

Facility Name & ID Number Courtyard Terrace Nursing Home

0040550 Report Period Beginning: 01/01/04 Ending: 12/31/04

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	<u>95</u>	Skilled (SNF)	<u>95</u>	<u>34,770</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>67</u>	Intermediate (ICF)	<u>67</u>	<u>24,522</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>162</u>	TOTALS	<u>162</u>	<u>59,292</u>	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				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>1,795</u>	<u>1,795</u>	8
9	SNF/PED					9
10	ICF	<u>25,608</u>	<u>1,874</u>		<u>27,482</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>25,608</u>	<u>1,874</u>	<u>1,795</u>	<u>29,277</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.38%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 11/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/01/94 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 19 and days of care provided 1,795

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/04 Ending: 12/31/04

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjustments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	139,023	1,601	6,250	146,874		146,874		146,874		1
2	Food Purchase		160,094		160,094	(15,061)	145,033	(370)	144,663		2
3	Housekeeping	101,015	30,705		131,720		131,720		131,720		3
4	Laundry	38,742	8,510	4,898	52,150		52,150		52,150		4
5	Heat and Other Utilities			97,189	97,189		97,189	2,122	99,311		5
6	Maintenance	53,807	5,399	58,761	117,967		117,967	2,487	120,454		6
7	Other (specify):*										7
8	TOTAL General Services	332,587	206,309	167,098	705,994	(15,061)	690,933	4,239	695,172		8
	B. Health Care and Programs										
9	Medical Director			4,000	4,000		4,000		4,000		9
10	Nursing and Medical Records	927,857	40,323	(87)	968,093		968,093		968,093		10
10a	Therapy	17,915		9,643	27,558		27,558		27,558		10a
11	Activities	49,196	1,388	1,000	51,584		51,584		51,584		11
12	Social Services	41,633			41,633		41,633		41,633		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,036,601	41,711	14,556	1,092,868		1,092,868		1,092,868		16
	C. General Administration										
17	Administrative	81,645		109,633	191,278		191,278	(89,713)	101,565		17
18	Directors Fees										18
19	Professional Services			64,402	64,402		64,402	(6,791)	57,611		19
20	Dues, Fees, Subscriptions & Promotions			6,613	6,613		6,613	95	6,708		20
21	Clerical & General Office Expenses	59,541	9,220	144,251	213,012		213,012	(36,820)	176,192		21
22	Employee Benefits & Payroll Taxes			273,144	273,144	15,061	288,205	10,516	298,721		22
23	Inservice Training & Education										23
24	Travel and Seminar			453	453		453		453		24
25	Other Admin. Staff Transportation			8,027	8,027		8,027	1,078	9,105		25
26	Insurance-Prop.Liab.Malpractice			190,443	190,443		190,443	1,661	192,104		26
27	Other (specify):*										27
28	TOTAL General Administration	141,186	9,220	796,966	947,372	15,061	962,433	(119,974)	842,459		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,510,374	257,240	978,620	2,746,234		2,746,234	(115,735)	2,630,499		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.

Courtyard Terrace Nursing Home
0040550
COST REPORT RECLASSIFICATIONS
01/01/04
12/31/04

SCHEDULE V LINE #

22	EMPLOYEE BENEFITS	15,061
2	FOOD	15,061

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	_____
19	PROFESSIONAL FEES	_____

To reclass cost of appealing real estate taxes

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			127,021	127,021		127,021	131,108	258,129			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			83,006	83,006		83,006	(23,410)	59,596			32
33	Real Estate Taxes			31,333	31,333		31,333	36,022	67,355			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,925	11,925		11,925	(8,548)	3,377			35
36	Other (specify):*											36
37	TOTAL Ownership			253,285	253,285		253,285	135,172	388,457			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		79,909	81,852	161,761		161,761		161,761			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			88,938	88,938		88,938		88,938			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		79,909	170,790	250,699		250,699		250,699			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,510,374	337,149	1,402,695	3,250,218		3,250,218	19,437	3,269,655			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	OHF 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	124,207	30		9
10	Interest and Other Investment Income	(12)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(370)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,005)	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	(91,720)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 27,100		\$	30

OHF 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)	55,398		34
35	Other- Attach Schedule	(63,061)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (7,663)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 19,437		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Courtyard Terrace Nursing Home

ID# 0040550

Report Period Beginning: 01/01/04

Ending: 12/31/04

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Courtyard:	\$		1
2	Bank Charges	(19,735)	21	2
3	Marketing	(76)	19	3
4	Interest Paid to Owners	(26,700)	32	4
5	Adjust RE taxes to whole year	31,267	33	5
6	Adjust prior year RE tax accrual	618	33	6
7	Trust Fees	(60)	19	7
8				8
9	From Management Company:			9
10	Home Office Expenses	(12,500)	17	10
11	Management Fees	(15,000)	17	11
12	Bank Charges	(899)	21	12
13	Late Fees	(1,529)	32	13
14	Rent Expense	(9,120)	35	14
15				15
16	Duplicate legal bill	(13,552)	19	16
17	Unrecorded legal bills:			17
18	Lawrence Schwartz 10/21/04	2,695	19	18
19	Lawrence Schwartz 11/26/04	1,530	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	(63,061)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Courtyard Terrace Nursing Home# 0040550

Report Period Beginning:

01/01/04

Ending:

12/31/04

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(370)	0	0	0	0	0	0	0	0	0	0	(370)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,122	0	0	0	0	0	0	0	0	2,122	5
6	Maintenance	0	0	2,487	0	0	0	0	0	0	0	0	2,487	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(370)	0	4,609	0	4,239	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(27,500)	0	(62,213)	0	0	0	0	0	0	0	0	(89,713)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,463)	0	2,672	0	0	0	0	0	0	0	0	(6,791)	19
20	Fees, Subscriptions & Promotions	0	0	95	0	0	0	0	0	0	0	0	95	20
21	Clerical & General Office Expenses	(117,359)	0	80,539	0	0	0	0	0	0	0	0	(36,820)	21
22	Employee Benefits & Payroll Taxes	0	0	10,516	0	0	0	0	0	0	0	0	10,516	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	1,078	0	0	0	0	0	0	0	0	1,078	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,661	0	0	0	0	0	0	0	0	1,661	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(154,322)	0	34,348	0	(119,974)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(154,692)	0	38,957	0	(115,735)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Courtyard Terrace Nursing Home# 0040550

Report Period Beginning:

01/01/04

Ending:

12/31/04

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	124,207	0	6,901	0	0	0	0	0	0	0	0	131,108	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(28,241)	0	4,831	0	0	0	0	0	0	0	0	(23,410)	32
33	Real Estate Taxes	31,885	0	4,137	0	0	0	0	0	0	0	0	36,022	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(9,120)	0	572	0	0	0	0	0	0	0	0	(8,548)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	118,731	0	16,441	0	135,172	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)	(35,961)	0	55,398	0	19,437	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
Schedule attached		Schedule attached				

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		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Management Fees	\$ 82,133	Future Associates		\$	\$(82,133)
16	V	5 Utilities		Future Associates		2,122	2,122
17	V	6 Maintenance		Future Associates		2,487	2,487
18	V	17 Administrative		Future Associates		19,920	19,920
19	V	19 Professional Fees		Future Associates		2,672	2,672
20	V	21 Clerical and General		Future Associates		80,539	80,539
21	V	22 Employee Benefits		Future Associates		10,516	10,516
22	V	25 Auto Expense		Future Associates		1,078	1,078
23	V	26 Insurance Expense		Future Associates		1,661	1,661
24	V	30 Depreciation		Future Associates		6,901	6,901
25	V	32 Interest Expense		Future Associates		4,831	4,831
26	V	33 Real Estate Taxes		Future Associates		4,137	4,137
27	V	35 Equipment Rental		Future Associates		572	572
28	V	20 License, Dues, Fees		Future Associates		95	95
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 82,133			\$ 137,531	\$ * 55,398

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

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/04 Ending: 12/31/04

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	Haim Perlstein	Administrator		17.42	99,600	12	0.20	Admin	\$ 19,920	17-7	1
2	Nachshon Draiman	Director		53.66							2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 19,920		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 Courtyard Terrace Nursing Home

0040550

Report Period Beginning:

01/01/04

Ending: 12/31/04

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 Future Associates
 Street Address 7514 N. Skokie Blvd
 City / State / Zip Code Skokie, IL
 Phone Number (847)982-1195
 Fax Number (847)982-0992

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	5	Utilities	1,044,567	4	\$ 10,933	\$	202,776	\$ 2,122	1
2	6	Maintenance	1,044,567	4	12,811		202,776	2,487	2
3	17	Administrative			326,600			19,920	3
4	19	Professional Fees	1,044,567	4	13,763		202,776	2,672	4
5	21	Clerical and General	1,044,567	4	389,695	332,310	202,776	75,649	5
6	22	Employee Benefits	1,044,567	4	52,169		202,776	10,127	6
7	25	Auto Expense	1,044,567	4	5,551		202,776	1,078	7
8	26	Insurance Expense	1,044,567	4	8,556		202,776	1,661	8
9	30	Depreciation	1,044,567	4	35,549		202,776	6,901	9
10	32	Interest Expense	1,044,567	4	24,887		202,776	4,831	10
11	33	Real Estate Taxes	1,044,567	4	21,313		202,776	4,137	11
12	35	Equipment Rental	1,044,567	4	2,948		202,776	572	12
13	20	License, Dues, Fees	1,044,567	4	491		202,776	95	13
14	21	Clerical and General			48,897	48,897		4,890	14
15	22	Employee Benefits			3,885			389	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 958,048	\$ 381,207		\$ 137,531	25

Facility Name & ID Number

Courtyard Terrace Nursing Home

0040550

Report Period Beginning:

01/01/04

Ending:

12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Yorkdale		X	Capitalized lease	\$43,800.00	11/01/94	\$ 4,729,652	\$	8/01/19	10.0000	\$ 39,428	1						
2	Partners	X					460,000	460,000			26,700	2						
3												3						
4	Allocation from Future	X									4,831	4						
5												5						
Working Capital																		
6	Provider Fee										6,660	6						
7	Insurance										5,707	7						
8	IRS										2,982	8						
9	TOTAL Facility Related				\$43,800.00		\$ 5,189,652	\$ 460,000			\$ 86,308	9						
B. Non-Facility Related*																		
10	Adjust out Partner Int										(26,700)	10						
11												11						
12	Interest Income										(12)	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (26,712)	14						
15	TOTALS (line 9+line14)						\$ 5,189,652	\$ 460,000			\$ 59,596	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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 2003 report.		\$	62,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	4,137	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(57,863)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	125,218	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.		\$	67,355	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1999	61,117	8
	2000	60,366	9
	2001	60,594	10
	2002	62,105	11
	2003	62,618	12
2003 Tax Bill		62618	
2004 Tax Bill		62600	
Allocation From Future		4137	

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2003	\$	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:** 2003 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 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 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 Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Courtyard Terrace Nursing Home COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0040550

CONTACT PERSON REGARDING THIS REPORT Bob Kagda

TELEPHONE (847)-675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 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 2003.

(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>11-11-354-001</u>	<u>Nursing Home</u>	\$ <u>62,618.00</u>	\$ <u>62,618.00</u>
2. <u>10-28-408-025</u>	<u>Management Office</u>	\$ <u>19,504.30</u>	\$ <u>1,076.00</u>
3. <u>10-28-408-026</u>	<u>Management Office</u>	\$ <u>9,526.97</u>	\$ <u>525.00</u>
4. <u>10-28-408-027</u>	<u>Management Office</u>	\$ <u>9,526.97</u>	\$ <u>525.00</u>
5. <u>10-28-408-028</u>	<u>Management Office</u>	\$ <u>13,827.82</u>	\$ <u>763.00</u>
6. <u>10-28-408-029</u>	<u>Management Office</u>	\$ <u>13,827.82</u>	\$ <u>763.00</u>
7. <u>10-28-408-030</u>	<u>Management Office</u>	\$ <u>1,657.06</u>	\$ <u>91.00</u>
8. <u>10-28-408-031</u>	<u>Management Office</u>	\$ <u>1,657.06</u>	\$ <u>91.00</u>
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>132,146.00</u>	\$ <u>66,452.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Courtyard Terrace Nursing Home

0040550

Report Period Beginning:

01/01/04

Ending:

12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,171 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>391,714</u>	<u>1994</u>	<u>\$ 160,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	391,714		\$ 160,000	3

Facility Name & ID Number Courtyard Terrace Nursing Home# 0040550

Report Period Beginning:

01/01/04

Ending:

12/31/04**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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	162	1994		\$ 3,749,157	\$ 96,132	20	\$ 187,457	\$ 91,325	\$ 2,046,620	4
5	Alloc LCF		1986	42,189	1,772	Var	3,713	1,941	86,329	5
6	Alloc LCF		1987	1,012	32	31.5	32		563	6
7										7
8										8
	Improvement Type**									
9	Various		1994	12,445	319	20	622	303	6,273	9
10	Various		1995	155,919	2,305	20	7,791	5,486	73,541	10
11	Various		1996	174,016	4,035	20	7,982	3,947	68,373	11
12	Various		1997	83,999	1,537	20	4,199	2,662	31,440	12
13	Various		1998	24,054	617	20	1,201	584	8,157	13
14	Various		1999	5,529	142	20	276	134	1,539	14
15	Various		2000	15,413	278	20	803	525	3,640	15
16	Compressor module		05/15/01	1,354	35	20	67	32	248	16
17	Boiler igniter		06/04/01	579	15	20	29	14	104	17
18	Storage tank		07/10/01	6,950	178	20	347	169	1,216	18
19	Hot water pump		07/12/01	1,026	26	20	52	26	180	19
20	Window A/C		08/01/01	3,472	89	20	173	84	593	20
21	Compressor		08/09/01	13,000	333	20	650	317	2,221	21
22	Ignition Control		10/03/01	610	15	20	30	15	99	22
23	Alarm system		11/12/01	2,580	66	20	129	63	409	23
24	Fire Alarm System		01/01/02	1,589	41	20	80	39	199	24
25	Power Unit Hydraulic elevator		11/21/02	8,475	218	20	423	205	1,059	25
26	Painting		12/02/02	1,202	31	20	60	29	150	26
27	Painting		12/06/02	1,642	42	20	82	40	205	27
28	Boiler work		12/11/02	2,208	57	20	110	53	276	28
29	Heat Exchanger on Boiler		12/13/02	6,500	166	20	325	159	813	29
30	Roof repairs		12/27/02	8,000	205	20	400	195	1,000	30
31	Inside double doors		01/01/03	1,391	36	20	69	33	104	31
32	Repair ceiling and painting 2nd floor		01/03/03	2,045	53	20	102	49	153	32
33	Paint, plastering		01/31/03	1,638	42	20	82	40	123	33
34	Clean up		02/06/03	5,430	139	20	271	132	407	34
35	Access control system		02/28/03	1,766	45	20	88	43	132	35
36										36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Courtyard Terrace Nursing Home

0040550

Report Period Beginning:

01/01/04

Ending:

12/31/04

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	Roof Repairs	03/19/03	\$ 6,380	\$ 163	20	\$ 319	\$ 156	\$ 479	37
38	Exit door locking system	05/12/03	1,270	33	20	63	30	95	38
39	Material	07/21/03	723	18		36	18	54	39
40	Tree removal	10/27/03			20				40
41	Fire alarm system	11/28/03	880	22	20	44	22	66	41
42	Door closures	12/21/03	755	19	20	38	19	57	42
43	Build office & exterior walls	01/22/04	2,750	68	20	69	1	69	43
44	Service on pagibng system	02/29/04	688	15	20	17	2	17	44
45	Tel lines & Monitoring sysytem	02/29/04	2,377	53	20	59	6	59	45
46	Electromagnetic door holder - basement	05/21/04	1,027	16	20	26	10	26	46
47	Electromagnetic door holder-1st floor	05/21/04	1,900	30	20	48	18	48	47
48	New railing	05/31/04	1,200	19	20	30	11	30	48
49									49
50	Alloc from LCF	1987	5,807	184	31.5	184		3,179	50
51	Alloc from LCF	1988	326	10	31.5	10		169	51
52	Alloc from LCF	1989	121	4	31.5	4		59	52
53	Alloc from LCF	1993	3,373	86	39	86		983	53
54	Alloc from LCF	1994	5,143	132	39	132		1,378	54
55	Allocation from LCF-Air Cond; Roof repairs	2001	1,432	37	39	37		99	55
56	Allocation from LCF-5 Ton Trane A/C	2002	351	9	39	9		21	56
57	Allocation from LCF-Office Remodeling	2003	213	5	39	5		5	57
58	Alloc from LCF-Electrical repairs	2004	738	16	39	16		16	58
59	Alloc fro Future Associates	1987	18,299	581	31.5	591	10	10,558	59
60	Alloc fro Future Associates	1994	5,352	73	Var	73		3,283	60
61									61
62									62
63	Additions by management company								63
64	Roof Repairs	10/27/2004	1,200						64
65	Replace door pane	12/27/2004	593						65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,398,088	\$ 110,594		\$ 219,541	\$ 108,947	\$ 2,356,916	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	\$ 183,300	\$ 19,607	\$ 19,136	\$ (471)	10	\$ 110,984	71
72	Current Year Purchases	7,115	1,519	356	(1,163)	10	356	72
73	Fully Depreciated Assets	378,960	234	17,129	16,895	10	378,960	73
74	Round off adj		1		(1)			74
75	TOTALS	\$ 569,375	\$ 21,361	\$ 36,621	\$ 15,260		\$ 490,300	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	From Future			\$ 52,779	\$ 1,967	\$ 1,967	\$	5	\$ 26,632	76
77										77
78										78
79										79
80	TOTALS			\$ 52,779	\$ 1,967	\$ 1,967	\$		\$ 26,632	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)	\$ 5,180,242	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 133,922	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 258,129	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 124,207	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,873,848	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: <u>Operating Capital Lease</u>			\$ _____			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: \$ 2,805 Description: Copier machine 2335; Postage machine 470;

(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>Allocation from Future</u>		\$ _____	\$ <u>572</u>	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ <u>572</u>	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. _____ /2005 \$ _____

13. _____ /2006 \$ _____

14. _____ /2007 \$ _____

* 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 NURSE AIDE TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED AIDES 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 AIDE _____</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 AIDE _____</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	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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	\$		\$ 40,286	\$		\$ 40,286	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,109			2,109	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			36,186			36,186	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				57,652		57,652	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Schedule</u>					3,271	22,257		25,528	13
14	TOTAL			\$		\$ 81,852	\$ 79,909		\$ 161,761	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 nurse aides, who help with the above activities should not be listed on this schedule.

Special Services - Supplies - (Column 6 -Other)

1 Oxygen	39-2	11455
2 Equipment Rental	39-2	10802
Total		<u>22257</u>

Outside Therapies (Column 5- Other)

1 Respiratory Therapy	39-3	
2 Lab & XRay	39-3	3271
Total		<u>3271</u>

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES

As of 12/31/04

OTHER CURRENT ASSETS:

Amount Amount

Real Estate Tax Escrow
Employee Advances

=====
=====

OTHER CURRENT LIABILITIES:

Amount Amount

Accrued Expenses

=====
=====

OTHER NON CURRENT ASSETS:

Construction In Progress
Utility Deposit
Loan Costs
Exchange

=====
=====

OTHER NON CURRENT LIABILITIES:

=====
=====

Facility Name & ID Number Courtyard Terrace Nursing Home

0040550

Report Period Beginning: 01/01/04

Ending:

12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04

(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	\$ 14,271	\$	1
2	Cash-Patient Deposits	7,135		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	624,917		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	46,963		6
7	Other Prepaid Expenses	1,722		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 695,008	\$	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			15
16	Equipment, at Historical Cost	4,644		16
17	Accumulated Depreciation (book methods)			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)	\$ 4,644	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 699,652	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 333,820	\$	26
27	Officer's Accounts Payable	252,000		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	40,828		31
32	Accrued Real Estate Taxes(Sch.IX-B)			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)	\$ 626,648	\$	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)	\$ 626,648	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 73,004	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 699,652	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (8,042,569)	1
2	Restatements (describe):		2
3			3
4	Transfer operations to Management group		4
5	Renaissance	8,042,569	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(390,349)	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)	\$ (390,349)	17
	B. Transfers (Itemize):		
18			18
19	Net Loss to 5/31/04	463,352	19
20	Round off adj	1	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 463,353	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 73,004	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	\$ 2,647,335	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,647,335	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	167,192	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 167,192	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	108	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	59,088	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,694	19
20	Radiology and X-Ray		20
21	Other Medical Services	90	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 64,980	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Schedule attached</u>	(19,650)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (19,650)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,859,869	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	705,994	31
32	Health Care	1,092,868	32
33	General Administration	947,372	33
	B. Capital Expense		
34	Ownership	253,285	34
	C. Ancillary Expense		
35	Special Cost Centers	161,761	35
36	Provider Participation Fee	88,938	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,250,218	40
41	Income before Income Taxes (line 30 minus line 40)**	(390,349)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (390,349)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** 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 Courtyard Terrace Nursing Home

0040550

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUPPLEMENTAL SCHEDULE OF REVENUES

12/31/04

DESCRIPTION	AMOUNT
1 Vending Commissions	
2 Adj of Prior period Expenses	1,021
3 Deposit errors	19,058
4 Depreciation adjustment	(429)
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	<u><u>19,650</u></u>

Facility Name & ID Number Courtyard Terrace Nursing Home

0040550

Report Period Beginning: 01/01/04

Ending: 12/31/04

12/31/04

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	2,424	2,679	\$ 58,994	\$ 22.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,705	2,893	62,175	21.49	3
4	Licensed Practical Nurses	16,379	17,276	331,350	19.18	4
5	Nurse Aides & Orderlies	48,122	49,740	462,580	9.30	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,034	4,219	30,673	7.27	8
9	Activity Director					9
10	Activity Assistants	5,322	5,781	49,196	8.51	10
11	Social Service Workers	2,393	2,684	41,633	15.51	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	18,142	19,097	139,023	7.28	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,628	5,024	53,807	10.71	17
18	Housekeepers	14,907	15,517	101,015	6.51	18
19	Laundry	6,620	6,761	38,742	5.73	19
20	Administrator	3,307	3,524	81,645	23.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,139	6,586	59,541	9.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	135,122	141,781	\$ 1,510,374 *	\$ 10.65	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	Monthly \$ 2,800	1-3	35
36	Medical Director	Monthly 4,000	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	(349)	10-3	39
40	Physical Therapy Consultant	Monthly 6,513	10a-3	40
41	Occupational Therapy Consultant	Monthly 1,286	10a-3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 14,250		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	(378)	10-3	50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$ (378)		53

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		\$	\$
<u>0</u>	<u>0</u>	\$ <u>0</u>	\$ <u>#DIV/0!</u>

Courtyard Terrace Nursing Home

01/01/04 to 12/31/04

0040550

Page 21 SUPP

Page 21- Professional Services:

-

Facility Name & ID Number Courtyard Terrace Nursing Home# 0040550

Report Period Beginning:

01/01/04

Ending:

12/31/04**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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. Am't not determinable Line 10
- (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 of Public Aid during this cost report period. \$ 88,938
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 of Public Aid, 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. \$ 15,061 Has any meal income been offset against related costs? No 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? None
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.** \$ _____
- (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 \$2500, 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