

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

0042671 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	74	Skilled (SNF)	74	27,010	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	18,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	126	TOTALS	126	45,990	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			2,983	2,983	8
9	SNF/PED					9
10	ICF	22,010	3,063		25,073	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,010	3,063	2,983	28,056	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.00%

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 05/01/97

J. Was the facility purchased or leased after January 1, 1978?

YES Date 05/01/97 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 53 and days of care provided 2,983

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENT # 0042671 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	151,016	13,979	4,804	169,799		169,799	169,799			1
2	Food Purchase		155,492		155,492	(17,849)	137,643	(453)	137,190		2
3	Housekeeping	94,214	34,631		128,845		128,845		128,845		3
4	Laundry	47,868	9,538		57,406		57,406		57,406		4
5	Heat and Other Utilities			101,330	101,330		101,330		101,330		5
6	Maintenance	25,283	25,946	39,871	91,100		91,100	8,572	99,672		6
7	Other (specify):*			14,627	14,627		14,627	58	14,685		7
8	TOTAL General Services	318,381	239,586	160,632	718,599	(17,849)	700,750	8,177	708,927		8
	B. Health Care and Programs										
9	Medical Director			5,500	5,500		5,500		5,500		9
10	Nursing and Medical Records	889,788	60,277	15,609	965,674		965,674	15,293	980,967		10
10a	Therapy	53,985	21,655	35,259	110,899		110,899	3,847	114,746		10a
11	Activities	48,522	3,776	8,410	60,708		60,708		60,708		11
12	Social Services	35,307		5,673	40,980		40,980		40,980		12
13	CNA Training										13
14	Program Transportation			3,024	3,024		3,024		3,024		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,027,602	85,708	73,475	1,186,785		1,186,785	19,140	1,205,925		16
	C. General Administration										
17	Administrative	80,939		50,000	130,939		130,939	16,263	147,202		17
18	Directors Fees										18
19	Professional Services			168,395	168,395		168,395	(139,742)	28,653		19
20	Dues, Fees, Subscriptions & Promotions			25,539	25,539		25,539	(20,847)	4,692		20
21	Clerical & General Office Expenses	27,547	12,328	141,602	181,477		181,477	(66,099)	115,378		21
22	Employee Benefits & Payroll Taxes			245,041	245,041	17,849	262,890		262,890		22
23	Inservice Training & Education			3,765	3,765		3,765	645	4,410		23
24	Travel and Seminar			1,212	1,212		1,212	130	1,342		24
25	Other Admin. Staff Transportation			1,575	1,575		1,575	6,646	8,221		25
26	Insurance-Prop.Liab.Malpractice			494,504	494,504		494,504	980	495,484		26
27	Other (specify):* MARKETING	20,424			20,424		20,424	8,810	29,234		27
28	TOTAL General Administration	128,910	12,328	1,131,633	1,272,871	17,849	1,290,720	(193,214)	1,097,506		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,474,893	337,622	1,365,740	3,178,255		3,178,255	(165,897)	3,012,358		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	4,804
	REPAIRS & MAINTENANCE	0
		0
		4,804
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	38,188
	ELECTRICITY	44,658
	WATER	18,484
	CABLE TV - LOBBY	0
		0
		101,330
6	MAINTENANCE	
	GROUNDS MAINTENANCE	7,907
	PAINTING & DECORATING	15
	BUILDING REPAIRS	1,832
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	22,577
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,214
	FIRE SERVICE	6,326
		0
		0
		0
		0
		39,871
7	OTHER	
	SCAVENGER	14,627
	SECURITY SERVICE	0
		0
		0
		14,627
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	5,500
		5,500

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	6,946
	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	2,663
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B 47-2	6,000
	RN CONSULTANT XVIII B 38-2	0
	DENTAL SERVICES	0
		0
		15,609
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	3,685
	SPEECH THERAPY SERVICES	611
	OCCUPATIONAL THERAPY SERVICES	1,557
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	THERAPY CONTRACT SERVICES	29,406
		35,259
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	8,410
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		8,410
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	5,673
		0
		5,673
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	3,024
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	50,000
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	30,332
	ADMINISTRATIVE CONSULTANTS XIX C	125,000
	PROFESSIONAL FEES XIX C	13,063
		0
		168,395
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	21,626
	EMPLOYEE WANT ADS XIX F	1,775
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	776
	LICENSES & PERMITS XIX F	1,012
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	350
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		25,539
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	4,343
	OUTSIDE CLERICAL SERVICES	80,000
	PENALTIES / OVERDRAFT CHARGES VI 18	10,891
	HOME OFFICE EXPENSE	29,840
	THEFT & DAMAGE LOSS	159
	TELEPHONE	13,064
	MESSENGER SERVICE	3,305
		0
		141,602

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	111,588
	UNEMPLOYMENT COMPENSATION XIX D	16,320
	WORKERS COMPENSATION INSURANC XIX D	78,110
	HOSPITALIZATION INSURANCE XIX D	34,772
	EMPLOYEE BENEFITS - OTHER XIX D	1,094
	EMPLOYEE PHYSICAL EXAMS XIX D	3,157
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		245,041
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	3,765
		3,765
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	1,212
		1,212
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,575
		1,575
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	494,504
		494,504
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,365,740

PRAIRIE VILLAGE HEALTHCARE CENTER
 SCHEDULES
 12/31/2009

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

TOTAL FOOD PURCHASE	155,492
LESS SALES TAX	(453)
NET FOOD	<u>155,039</u>
TOTAL PATIENT CENSUS	28,056
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	<u>84,168</u>
ADD # EMPLOYEE MEALS/DAY	30
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	<u>10,950</u>
PATIENT MEALS	84,168
ADD EMPLOYEE MEALS	<u>10,950</u>
TOTAL MEALS/YEAR	<u>95,118</u>
NET FOOD	155,039
DIVIDE TOTAL MEALS/YEAR	<u>95,118</u>
COST PER MEAL	1.63
TIME EMPLOYEE MEALS	<u>10,950</u>
EMPLOYEE MEAL RECLASSIFICATION	<u>17,849</u>
	=====

PROFESSIONAL FEES
 PAGE 21 SCHEDULE XIX PART C

		<u>DATE</u>
CAREPLUS MGT	DATA PROCESSING	19,540 1.09
ACHIEVE HEALTHCARE	DATA PROCESSING	1,602
AMERICAN DATA	DATA PROCESSING	4,353 1.09
NATIONAL DATA CARE	DATA PROCESSING	1,957 1.09
e-HEALTH DATA SOLUTIONS	DATA PROCESSING	2,100 1.09
ADAPTASOFT	DATA PROCESSING	387
EMDEON	DATA PROCESSING	350 2.09
NEBO SYSTEMS	DATA PROCESSING	44
CAREPLUS MGT	ADMINISTRATIVE CONSULTANT	125,000 2.09
KRUPNICK, BOKOR, KAGDA, LTD	ACCOUNTING	6,750 3.09
MEYER MAGENCE	LEGAL	3,712 3.09
EDDIE CARPENTER	LEGAL-SEE PAGE 5A LINE 2	283 3.09
HONKAMP KREUGER	WOTC PROGRAM CONSULTANT	137 3.09
PERSONNEL PLANNER	UC CONSULTANT	2,180 3.09
RICHARD PEELO	MEDICARE COST REPORT	
		----- 12.09
TOTAL PROFESSIONAL FEES		168,395 12.09
		===== 12.09

EQUIPMENT RENTAL EXPENSE
 PAGE 14 SCHEDULE XII PART B LINES 15

MEMORIAL HOME SERVICE	NURSING EQUIPMENT	1,400
QUALITY WATER SERVICE	PLANT EQUIPMENT	1,428
CENTRAL RENTAL	PLANT EQUIPMENT	258
FLYNN SALES & SERVICE	WASHER/DRYER	6,875
GE CAPITAL	COPIERS	6,965
STORAGE	STORAGE SHED	934

TOTAL EQUIPMENT RENTAL EXPENSE

17,860
=====

EDUCATION AND SEMINARS
LINE 23 COLUMN 3 OTHER

SPONSOR OF SEMINAR	SEMINAR PURPOSE	EMPLOYEE	LOC	COST
INR	DEPRESSION, HEART DISEASE & STROKE	P ROONEY-BROWN D BLACKKETTER	IL	168
LIPPINCOTT WILLIAMS & WILK	PSYCHIATRIC NURSING MADE INCREDIBLE		IL	51
LINCOLN LAND COMMUNITY COLLEGE	TEXTBOOKS FOR NURSING ASSISTANTS		IL	152
LIFE SERVICES NETWORK	THE NEW FIVE STAR RATING - WHAT IT MEANS FOR PROVIDERS AND WHAT THEY CAN DO ABOUT IT	P ROONEY-BROWN D BLACKKETTER	IL	300
OSI	INS AND OUTS OF PSYCH REHAB & PSYCHOSOCIAL PROGRAMMING	D BLACKKETTER T NAVE	IL	180
LIPPINCOTT WILLIAMS & WILK	PHOTOGUIDE COMMON SKIN DISEASE		IL	196
ELSEVIER HEALTH SCIENCE	UROLOGIC DISORDERS & MOSBY'S SUREFIRE DOCUMENTATION		IL	143
CENTRAL PRAIRIE AMERICAN RED CROSS	CPR FOR PR RECERTIFICATION	10 EMPLOYEES	IL	90
CENTRAL PRAIRIE AMERICAN RED CROSS	CPR FOR PR AND CPR FOR PR RECERTIFICATION	21 EMPLOYEES	IL	156
MORGAN COUNTY HEALTH	REFRESHER COURSE DIETARY MANAGER	K CURRIE	IL	40
MMS LTC SOLUTIONS	MEDICARE, MEDICAID, MDS, CARE PLANS AND NEW WAYS TO GAIN MORE REIMBURSEMENT WITH MEDICARE	K ROTHERENT	IL	159
COASTAL TRAINING TECH	COASTAL TRAINING DVD'S		IL	1,509
FAMILY HEALTH MEDIA	PRESSURE ULCER PREVENTION DVD		IL	46
OMNICARE INFUSION	INFUSION THERAPY SERVICES 2-DAY IV CLASS		IL	575
	TOTAL EDUCATION AND SEMINARS			3,765

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			11,712	11,712		11,712	73,023	84,735			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,554	4,554		4,554	198,843	203,397			32
33	Real Estate Taxes			23,899	23,899		23,899	3,183	27,082			33
34	Rent-Facility & Grounds			252,201	252,201		252,201	(252,201)				34
35	Rent-Equipment & Vehicles			24,020	24,020		24,020	4,554	28,574			35
36	Other (specify):* OFFICE RENT			12,600	12,600		12,600	352	12,952			36
37	TOTAL Ownership			328,986	328,986		328,986	27,754	356,740			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		95,022	150,118	245,140		245,140		245,140			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			68,985	68,985		68,985		68,985			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		95,022	219,103	314,125		314,125		314,125			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,474,893	432,644	1,913,829	3,821,366		3,821,366	(138,143)	3,683,223			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	5,432	30		9
10	Interest and Other Investment Income	(37)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(453)	2		13
14	Non-Care Related Interest	(1,048)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(350)	20		17
18	Fines and Penalties	(10,891)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(21,626)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(20,707)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (49,680)		\$	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
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(88,463)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (88,463)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (138,143)		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					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

STATE OF ILLINOIS
 PRAIRIE VILLAGE HEALTHCARE CENTER

Report Period Beginning: 01/01/2009
 Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARY	\$ (20,424)	27	1
2	CARPENTER-LEGAL-COLLECTIONS	(283)	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		(20,707)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER# 0042671

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	(453)	0	0	0	0	0	0	0	0	0	0	(453)	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	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	8,570	2	0	0	0	0	0	0	0	0	8,572	6
7	Other (specify):*	0	58	0	0	0	0	0	0	0	0	0	58	7
8	TOTAL General Services	(453)	8,628	2	0	8,177	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	15,293	0	0	0	0	0	0	0	0	0	15,293	10
10a	Therapy	0	3,847	0	0	0	0	0	0	0	0	0	3,847	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	19,140	0	0	0	0	0	0	0	0	0	19,140	16
	C. General Administration													
17	Administrative	0	16,263	0	0	0	0	0	0	0	0	0	16,263	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(283)	(139,459)	0	0	0	0	0	0	0	0	0	(139,742)	19
20	Fees, Subscriptions & Promotions	(21,976)	1,115	14	0	0	0	0	0	0	0	0	(20,847)	20
21	Clerical & General Office Expenses	(10,891)	(80,000)	24,792	0	0	0	0	0	0	0	0	(66,099)	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	645	0	0	0	0	0	0	0	0	645	23
24	Travel and Seminar	0	0	130	0	0	0	0	0	0	0	0	130	24
25	Other Admin. Staff Transportation	0	0	6,646	0	0	0	0	0	0	0	0	6,646	25
26	Insurance-Prop.Liab.Malpractice	0	0	980	0	0	0	0	0	0	0	0	980	26
27	Other (specify):*	(20,424)	0	29,234	0	0	0	0	0	0	0	0	8,810	27
28	TOTAL General Administration	(53,574)	(202,081)	62,441	0	(193,214)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(54,027)	(174,313)	62,443	0	(165,897)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

0042671

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	5,432	0	13,042	54,549	0	0	0	0	0	0	0	73,023	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,085)	0	54,352	145,576	0	0	0	0	0	0	0	198,843	32
33	Real Estate Taxes	0	0	3,183	0	0	0	0	0	0	0	0	3,183	33
34	Rent-Facility & Grounds	0	0	0	(252,201)	0	0	0	0	0	0	0	(252,201)	34
35	Rent-Equipment & Vehicles	0	0	4,554	0	0	0	0	0	0	0	0	4,554	35
36	Other (specify):*	0	(12,600)	0	12,952	0	0	0	0	0	0	0	352	36
37	TOTAL Ownership	4,347	(12,600)	75,131	(39,124)	0	27,754	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(49,680)	(186,913)	137,574	(39,124)	0	0	0	0	0	0	0	(138,143)	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
				CAREPLUS MGMT	EVANSTON	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					EVANSTON	THERAPY
				PRAIRIE VILLAGE HEALTHCARE CENTER LLC		
					EVANSTON	REAL ESTATE
				EXTENDED CARE	EVANSTON	MGMT/CLERICAL

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	17	MANAGEMENT FEES	\$ 50,000	CAREPLUS MGMT INC		\$	(50,000)	1
2	V	19	ADMIN. CONSULTANT FEES	125,000	" "			(125,000)	2
3	V	19	DATA PROCESSING FEES	19,540	" "			(19,540)	3
4	V	21	CLERICAL FEES	80,000	" "			(80,000)	4
5	V	36	OFFICE RENT	12,600	" "			(12,600)	5
6	V				" "				6
7	V	6	MAINTENANCE		" "		8,570	8,570	7
8	V	7	SECURITY		" "		58	58	8
9	V	10	NURSING		" "		15,293	15,293	9
10	V	10a	THERAPY		" "		3,847	3,847	10
11	V	17	ADMIN		" "		66,263	66,263	11
12	V	19	PROFESSIONAL FEES		" "		5,081	5,081	12
13	V	20	DUES/LICENSES/WANT ADS		" "		1,115	1,115	13
14	Total		\$ 287,140				\$ 100,227	\$ * (186,913)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 OFFICE	\$	CAREPLUS MGMT INC		\$ 54,049	\$ 54,049
16	V	23 SEMINARS		" "		518	518
17	V	24 IN-STATE TRAVEL/LODGING		" "		126	126
18	V	25 TRANSPORTATION		" "		5,554	5,554
19	V	26 INSURANCE		" "		980	980
20	V	27 EMPLOYEE BENEFITS		" "		27,861	27,861
21	V	30 SL DEPRECIATION		" "		4,657	4,657
22	V	32 INTEREST		" "		54,352	54,352
23	V	33 REAL ESTATE TAX		" "		3,183	3,183
24	V	35 EQUIPMENT RENT		" "		4,554	4,554
25	V						
26	V	21 HOME OFFICE EXPENSE	29,840	EXTENDED CARE CONSULTING/CLINICAL			(29,840)
27	V	6 MAINTENANCE & REPAIR		" "		2	2
28	V	20 DUES/LICENSES		" "		14	14
29	V	21 OFFICE EXPENSE		" "		583	583
30	V	23 SEMINARS		" "		127	127
31	V	24 TRAVEL		" "		4	4
32	V	25 TRANSPORTATION		" "		1,092	1,092
33	V	27 EMPLOYEE BENEFITS		" "		1,373	1,373
34	V						
35	V						
36	V						
37	V	30 SL DEPRECIATION		CAREPLUS REHABILITATIVE SERVICES		8,385	8,385
38	V						
39	Total		\$ 29,840			\$ 167,414	\$ * 137,574

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 RENT	\$ 252,201	PRAIRIE VILLAGE HEALTHCARE CENTER LLC		\$	(252,201)
16	V	30 SL DEPRECIATION		" "		54,549	54,549
17	V	32 INTEREST		" "		145,576	145,576
18	V	36 MIP INSURANCE		" "		12,952	12,952
19	V	19 ACCOUNTING FEES		" "			
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		\$ 252,201			\$ 213,077	\$ * (39,124)

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

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	2	3	4	5	6		7		8	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	CAREPLUS MGMT ALLOCATIONS:									
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	SEE ATTACHED	3.2	7.88	SALARY	15,367	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	SCHEDULES	3.2	7.88	" "	15,367	17-7	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13							TOTAL	\$ 30,734		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 VILLAGE HEALTHCARE CENTER

0042671

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization CAREPLUS MANAGEMENT INC
 Street Address 2201 MAIN ST
 City / State / Zip Code EVANSTON, IL 60202-1519
 Phone Number (847)905-3000
 Fax Number (847)491-9565

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	MAINTENANCE	CENSUS DAYS	356,012	8 FACILITIES	\$ 108,743	\$ 50,792	28,056	\$ 8,570	1
2	7	SECURITY	" "	356,012	8 FACILITIES	738		28,056	58	2
3	10	NURSING	" "	356,012	8 FACILITIES	194,059	194,059	28,056	15,293	3
4	10a	THERAPY	" "	356,012	8 FACILITIES	48,814	48,814	28,056	3,847	4
5	17	ADMIN SALARIES	" "	356,012	8 FACILITIES	840,831	840,831	28,056	66,263	5
6	19	PROFESSIONAL FEES	" "	356,012	8 FACILITIES	64,478		28,056	5,081	6
7	20	DUES/LICENSES/WANT ADS	" "	356,012	8 FACILITIES	14,148		28,056	1,115	7
8	21	OFFICE EXPENSES	" "	356,012	8 FACILITIES	685,841	547,685	28,056	54,049	8
9	23	SEMINARS	" "	356,012	8 FACILITIES	6,573		28,056	518	9
10	24	TRAVEL	" "	356,012	8 FACILITIES	1,601		28,056	126	10
11	25	TRANSPORTATION	" "	356,012	8 FACILITIES	70,475		28,056	5,554	11
12	26	INSURANCE	" "	356,012	8 FACILITIES	12,432		28,056	980	12
13	27	EMPLOYEE BENEFITS	" "	356,012	8 FACILITIES	353,538		28,056	27,861	13
14	30	SL DEPRECIATION	" "	356,012	8 FACILITIES	59,093		28,056	4,657	14
15	32	INTEREST-TAG MTG/LOC	" "	356,012	8 FACILITIES	689,687		28,056	54,352	15
16	33	REAL ESTATE TAX	" "	356,012	8 FACILITIES	40,394		28,056	3,183	16
17	35	EQUIP RENT/AUTO LEASE	" "	356,012	8 FACILITIES	57,785		28,056	4,554	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,249,230	\$ 1,682,181		\$ 256,061	25

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

0042671

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization EXTENDED CARE CONSULTING/CLINICAL
 Street Address 2201 MAIN ST
 City / State / Zip Code EVANSTON, IL 60202-1519
 Phone Number (847)905-3000
 Fax Number (847)491-9565

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE & REPAIR	CENSUS DAYS	8 FACILITIES	\$ 32	\$	4,482	\$ 2	1
2	20	DUES/LICENSES	" "	8 FACILITIES	184		4,482	14	2
3	21	OFFICE EXPENSES	" "	8 FACILITIES	7,605		4,482	583	3
4	23	SEMINARS	" "	8 FACILITIES	1,657		4,482	127	4
5	24	TRAVEL	" "	8 FACILITIES	57		4,482	4	5
6	25	TRANSPORTATION	" "	8 FACILITIES	14,249		4,482	1,092	6
7	27	EMPLOYEE BENEFITS	" "	8 FACILITIES	17,921		4,482	1,373	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				\$ 41,705	\$		\$ 3,195	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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	RELATED PARTY: PRAIRIE VILLAGE HEALTHCARE CENTER LLC						\$	\$		\$	1						
2	HEARTLAND		X	MORTGAGE	\$16,072.41	11/03	2,830,700	2,567,111	10/33	5.5000	143,020						
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN	11/03	76,676	61,021	10/33		2,556						
4											4						
5											5						
Working Capital																	
6	INSURANCE FINANCING		X	INSUR. FINANCE							2,547						
7	CAREPLUS MGMT LOC		X	WORKING CAPITAL							959						
8	CAREPLUS MGMT ALLOCATION: TAG MTG INT/LOC										54,352						
9	TOTAL Facility Related				\$16,072.41		\$ 2,907,376	\$ 2,628,132			\$ 203,434						
B. Non-Facility Related*																	
10	IRS		X	LATE FEES							1,048						
11											11						
12											12						
13											13						
14	TOTAL Non-Facility Related						\$	\$			\$ 1,048						
15	TOTALS (line 9+line14)						\$ 2,907,376	\$ 2,628,132			\$ 204,482						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 12,952 Line # 36-7

* 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

1. Real Estate Tax accrual used on 2008 report.	\$	21,670	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.)	\$	22,669	2
3. Under or (over) accrual (line 2 minus line 1).	\$	999	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	22,900	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.	\$	23,899	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	24,815	8
	2005	25,752	9
	2006	27,034	10
	2007	21,455	11
	2008	22,669	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$	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 2008 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.

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>22,668.96</u>	\$ <u>22,668.96</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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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: 27,028 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1 + BASEMENT

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>RELATED PARTY:PRAIRIE VILLAGE HEALTHCARE CENTER LI</u>			\$	1
2	<u>NURSING HOME: ACRES</u>	<u>8,686</u>	<u>1997</u>	<u>170,000</u>	2
3	TOTALS	8,686		\$ 170,000	3

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	RELATED PARTY: PRAIRIE VILLAGE HEALTHCARE CENTER LLC:			\$	\$		\$	\$	4
5	126	1997		1,114,539	28,577	39	28,577		356,043
6									6
7									7
8									8
Improvement Type**									
9	ELECTRIC PANEL IN BOILER ROOM	1997		1,192	31	39	31		389
10	NURSE CALL SYSTEM	1997		17,863	458	39	458		5,686
11	40 TON A/C AND GAS LINE	1997		114,953	2,947	39	2,947		36,225
12	NEW ROOF	1997		35,981	923	39	923		11,268
13	CUBICLE TRACK / PAINTING / HAND & BUMPER RAILS	1997		18,875	484	39	484		5,909
14	CEILING TILE / LIGHT FIXTURES / CUBICLE TRACK	1997		44,010	1,128	39	1,128		13,677
15	MECHANICAL, PLUMBING, HVAC & ELECTRICAL OVERHAUL	1997		165,706	4,249	39	4,249		51,520
16	FLOOR TILE	1997		35,928	921	39	921		11,090
17	REMODELLING / PAINTING / WALLCOVERINGS / BUMPER RAIL	1997		52,605	1,349	39	1,349		16,244
18	REMODELLING / WALLCOVERINGS / RAILS / WINDOW TREATM	1998		58,466	1,500	39	1,500		17,612
19	TILING / FLOORING / DOORS	1998		36,939	948	39	948		11,061
20	ELECTRICAL / ELEVATOR / PLUMBING REPAIRS	1998		69,378	1,778	39	1,778		20,667
21	GENERATOR	1998		21,049	540	39	540		6,233
22	JFK CONTEMPORARY DESIGNS	1999		3,549	91	39	91		914
23	CANOPY/BARRIERS/CORNER GUARDS/KICKPLATES	2000		9,164	333	27.5	333		3,101
24	SHAYMAN,SALK ARENSON SETTLEMENT / PUMP	2001		54,531	1,983	27.5	1,983		17,401
25	NEW ROOF / FIRE SUPPRESSION SYSTEM / HOOD SYSTEM	2008		128,307	4,665	27.5	4,665		5,588
26	CONCRETE SIDEWALKS	2008		5,860	391	15	391		586
27	WINDOWS	2009		63,595	1,253	27.5	1,253		1,253
28									28
29									29
30									30
31									31
32									32
33									33
34									34
35									35
36									36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER

0042671

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	PRAIRIE VILLAGE HEALTHCARE CENTER INC:		\$	\$		\$	\$	\$	37
38	CONCRETE WORK / DRYWALL / DOORS	2002	4,490	163	27.5	163		1,165	38
39	DOOR INSTALLATIONS / 6 VENTILATOR RECEPTACLES	2003	9,733	353	27.5	354	1	2,303	39
40	CONCRETE SLABS OUTSIDE EXIT DOORS	2003	3,350	223	15	223		1,450	40
41	OUTLET INSTALLATION AND REWIRING	2004	5,343	194	27.5	194		1,156	41
42	SIDEWALKS	2005	4,475	298	15	298		1,341	42
43	SHOWER REMODEL / ROOFING	2006	11,421	416	27.5	415	(1)	1,409	43
44	PAVING	2006	1,600	107	15	107		374	44
45	ROOFTOP A/C COMPRESSOR/HEAT EXCHANGER	2007	3,530	129	27.5	128	(1)	285	45
46	SIDEWALK / BUILDING SIGN	2007	3,891	259	15	260	1	650	46
47	BATHROOM /WATER LINES/FAUCETS/CONDUITS/LIGHTS	2009	6,987	216	27.5	216		216	47
48	HANDRAIL/BUMPER/KICKPLATES/BASE/DRAPERIES	2009	4,390	2,463	10	220	(2,243)	220	48
49									49
50									50
51									51
52									52
53									53
54									54
55	RELATED PARTY ALLOCATION - CAREPLUS MGMT								55
56	BUILDING-TAG-18 PROPERTIES	2004	36,308	1,191	39	1,191		5,121	56
57	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES	2004	14,264	718	39	718		3,243	57
58	BUILDING IMPROVEMENTS-CAREPLUS MGMT	2007		5	39	5			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)		\$ 2,162,272	\$ 61,284		\$ 59,041	\$ (2,243)	\$ 611,400	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	\$ 197,466	\$ 4,715	\$ 14,401	\$ 9,686	8-15 YRS	\$ 143,151	71
72	Current Year Purchases	3,860	2,110	165	(1,945)	10-15 YRS	165	72
73	Fully Depreciated Assets	2,561	66		(66)	8 YRS	2,561	73
74	**REL'D PARTY-SL DEPN:CAREPL MGT,2,743/CP REHAB, 8,385		11,128	11,128		8-15 YRS		74
75	TOTALS	\$ 203,887	\$ 18,019	\$ 25,694	\$ 7,675		\$ 145,877	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,536,159	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 79,303	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 84,735	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,432	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 757,277	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions. YES NO

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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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: \$ 17,860 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	<u>ACTIVITY/HSKP/</u>	<u>2005 CHEVY</u>	\$ <u>684.49</u>	\$ <u>6,160</u>	17
18	<u>MAINT/BANKING/</u>				18
19	<u>ADMIN/ETC</u>				19
20					20
21	TOTAL		\$ <u>684.49</u>	\$ <u>6,160</u>	21

* 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.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2009 Ending: 12/31/2009
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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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>
---	---	--

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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 17,831	\$		\$ 17,831	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			7,029			7,029	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			120,157			120,157	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				95,022		95,022	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	LAB/OTHER SERVICES Other (specify):					5,101			5,101	13
14	TOTAL			\$		\$ 150,118	\$ 95,022		\$ 245,140	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 VILLAGE HEALTHCARE CENTER**

0042671

Report Period Beginning: **01/01/2009**

Ending: **12/31/2009**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2009** (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	\$ 1,037	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>50,000</u>)	727,481		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	810,264		5
6	Prepaid Insurance	116,337		6
7	Other Prepaid Expenses	7,748		7
8	Accounts Receivable (owners or related parties)	62,603		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,725,470	\$	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	61,771		15
16	Equipment, at Historical Cost	201,327		16
17	Accumulated Depreciation (book methods)	(206,985)		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>SECURITY DEPOSITS</u>	16,328		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 72,441	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,797,911	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,403,919	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	155,407		29
30	Accrued Salaries Payable	109,208		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,898		31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,900		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,695,332	\$	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	<u>DUE TO LLC</u>	122,354		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 122,354	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,817,686	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (19,775)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,797,911	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 123,288	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 123,288	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(143,063)	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)	\$ (143,063)	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)	\$ (19,775)	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	\$ 3,695,533	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,695,533	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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***	37	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 37	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,695,570	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	718,599	31
32	Health Care	1,186,785	32
33	General Administration	1,272,871	33
B. Capital Expense			
34	Ownership	328,986	34
C. Ancillary Expense			
35	Special Cost Centers	245,140	35
36	Provider Participation Fee	68,985	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES	17,267	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,838,633	40
41	Income before Income Taxes (line 30 minus line 40)**	(143,063)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (143,063)	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 VILLAGE HEALTHCARE CENTER**

0042671

Report Period Beginning: **01/01/2009**

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,814	1,892	\$ 59,965	\$ 31.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,885	4,124	89,280	21.65	3
4	Licensed Practical Nurses	17,149	18,148	327,035	18.02	4
5	CNAs & Orderlies	37,390	39,399	373,897	9.49	5
6	CNA Trainees					6
7	Licensed Therapist	1,008	1,099	22,152	20.16	7
8	Rehab/Therapy Aides	2,439	2,730	31,833	11.66	8
9	Activity Director	1,967	2,182	25,788	11.82	9
10	Activity Assistants	2,647	2,856	22,734	7.96	10
11	Social Service Workers	1,991	2,119	35,307	16.66	11
12	Dietician					12
13	Food Service Supervisor	2,821	2,980	41,865	14.05	13
14	Head Cook	5,785	6,324	52,935	8.37	14
15	Cook Helpers/Assistants	6,403	6,992	56,216	8.04	15
16	Dishwashers					16
17	Maintenance Workers	2,221	2,390	25,283	10.58	17
18	Housekeepers	10,512	11,590	94,214	8.13	18
19	Laundry	5,618	5,984	47,868	8.00	19
20	Administrator	2,048	2,339	80,939	34.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,847	2,064	21,367	10.35	23
24	Clerical	534	597	6,180	10.35	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	1,740	1,879	19,109	10.17	31
32	Other Health C: CP COORD	1,743	1,954	20,502	10.49	32
33	Other(specify) <u>MARKETING</u>	1,216	1,284	20,424	15.91	33
34	TOTAL (lines 1 - 33)	112,778	120,926	\$ 1,474,893 *	\$ 12.20	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	\$ 4,804	1-3	35
36	Medical Director	O	5,500	9-3	36
37	Medical Records Consultant	N	2,663	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	5,673	12-3	45
46	Other(specify)	S			46
47	<u>PSYCHIATRIC</u>		6,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 24,640		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL ASSOC HEALTHCARE FACIL \$756
- (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. \$ 68,985
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. \$ 17,849 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: _____
- (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.