

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN

0040303 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	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	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			1,971	1,971	8
9	SNF/PED					9
10	ICF	21,428	2,289	541	24,258	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,428	2,289	2,512	26,229	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.59%

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 2/1/1993

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/1/1993 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 10 and days of care provided 1,971

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 PRAIRIE VIEW CARE CENTER-LEWISTC # 0040303 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	115,877	11,276	10,091	137,244		137,244		137,244		1
2	Food Purchase		182,782		182,782		182,782	(330)	182,452		2
3	Housekeeping	88,553	25,341		113,894		113,894		113,894		3
4	Laundry	48,844	10,236	16	59,096		59,096		59,096		4
5	Heat and Other Utilities			80,912	80,912		80,912	994	81,906		5
6	Maintenance	35,999	28,528	14,853	79,380		79,380		79,380		6
7	Other (specify):*			6,048	6,048		6,048		6,048		7
8	TOTAL General Services	289,273	258,163	111,920	659,356		659,356	664	660,020		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	961,434	84,060	5,459	1,050,953		1,050,953	27,316	1,078,269		10
10a	Therapy	29,985	5,533	2,914	38,432		38,432		38,432		10a
11	Activities	75,582	1,824	692	78,098		78,098		78,098		11
12	Social Services	64,607		780	65,387		65,387		65,387		12
13	CNA Training										13
14	Program Transportation			6,737	6,737		6,737		6,737		14
15	Other (specify):* nsg benefit alloc							4,916	4,916		15
16	TOTAL Health Care and Programs	1,131,608	91,417	16,582	1,239,607		1,239,607	32,232	1,271,839		16
	C. General Administration										
17	Administrative			56,592	56,592		56,592	(25,061)	31,531		17
18	Directors Fees										18
19	Professional Services			170,174	170,174		170,174	(89,496)	80,678		19
20	Dues, Fees, Subscriptions & Promotions			8,855	8,855		8,855	(4,938)	3,917		20
21	Clerical & General Office Expenses	34,712	11,833	127,315	173,860		173,860	(20,134)	153,726		21
22	Employee Benefits & Payroll Taxes			278,411	278,411		278,411	14,236	292,647		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,955	9,955		9,955	4,069	14,024		24
25	Other Admin. Staff Transportation			267	267		267	9,483	9,750		25
26	Insurance-Prop.Liab.Malpractice			48,257	48,257		48,257	5,249	53,506		26
27	Other (specify):* admin benefit alloc							5,674	5,674		27
28	TOTAL General Administration	34,712	11,833	699,826	746,371		746,371	(100,918)	645,453		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,455,593	361,413	828,328	2,645,334		2,645,334	(68,022)	2,577,312		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	6,390
	REPAIRS & MAINTENANCE	3,701
		0
		10,091
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	16
		0
		16
5	HEAT & OTHER UTILITIES	
	GAS HEAT	32,604
	ELECTRICITY	38,105
	WATER	10,203
	CABLE TV - LOBBY	0
		0
		80,912
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,037
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	6,768
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,238
	FIRE SERVICE	4,810
		0
		0
		0
		0
		14,853
7	OTHER	
	SCAVENGER	6,048
	SECURITY SERVICE	0
		0
		0
		6,048
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	0
		0

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	3,420
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,214
	PHARMACY CONSULTANT XVIII B 39-2	825
	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
		5,459
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	72
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	2,842
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		2,914
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	482
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	210
		0
		692
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	780
		0
		780
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	6,737
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	56,592
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	6,910
	ADMINISTRATIVE CONSULTANTS XIX C	48,744
	PROFESSIONAL FEES XIX C	114,520
		0
		170,174
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	3,895
	EMPLOYEE WANT ADS XIX F	634
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	701
	LICENSES & PERMITS XIX F	2,282
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,043
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	150
	PATIENT BACKGROUND CHECKS XIX F	150
		8,855
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,728
	EQUIPMENT REPAIR & MAINTENANCE	865
	OUTSIDE CLERICAL SERVICES	98,804
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	465
	TELEPHONE	10,345
	MESSENGER SERVICE/POSTAGE	3,108
		0
		115,315

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	109,403
	UNEMPLOYMENT COMPENSATION XIX D	24,184
	WORKERS COMPENSATION INSURANC XIX D	65,254
	HOSPITALIZATION INSURANCE XIX D	75,327
	EMPLOYEE BENEFITS - OTHER XIX D	1,125
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	3,118
	CHICAGO HEAD TAX XIX D	0
		0
		278,411
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	3,733
	TRAVEL XIX G	6,222
		9,955
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	267
		267
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	48,257
		48,257
27	OTHER	
	BAD DEBTS VI 24	12,000
		12,000

GRAND TOTAL COLUMN 3 OTHER

828,328

**PRAIRIE VIEW CARE CENTER-LEWISTOWN
SCHEDULES
12/31/2007**

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

TOTAL FOOD PURCHASE	182,782
LESS SALES TAX	<u>(330)</u>
NET FOOD	182,452

TOTAL PATIENT CENSUS	26,229
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	78,687

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

PATIENT MEALS	78,687
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	78,687

NET FOOD	182,452
DIVIDE TOTAL MEALS/YEAR	<u>78,687</u>

COST PER MEAL	2.32
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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Facility Name & ID Number

PRAIRIE VIEW CARE CENTER-LEWISTOWN

#0040303

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			13,474	13,474		13,474	107,199	120,673			30
31	Amortization of Pre-Op. & Org.							7,357	7,357			31
32	Interest			31,616	31,616		31,616	256,467	288,083			32
33	Real Estate Taxes			24,235	24,235		24,235		24,235			33
34	Rent-Facility & Grounds			375,235	375,235		375,235	(369,323)	5,912			34
35	Rent-Equipment & Vehicles			36,814	36,814		36,814		36,814			35
36	Other (specify):* storage			1,100	1,100		1,100	41	1,141			36
37	TOTAL Ownership			482,474	482,474		482,474	1,741	484,215			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,672	216,663	267,335		267,335		267,335			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		50,672	270,866	321,538		321,538		321,538			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,455,593	412,085	1,581,668	3,449,346		3,449,346	(66,281)	3,383,065			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	1,970	30		9
10	Interest and Other Investment Income	(24)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(330)	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		21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	21		24
25	Fund Raising, Advertising and Promotional	(3,895)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,043)	20		28
29	Other-Attach Schedule	(43,119)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (58,441)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(7,840)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (7,840)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (66,281)		37

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

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

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

ID# 0040303

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	(43,119)	19	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(43,119)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN

0040303

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	(330)	0	0	0	0	0	0	0	0	0	0	(330)	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	994	0	0	0	0	0	0	0	0	994	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	TOTAL General Services	(330)	0	994	0	664	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	27,316	0	0	0	0	0	0	0	0	27,316	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	4,916	0	0	0	0	0	0	0	0	4,916	15
16	TOTAL Health Care and Programs	0	0	32,232	0	32,232	16							
	C. General Administration													
17	Administrative	0	(56,592)	31,531	0	0	0	0	0	0	0	0	(25,061)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(43,119)	(48,744)	2,367	0	0	0	0	0	0	0	0	(89,496)	19
20	Fees, Subscriptions & Promotions	(4,938)	0	0	0	0	0	0	0	0	0	0	(4,938)	20
21	Clerical & General Office Expenses	(12,000)	(98,357)	90,223	0	0	0	0	0	0	0	0	(20,134)	21
22	Employee Benefits & Payroll Taxes	0	0	14,236	0	0	0	0	0	0	0	0	14,236	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	4,069	0	0	0	0	0	0	0	0	4,069	24
25	Other Admin. Staff Transportation	0	0	9,483	0	0	0	0	0	0	0	0	9,483	25
26	Insurance-Prop.Liab.Malpractice	0	0	5,249	0	0	0	0	0	0	0	0	5,249	26
27	Other (specify):*	0	0	5,674	0	0	0	0	0	0	0	0	5,674	27
28	TOTAL General Administration	(60,057)	(203,693)	162,832	0	(100,918)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(60,387)	(203,693)	196,058	0	(68,022)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 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	1,970	102,766	2,463	0	0	0	0	0	0	0	0	107,199	30
31	Amortization of Pre-Op. & Org.	0	7,357	0	0	0	0	0	0	0	0	0	7,357	31
32	Interest	(24)	256,491	0	0	0	0	0	0	0	0	0	256,467	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(375,235)	5,912	0	0	0	0	0	0	0	0	(369,323)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	41	0	0	0	0	0	0	0	0	41	36
37	TOTAL Ownership	1,946	(8,621)	8,416	0	1,741	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(58,441)	(212,314)	204,474	0	(66,281)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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	\$ 56,592	CETIFIED HEALTH MANAGEMENT		\$	\$	(56,592) 1
2	V	21 BOOKKEEPING	98,804					(98,804) 2
3	V	19 ADMIN CONSULTING FEES	48,744					(48,744) 3
4	V							
5	V							
6	V							
7	V	34 RENT	375,235	PRAIRIE VIEW CARE CENTER OF LEWISTOWN LLC				(375,235) 7
8	V	21 OFFICE EXPENSE		"		447	447	447 8
9	V	30 DEPRECIATION		"		102,766	102,766	102,766 9
10	V	31 AMORTIZATION		"		7,357	7,357	7,357 10
11	V	32 INTEREST		"		256,491	256,491	256,491 11
12	V							
13	V							
14	Total		\$ 579,375			\$ 367,061	\$ *	(212,314) 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		" " "		994		994 16
17	V	6 MAINTENANCE		" " "		0		17
18	V	10 NURSING/MEDICAL RECORDS		" " "		27,316		27,316 18
19	V	15 NURSING BENEFITS		" " "		4,916		4,916 19
20	V	17 ADMIN SALARIES		" " "		31,531		31,531 20
21	V	19 PROFESSIONAL FEES		" " "		2,367		2,367 21
22	V	20 FEES, SUBSCRIPTIONS		" " "		0		22
23	V	21 OFFICE EXP		" " "		90,223		90,223 23
24	V	22 EMPLOYEE BENEFITS		" " "		14,236		14,236 24
25	V	24 TRAVEL/SEMINAR		" " "		4,069		4,069 25
26	V	25 TRANSPORTATION		" " "		9,483		9,483 26
27	V	26 INSURANCE		" " "		5,249		5,249 27
28	V	27 ADMIN BENEFITS		" " "		5,674		5,674 28
29	V	30 DEPRECIATION		" " "		2,463		2,463 29
30	V	32 INTEREST		" " "		0		30
31	V	34 OFFICE RENT		" " "		5,912		5,912 31
32	V	36 EQUIPMENT RENTAL		" " "		41		41 32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 204,474	\$ *	204,474 39

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

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWIST # 0040303 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	\$ 41,592	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	\$ 56,592		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 PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 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 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

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	\$	26,229	\$ 0	1
2	5	ELECTRIC/GAS	" " "	4	6,050		26,229	994	2
3	6	MAINTENANCE	" " "	4	0		26,229	0	3
4	10	NURSING/MEDICAL RECORDS	" " "	4	166,338	166,338	26,229	27,316	4
5	15	NURSING BENEFITS	" " "	4	29,933	192,000	26,229	4,916	5
6	17	ADMIN SALARIES	" " "	4	192,000		26,229	31,531	6
7	19	PROFESSIONAL FEES	" " "	4	14,414		26,229	2,367	7
8	20	FEES, SUBSCRIPTIONS	" " "	4	0	481,726	26,229	0	8
9	21	OFFICE EXP	" " "	4	549,397		26,229	90,223	9
10	22	EMPLOYEE BENEFITS	" " "	4	86,688		26,229	14,236	10
11	24	TRAVEL/SEMINAR	" " "	4	24,776		26,229	4,069	11
12	25	TRANSPORTATION	" " "	4	57,744		26,229	9,483	12
13	26	INSURANCE	" " "	4	31,963		26,229	5,249	13
14	27	ADMIN BENEFITS	" " "	4	34,551		26,229	5,674	14
15	30	DEPRECIATION	" " "	4	15,000		26,229	2,463	15
16	32	INTEREST	" " "	4	0		26,229	0	16
17	34	OFFICE RENT	" " "	4	36,000		26,229	5,912	17
18	36	EQUIPMENT RENTAL	" " "	4	250		26,229	41	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,245,104	\$ 840,064		\$ 204,474	25

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 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 PRAIRIE VIEW CARE CENTER OF LEWISTOWN
 Street Address 3856 OAKTON SUITE 200
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 674-4700
 Fax Number (847) 674-4733

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT COSTS	1	1	\$ 102,766	\$ 1	\$ 102,766	1
2	31	AMORTIZATION		1	1	7,357	1	7,357	2
3	32	INTEREST		1	1	256,491	1	256,491	3
4	21	OFFICE EXPENSE		1	1	447	1	447	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					\$ 367,061	\$	\$ 367,061	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
Working Capital																				
6	BANK FINANCIAL		X	WORKING CAPITAL					PRIME+	26,133										
7	INS FINANCING		X							2,830										
8	BANK FINANCIAL		X	WORKING CAPITAL					PRIME+	2,653										
9	TOTAL Facility Related					\$	\$			\$ 31,616										
B. Non-Facility Related*																				
10	IRS, IDR, ETC		X	LATE FEES																
11																				
12																				
13																				
14	TOTAL Non-Facility Related					\$	\$			\$										
15	TOTALS (line 9+line14)					\$	\$			\$ 31,616										

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.	\$	24,220	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.)	\$	23,985	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(235)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	24,470	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.	\$	24,235	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	21,396	8
	2003	22,444	9
	2004	23,549	10
	2005	23,741	11
	2006	23,985	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

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

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

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 PRAIRIE VIEW CARE CENTER-LEWISTOWN COUNTY FULTON

FACILITY IDPH LICENSE NUMBER 0040303

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>18-19-27-141-004</u>	<u>NURSING HOME</u>	\$ <u>23,985.44</u>	\$ <u>23,985.44</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>23,985.44</u>	\$ <u>23,985.44</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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>			\$ <u>148,500</u>	1
2					2
3	TOTALS			\$ 148,500	3

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN

0040303

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	99	2000		\$ 2,673,000	\$ 97,200	27.5	\$ 97,200	\$	\$ 785,614	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	AUTO SPRINKLER		1993	17,150	439	39	440	1	6,171	9
10	CONDENSOR		1993	2,414	62	39	62	(0)	896	10
11	EXPANDER		1993	6,354	163	39	163	(0)	2,316	11
12	NEW DOOR		1993	620	16	39	16	(0)	230	12
13	FIRE ALARM		1994	6,942	178	39	178		2,485	13
14	CIBICLE TRACKS/CURTAINS		1994	8,149	209	39	209	(0)	2,883	14
15	ARCHITECH CONSULTING		1994	1,050	27	39	27	(0)	363	15
16	TILE		1995	1,113	29	39	29	(0)	373	16
17	REPLACE SHINGLES		1997	1,075	28	39	28	(0)	296	17
18	MODIFIED BITUMEN RUBBER PLUMPING/TILES		1997	13,173	338	39	338	(0)	3,620	18
19	INSTALL METALCAP		1997	2,670	68	39	68	0	723	19
20	ROOF REPAIR		1998	12,640	324	39	324	0	3,065	20
21	FLOOR TILE		1998	8,800	226	39	226	(0)	2,062	21
22	BATHROOM & CEILING REMODELING		1999	18,947	486	39	486	(0)	4,275	22
23	LANDSCAPING		1999	2,935	196	15	196	(0)	1,666	23
24	BOILER REPAIR		2000	2,159		7	154	154	2,531	24
25	NEW ROOF WEST WING		2000	6,000	218	27.5	218	0	1,553	25
26	FAUCETS FOR KITCHEN		2001	1,107	40	27.5	40	0	279	26
27	KITCHEN SINK		2001	1,671	61	27.5	61	(0)	414	27
28	A/C UNITS		2001	2,115	77	27.5	77	(0)	510	28
29	BUMPER GUARDS		2001	5,460	198	27.5	199	1	1,252	29
30	WALLPAPER		2001	2,708	386	7	387	1	2,709	30
31	DOORS 200/300 HALLS		2002	1,750	64	27.5	64	(0)	352	31
32	ZONE FIRE CONTROL		2003	1,402	51	27.5	51	(0)	249	32
33	WALLCOVERING/BUMPER GUARDS		2003	11,023	1,203	5	2,205	1,002	9,922	33
34	WINDOW TREATMENTS		2004	1,218	44	27.5	44	0	154	34
35	TILE/BASE COVE		2004	6,014	219	27.5	219	(0)	766	35
36			2004	6,467	235	27.5	235	0	823	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	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	HANDRAILS/CRASH RAILS	2005	\$ 7,000	\$ 255	27.5	\$ 255	\$ (0)	\$ 637	37
38	FENCE/POSTS/GATES	2005	2,041	136	15	136	0	340	38
39	ALARM SYSTEM	2006	17,481	636	27.5	636	(0)	954	39
40	HOT WATER SYSTEM REPAIR/REPLACE	2006	2,519	92	27.5	92	(0)	138	40
41	CONCRETE REPLACEMENT	2007	8,592	175	39	358	183	358	41
42	COMPRESSOR REPL	2007	707	8	39	18	10	18	42
43	SIDEWALKS	2007	6,300	81	39	170	89	170	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)		\$ 2,870,766	\$ 104,168		\$ 105,605	\$ 1,437	\$ 841,163	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	\$ 101,465	\$ 5,739	\$ 6,782	\$ 1,043	5-7	\$ 71,280	71
72	Current Year Purchases	4,976	767	257	(510)	5	257	72
73	Fully Depreciated Assets	66,949						73
74			8,029	8,029				74
75	TOTALS	\$ 173,390	\$ 14,535	\$ 15,068	\$ 533		\$ 71,537	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/nsg/act			\$ 20,436	\$	\$	\$		\$ 20,436	76
77	maint/nsg/act	1985 dodge van	1999	4,476					4,476	77
78										78
79										79
80	TOTALS			\$ 24,912	\$	\$	\$		\$ 24,912	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,217,568	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 118,703	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 120,673	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,970	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 937,612	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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

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

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

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

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

16. Rental Amount for movable equipment: \$ 36,814 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	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 92,587	\$		\$ 92,587	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			14,527			14,527	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			109,549			109,549	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				48,116		48,116	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): laobratory						2,556		2,556	13
14	TOTAL			\$		\$ 216,663	\$ 50,672		\$ 267,335	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 **PRAIRIE VIEW CARE CENTER-LEWISTOWN** # **0040303** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**
XV. BALANCE SHEET - Unrestricted Operating Fund. As of **12/31/2007** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>182,283</u>)	619,289		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,014		6
7	Other Prepaid Expenses	141,325		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>real estate tax escrow</u>	5,576		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 788,204	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	203,082		15
16	Equipment, at Historical Cost	188,849		16
17	Accumulated Depreciation (book methods)	(232,905)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 159,026	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 947,230	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 932,718	\$	26
27	Officer's Accounts Payable	2,609,509		27
28	Accounts Payable-Patient Deposits	500		28
29	Short-Term Notes Payable	1,426,488		29
30	Accrued Salaries Payable	121,942		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,684		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,470		32
33	Accrued Interest Payable	93,428		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	_____			36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,215,739	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,215,739	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,268,509)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 947,230	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,847,389)	1
2	Restatements (describe):		2
3			3
4	bad debt	(82,862)	4
5	accrued vacation	(42,913)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,973,164)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(295,345)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (295,345)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (4,268,509)	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,864,193	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,864,193	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	253,311	6
7	Oxygen	21,602	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 274,913	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 24	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>medical transp</u>	21,486	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 21,486	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,160,616	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	659,356	31
32	Health Care	1,239,607	32
33	General Administration	746,371	33
	B. Capital Expense		
34	Ownership	482,474	34
	C. Ancillary Expense		
35	Special Cost Centers	267,335	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37	<u>OUT-OF-PERIOD EXPENSES</u>	6,615	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,455,961	40
41	Income before Income Taxes (line 30 minus line 40)**	(295,345)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (295,345)	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 **PRAIRIE VIEW CARE CENTER-LEWISTOWN**

0040303

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	2,040	2,080	\$ 57,947	\$ 27.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,817	3,945	95,081	24.10	3
4	Licensed Practical Nurses	11,533	12,305	254,942	20.72	4
5	CNAs & Orderlies	43,267	44,003	485,516	11.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,452	2,677	29,985	11.20	8
9	Activity Director	1,895	2,223	29,315	13.19	9
10	Activity Assistants	5,209	5,537	46,267	8.36	10
11	Social Service Workers	5,003	5,315	64,607	12.16	11
12	Dietician					12
13	Food Service Supervisor	1,926	2,089	24,335	11.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,586	5,946	53,638	9.02	15
16	Dishwashers	4,586	4,746	37,904	7.99	16
17	Maintenance Workers	2,569	2,705	35,999	13.31	17
18	Housekeepers	8,344	9,254	88,553	9.57	18
19	Laundry	4,830	5,510	48,844	8.86	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,972	2,148	34,712	16.16	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	1,788	2,028	23,740	11.71	31
32	Other Health Care <u>care plan</u>	2,017	2,201	44,208	20.09	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	108,834	114,712	\$ 1,455,593 *	\$ 12.69	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	\$ 6,390	1-3	35
36	Medical Director	O	0	9-3	36
37	Medical Records Consultant	N	1,214	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	825	10-3	39
40	Physical Therapy Consultant	L	72	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		2,842	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	210	11-3	44
45	Social Service Consultant	E	780	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 12,333		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

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN

0040303

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? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES _____ 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. \$ 54,203
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