	20,788	20,788	969	14
15	25	TRANSPORATION	PATIENT DAYS	445,767	11	81,177	20,788	3,786	15
16	26	INSURANCE	PATIENT DAYS	445,767	11	17,511	20,788	817	16
17	27	EMPLOYEE BENEFITS	PATIENT DAYS	445,767	11	579,494	20,788	27,024	17
18	30	DEPRECIATION	PATIENT DAYS	445,767	11	123,201	20,788	5,744	18
19	32	INTEREST	PATIENT DAYS	445,767	11	361,224	20,788	16,845	19
20	32	INTEREST TAG 18	PATIENT DAYS	445,767	11	38,177	20,788	1,780	20
21	32	INTEREST CP REHAB EQUIP	PATIENT DAYS	445,767	11	3,007	20,788	140	21
22	33	REAL ESTATE TAX TAG 18	PATIENT DAYS	445,767	11	56,199	20,788	2,621	22
23	35	EQUIPMENT RENT	PATIENT DAYS	445,767	11	82,599	20,788	3,852	23
24									24
25	TOTALS					\$ 3,692,731	\$ 1,978,986	\$ 172,205	25

Facility Name &amp; ID Number

EAST PEORIA GARDENS HEALTHCARE

# 0045492

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	HIGHLAND PARK BANK		X				\$ 1,840,000	\$ 1,710,315				\$ 119,379	1					
2													2					
3													3					
4	RELATED PARTY											30,061	4					
5													5					
	<b>Working Capital</b>																	
6	CAREPLUS MANAGEMENT	X		WORKING CAPITAL	DEMAND			1,813,640		PRIME+		135,173	6					
7												1,199	7					
8													8					
9	<b>TOTAL Facility Related</b>						\$ 1,840,000	\$ 3,523,955				\$ 285,812	9					
	<b>B. Non-Facility Related*</b>																	
10													10					
11													11					
12													12					
13													13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$				\$	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 1,840,000	\$ 3,523,955				\$ 285,812	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.

\$ **26,900** 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.)

\$ **27,911** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **1,011** 3

4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **28,500** 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.

\$ **29,511** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>24,029</b>	8
	2003	<b>24,566</b>	9
	2004	<b>25,668</b>	10
	2005	<b>26,288</b>	11
	2006	<b>27,911</b>	12

<b>FOR BHF USE ONLY</b>		
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 ~ 101% 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 EAST PEORIA GARDENS HEALTHCARE COUNTY TAZWELL

FACILITY IDPH LICENSE NUMBER 0045492

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>05-05-09-102-018</u>	<u>NURSING HOME</u>	\$ <u>289.78</u>	\$ <u>289.78</u>
2. <u>05-05-04-301-038</u>	<u>NURSING HOME</u>	\$ <u>27,555.90</u>	\$ <u>27,555.90</u>
3. <u>05-05-04-301-036</u>	<u>NURSING HOME</u>	\$ <u>65.32</u>	\$ <u>65.32</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>27,911.00</u>	\$ <u>27,911.00</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.

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	NURSING HOME		2001	\$ 18,625	1
2					2
3	TOTALS			\$ 18,625	3

Facility Name &amp; ID Number EAST PEORIA GARDENS HEALTHCARE

# 0045492

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		2001		\$ 293,875	\$ 10,686	27.5	\$ 10,686	\$	\$ 66,344	4
5				67,500	2,455	27.5	2,455		13,400	5
6										6
7										7
8	RELATED PARTY				1,194		1,194			8
	<b>Improvement Type**</b>									
9	SPRINKLER REPAIR/ALARM PANEL		2001	33,563	1,220	27.5	1,220		7,324	9
10	FENCE		2001	6,500	237	27.5	237		1,418	10
11	SPRINKLE REPAIR/SMOKE DETECTORS		2002	61,025	2,219	27.5	2,219		12,297	11
12	BASEBOARD HEATING/MIXING VALVE		2002	7,621	277	27.5	277		1,535	12
13	ARCHITECTURAL DRAWINGS		2003	14,305	520	27.5	520		2,318	13
14	HEATING & A/C REPAIRS/SMOKE DETECTORS		2003	3,818	139	27.5	139		620	14
15	ASBESTOS CONSULTING & REMOVAL/HEATING		2004	9,396	342	27.5	342		1,186	15
16	AIR COMPRESSOR / BOILER		2005	19,625	714	27.5	714		1,755	16
17										17
18										18
19	CAREPLUS REHAB:									19
20	OFFICES, 200 WING, REHAB ROOM RENOVATION		2004	127,475	3,285	39	3,285		12,959	20
21	PAINTING, CUBICLE CURTAINS, HANDRAILS, BUMPERS		2004	48,076	1,215	39	1,215		4,793	21
22										22
23										23
24	SPRINKLER SYSTEM/ALARM CONTROL PANEL		2006	99,014	3,600	27.5	3,600		5,250	24
25	LIGHTING/ELECTRICAL WIRING		2006	8,387	305	27.5	305		445	25
26	CONCRETE WORK		2006	8,416	561	15	561		842	26
27	HANDRAIL/TILE/COVE BASE		2006	31,417	1,142	27.5	1,142		1,666	27
28	PAINTING		2006	3,960	144	27.5	144		210	28
29	NURSE CALL REPAIRS		2006	1,750	64	27.5	64		93	29
30	WATER DAMAGE REPAIRS		2006	3,321	121	27.5	121		176	30
31	SIDEWALKS/RAMPS		2007	2,000	50	15	50		50	31
32	PC BOARD/PROBE		2007	2,250	37	27.5	37		37	32
33	LOCKING SYSTEM-GATES		2007	2,694	45	27.5	45		45	33
34	RECIRCULATING LINE & PUMP		2007	1,550	26	27.5	26		26	34
35	DOOR ALARM KEYPAD/TRANSFORMER		2007	3,134	52	27.5	52		52	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.

XI. OWNERSHIP COSTS (continued)

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

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

\*\*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	\$ 66,087	\$ 10,412	\$ 6,610	\$ (3,802)	10 YRS	\$ 23,643	71
72	Current Year Purchases	19,140	2,873	957	(1,916)	10 YRS	957	72
73	Fully Depreciated Assets							73
74	<b>RELATED PARTY</b>		7,753	7,753				74
75	<b>TOTALS</b>	\$ 85,227	\$ 21,038	\$ 15,320	\$ (5,718)		\$ 24,600	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	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 964,524	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 51,688	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 45,970	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,718)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 159,441	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: N/A

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: \$ 67,070 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	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	\$		\$ 9,113	\$		\$ 9,113	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,344			3,344	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			11,758			11,758	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				36,288		36,288	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, OTHER Other (specify):						1,487		1,487	13
14	<b>TOTAL</b>			\$		\$ 24,215	\$ 37,775		\$ 61,990	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 EAST PEORIA GARDENS HEALTHCARE

# 0045492

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>25,622</u> )	569,355		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,164		6
7	Other Prepaid Expenses	1,475		7
8	Accounts Receivable (owners or related parties)	301,826		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 897,820	\$	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	323,746		15
16	Equipment, at Historical Cost	85,227		16
17	Accumulated Depreciation (book methods)	(93,441)		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): <u>DUE FROM LLC</u>	447,341		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 762,873	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,660,693	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 686,914	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,813,640		29
30	Accrued Salaries Payable	69,537		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,859		31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,500		32
33	Accrued Interest Payable			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 (sum of lines 26 thru 37)</b>	\$ 2,608,450	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	600,000		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 (sum of lines 39 thru 44)</b>	\$ 600,000	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,208,450	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,547,757)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,660,693	\$	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>(406,014)</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>(406,014)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(1,141,743)	<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>(1,141,743)</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>(1,547,757)</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	\$ 2,038,346	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,038,346	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	23,527	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 23,527	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		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	993	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 993	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>	\$ 2,062,866	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	592,680	31
32	Health Care	1,124,558	32
33	General Administration	941,753	33
	<b>B. Capital Expense</b>		
34	Ownership	427,235	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	61,990	35
36	Provider Participation Fee	56,393	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,204,609	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,141,743)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,141,743)	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 EAST PEORIA GARDENS HEALTHCARE

# 0045492

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	2,377	2,576	\$ 40,533	\$ 15.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,433	4,853	125,830	25.93	3
4	Licensed Practical Nurses	9,692	10,530	223,139	21.19	4
5	CNAs & Orderlies	30,147	32,049	355,446	11.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,944	1,977	20,097	10.17	8
9	Activity Director	2,196	2,269	11,126	4.90	9
10	Activity Assistants	2,989	3,257	16,173	4.97	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,767	1,929	26,913	13.95	13
14	Head Cook	6,754	7,414	51,019	6.88	14
15	Cook Helpers/Assistants	5,448	5,849	49,902	8.53	15
16	Dishwashers					16
17	Maintenance Workers	3,210	3,453	33,495	9.70	17
18	Housekeepers	9,382	10,418	90,528	8.69	18
19	Laundry	4,323	4,803	37,871	7.88	19
20	Administrator	2,648	2,839	81,541	28.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,165	1,295	23,692	18.29	23
24	Clerical	4,354	4,787	93,727	19.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,128	1,186	29,226	24.64	31
32	Other Health Care(specify)	8,456	8,908	165,990	18.63	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	102,413	110,392	\$ 1,476,248 *	\$ 13.37	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	\$ 4,986	1-3	35
36	Medical Director	O	11,000	9-3	36
37	Medical Records Consultant	N	625	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,200	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	2,106	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 30,717		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	
TAMMY STONEBERGER	ADMINISTRATOR	0	\$ 67,016	Workers' Compensation Insurance	\$ 50,315	IDPH License Fee	\$	
STACEY DIKEMAN	ADMINISTRATOR	0	14,525	Unemployment Compensation Insurance	44,721	Advertising: Employee Recruitment	15,329	
			0	FICA Taxes	111,465	Health Care Worker Background Check	30	
				Employee Health Insurance	1,621	(Indicate # of checks performed )		
				Employee Meals	0	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	425	MARKETING/ADV/PROMO	9,809	
				EMPLOYEE PHYSICAL EXAMS	136	LICENSES/DUES/SUBSCRIPTIONS	976	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	1,306	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	0	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	( 0 )	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(9,809)	
						Yellow page advertising	( 0 )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 81,541	TOTAL (agree to Schedule V, line 22, col.8)	\$ 208,683	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,641	
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
			\$ 60,000			\$	Out-of-State Travel	\$
							In-State Travel	
								0
							MGMT CO ALLOC	969
							Seminar Expense	
								0
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 60,000	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 969
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			175,870					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 175,870					

\* Attach copy of IMRF notifications

\*\*See instructions.



XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? \_\_\_\_\_
- (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? 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. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 56,393  
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