

Facility Name & ID Number Country Club Terrace

0037267 Report Period Beginning: 7/1/04 Ending: 6/30/05

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 16

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	16	Intermediate (ICF)	16	5,840	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Medicaid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	5,840			5,840	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,840			5,840	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 100.00%

D. How many bed-hold days during this year were paid by the Department? _____ (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) _____

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 3/11/91

J. Was the facility purchased or leased after January 1, 1978?
YES Date 9/12/91 NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31 Fiscal Year: 6/30

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

STATE OF ILLINOIS

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/04 Ending: 6/30/05

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	24,381		960	25,341		25,341		25,341		1
2	Food Purchase		28,638		28,638		28,638	51	28,689		2
3	Housekeeping		13,367	14,400	27,767		27,767	1,448	29,215		3
4	Laundry		2,788		2,788		2,788		2,788		4
5	Heat and Other Utilities			10,953	10,953		10,953	2,229	13,182		5
6	Maintenance			5,125	5,125		5,125	12,197	17,322		6
7	Other (specify):*										7
8	TOTAL General Services	24,381	44,793	31,438	100,612		100,612	15,925	116,537		8
	B. Health Care and Programs										
9	Medical Director		2,162	6,000	8,162		8,162	1,824	9,986		9
10	Nursing and Medical Records	263,577	9,261	198	273,036		273,036	8,862	281,898		10
10a	Therapy										10a
11	Activities		1,869		1,869		1,869	48	1,917		11
12	Social Services							5,312	5,312		12
13	CNA Training							1,859	1,859		13
14	Program Transportation		5,045		5,045		5,045	2,868	7,913		14
15	Other (specify):* dental&psychiatrist			621	621		621	23,924	24,545		15
16	TOTAL Health Care and Programs	263,577	18,337	6,819	288,733		288,733	44,697	333,430		16
	C. General Administration										
17	Administrative	33,133			33,133		33,133	7,522	40,655		17
18	Directors Fees										18
19	Professional Services							8,833	8,833		19
20	Dues, Fees, Subscriptions & Promotions			150	150		150	1,964	2,114		20
21	Clerical & General Office Expenses		792	5,692	6,484		6,484	15,998	22,482		21
22	Employee Benefits & Payroll Taxes							83,790	83,790		22
23	Inservice Training & Education										23
24	Travel and Seminar			763	763		763	237	1,000		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice							8,232	8,232		26
27	Other (specify):* staff cost/events			972	972		972	579	1,551		27
28	TOTAL General Administration	33,133	792	7,577	41,502		41,502	127,155	168,657		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	321,091	63,922	45,834	430,847		430,847	187,777	618,624		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.

Facility Name & ID Number

Country Club Terrace

#0037267

Report Period Beginning:

7/1/04

Ending:

6/30/05

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						1,945	1,945				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						4,152	4,152				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			59,160	59,160		59,160	9,386	68,546			34
35	Rent-Equipment & Vehicles			702	702		702	1,939	2,641			35
36	Other (specify):* Equip. under \$500			2,654	2,654		2,654	449	3,103			36
37	TOTAL Ownership			62,516	62,516		62,516	17,871	80,387			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,508	1,508		1,508		1,508			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,852	49,852		49,852		49,852			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			51,360	51,360		51,360		51,360			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	321,091	63,922	159,710	544,723		544,723	205,648	750,371			45

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

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Report Period Beginning: 7/1/04

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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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	1,848	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties				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				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 1,848		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 1,848		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

Country Club Terrace

ID# 0037267

Report Period Beginning: 7/1/04

Ending: 6/30/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Country Club Terrace

0037267

Report Period Beginning:

7/1/04

Ending:

6/30/05

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	1,848	0	0	0	0	0	0	0	0	0	0	1,848	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	1,848	0	0	0	0	0	0	0	0	0	0	1,848	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	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	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	1,848	0	0	0	0	0	0	0	0	0	0	1,848	29

Facility Name & ID Number Country Club Terrace

0037267

Report Period Beginning: 7/1/04

Ending: 6/30/05

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
		NOT APPLICABLE				

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		\$	NOT APPLICABLE		\$	\$	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)

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	NOT APPLICABLE								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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 Country Club Terrace # 0037267 Report Period Beginning: 7/1/04 Ending: 6/30/05

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 St. Coletta's of Illinois
 Street Address 18350 Crossing Drive
 City / State / Zip Code Tinley park, IL 60477
 Phone Number (708) 342-5200
 Fax Number (708) 342-2579

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/(col.4)x col.6)	
1	2	coffee&supplies	tinley park salary	7	\$ 2,971	\$ 0	63,392	\$ 48	1
2	2	food purchases	program direct salary	4	234	0	3,790	3	2
3	3	housekeeping-consultant #200	tinley park salary	7	88,800	0	63,392	1,448	3
4	5	electricity,heat,other # 100	direct hours	7	338	0	31,856	16	4
5	5	electricity,heat,other # 200	tinley park salary	7	135,703	0	63,392	2,213	5
6	6	maintenance supplies # 200	tinley park salary	7	918	0	63,392	15	6
7	6	maintenance supplies # 300	avg hours direct salary	7	5,140	0	467,997	274	7
8	6	maintenance services # 300	direct	1	3,204	0	1	3,204	8
9	6	maintenance other # 102	direct hours	7	2,564	0	31,856	122	9
10	6	maintenance other # 200	tinley park salary	7	28,656	0	63,392	467	10
11	6	maint-carpet clean # 600	direct salary # 600	4	1,813	0	3,790	20	11
12	9	consultant-medical #501	weighted contact hours	7	28,500	0	5,840	1,327	12
13	9	consultant-pharmacy #501	weighted contact hours	7	3,300	0	5,840	154	13
14	9	medical supplies #501	direct salary # 501	6	6,528	0	8,476	272	14
15	9	medical supplies #600	direct salary # 600	4	6,468	0	3,790	71	15
16	10	consultant-nursing #501	weighted contact hours	7	8,302	0	5,840	386	16
17	11	behavior pg supplies #108	direct salary #108	5	306	0	19,692	34	17
18	11	atrium supplies #200	tinley park salary	7	883	0	63,392	14	18
19	13	staff training supplies # 107	direct hours	7	687	0	31,856	33	19
20	13	staff tng # 107	direct hours	7	26,410	0	31,856	1,260	20
21	14	vehicle operating costs#325	mileage	7	38,052	0	9,485	609	21
22	14	vehicle operating costs#100	direct hours	7	3,891	0	31,856	186	22
23	14	vehicle operating costs#102	overhead salary	7	18,562	0	63,392	698	23
24	14	vehicle operating costs#300	direct hours	7	17,827	0	31,856	851	24
25	TOTALS				\$ 430,057	\$		\$ 13,725	25

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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 St. Coletta's of Illinois
 Street Address 18350 Crossing Drive
 City / State / Zip Code Tinley park, IL 60477
 Phone Number (708) 342-5200
 Fax Number (708) 342-2579

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/(col.4)x col.6)	
1	14	staff transp- #100,102,103,300	direct hours	667,495	7	\$ 553	\$ 31,856	\$ 26	1
2	14	staff transp- #501	direct salary-501	203,196	6	60	8,476	2	2
3	14	staff transp- #600	direct salary-600	344,106	4	148	3,790	2	3
4	15	consultant-psychiatrists #108	dd client	1,444,824	4	43,621	140,160	4,232	4
5	19	legal fees#100,audit fees#102	direct hours	667,495	7	134,880	31,856	6,437	5
6	19	consultant -#102,103	direct hours	667,495	7	50,200	31,856	2,396	6
7	20	dues, fees,subscriptions #100	direct hours	667,495	7	9,566	31,856	457	7
8	20	dues, fees,subscriptions #103	direct hours	667,495	7	16,507	31,856	788	8
9	20	dues, fees,subscriptions #105	total salary	8,491,854	7	15,128	391,229	697	9
10	20	dues, fees,subscriptions #107	direct hours	667,495	7	135	31,856	6	10
11	20	dues, fees,subscriptions #108	direct salary-108	177,017	5	84	19,692	9	11
12	20	dues, fees,subscriptions #200	tinley park salary	3,887,377	7	450	63,392	7	12
13	21	office supplies,tel, internet #100	direct hours	667,495	7	7,483	31,856	357	13
14	21	office supplies,tel, internet #102	direct hours	667,495	7	8,225	31,856	393	14
15	21	office supplies,tel, internet #103	direct hours	667,495	7	3,277	31,856	156	15
16	21	office supplies,tel, internet #104	direct hours	667,495	7	146	31,856	7	16
17	21	office supplies,tel, internet #105	total salary	8,491,854	7	14,158	391,229	652	17
18	21	office supplies,tel, internet #107	direct hours	667,495	7	197	31,856	9	18
19	21	office supplies,tel, internet #108	direct salary-108	177,017	7	318	19,692	35	19
20	21	office supplies,tel, internet #300	direct hours	667,495	7	3,133	31,856	150	20
21	21	office supplies,tel, internet #501	direct salary-501	203,196	6	3,495	8,476	146	21
22	21	office supplies,tel, internet #600	direct salary-600	344,106	4	7,919	3,790	87	22
23	21	telephone,cable,internet	overhead salary	1,686,358	7	23,895	63,392	898	23
24	22	sister's fica #104	direct hours	667,495	7	2,380	31,856	114	24
25	TOTALS					\$ 345,958	\$	\$ 18,063	25

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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

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 Street Address 18350 Crossing Drive
 City / State / Zip Code Tinley park, IL 60477
 Phone Number (708) 342-5200
 Fax Number (708) 342-2579

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/(col.4)x col.6)	
1	22	christmas gift	total salary	7	\$ 2,500	\$	391,229	\$ 115	1
2	22	employee benefits #120	total salary	7	1,813,744		391,229	83,561	2
3	24	conventions,meeting #100,102	direct hours	7	4,791		31,856	229	3
4	24	conventions,meeting #108	direct salary-108	5	75		19,692	8	4
5	26	property insurance	total salary	7	178,677		391,229	8,232	5
6	27	board related exp #100	direct hours	7	3,549		31,856	169	6
7	27	misc exp #100	direct hours	7	1,878		31,856	90	7
8	27	bank charge #102	direct hours	7	350		31,856	17	8
9	27	late fees #102	direct hours	7	300		31,856	14	9
10	27	misc exp #102	direct hours	7	1,534		31,856	73	10
11	27	misc exp #103	direct hours	7	95		31,856	5	11
12	27	memorial& spe par pr	direct hours	7	2,611		31,856	125	12
13	27	start-up exp #200	tinley park salary	7	2,946		63,392	48	13
14	27	misc exp #200	tinley park salary	7	1,750		63,392	29	14
15	27	staff cost/meal/events#600	direct salary#600	4	272		3,790	3	15
16	27	misc exp#600	direct salary#600	4	500		3,790	6	16
17	30	depr.-auto #102	direct hours	7	4,366		31,856	208	17
18	30	depr.-other#102	direct hours	7	19,668		31,856	939	18
19	30	depr.-computer#102	direct hours	7	10,469		31,856	500	19
20	30	depr.-auto#600	direct hours	7	6,240		31,856	298	20
21	32	scif interest exp#100	direct exp	7	58,509		544,724	3,785	21
22	32	auto loan exp#102	direct exp	7	4,694		544,724	304	22
23	32	auto loan exp #300	direct exp	7	973		544,724	63	23
24	34	rental exp#100	direct hours	7	9,300		31,856	444	24
25	TOTALS				\$ 2,129,791	\$		\$ 99,265	25

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/04 Ending: 6/30/05

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 St. Coletta's of Illinois
 Street Address 18350 Crossing Drive
 City / State / Zip Code Tinley park, IL 60477
 Phone Number (708) 342-5200
 Fax Number (708) 342-2579

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	34 rental exp #200	tinley park salary	3,887,377	7	\$ 452,761	\$	63,392	\$ 7,383	1
2	34 rental office#200	overhead salary	1,686,358	7	41,478		63,392	1,559	2
3	35 copier lease#105	total salary	8,491,854	7	42,080		391,229	1,939	3
4	36 equipment under 500-#100	avg hours direct salary	8,768,776	7	1,847		467,997	99	4
5	36 group home repairs-#100	avg hours direct salary	8,768,776	7	6,390		467,997	341	5
6	36 equipment under 500-#200	tinley park salary	3,887,377	7	553		63,392	9	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 545,109	\$		\$ 11,330	25

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/04 Ending: 6/30/05

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 St. Coletta's of Illinois
 Street Address 18350 Crossing Drive
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B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	6	maintenance staff salary - #300	direct hours	667,495	7	\$ 169,618	\$ 169,618	31,856	\$ 8,095	1
2	10	nursing staff salary - #501	direct salary-501	203,196	6	203,197	203,197	8,476	8,476	2
3	12	ministry salary - #104	direct hours	667,495	7	31,664	31,664	31,856	1,511	3
4	12	residential staff salary - #600	direct salary-600	344,106	4	345,141	345,141	3,790	3,801	4
5	13	staff training salary - #107	direct hours	667,495	7	11,815	11,815	31,956	566	5
6	14	vehicle maint salary - #325	mileage	592,703	7	30,891	30,891	9,485	494	6
7	15	psychological staff salary - #108	direct salary-108	177,017	5	177,017	177,017	19,692	19,692	7
8	17	executive director salary - #100	direct hours	667,495	7	157,613	157,613	31,856	7,522	8
9	21	executive staff salary - #100	direct hours	667,495	7	52,169	52,169	31,856	2,490	9
10	21	finance staff salary - #102	direct hours	667,495	7	137,785	137,785	31,856	6,576	10
11	21	human resource salary - #103	direct hours	667,495	7	87,623	87,623	31,856	4,182	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					\$ 1,404,533	\$ 1,404,533		\$ 63,405	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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1				NOT APPLICABLE			\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6				NOT APPLICABLE								6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10				NOT APPLICABLE								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	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.)

Facility Name & ID Number **Country Club Terrace**# **0037267** Report Period Beginning: **7/1/04** Ending: **6/30/05****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 2004 report.			\$	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.)			\$	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	3
4.	Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	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.			\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000	_____	8	
		2001	_____	9	
		2002	_____	10	
		2003	_____	11	
		2004	_____	12	
FOR OHF USE ONLY					
13	FROM R. E. TAX STATEMENT FOR 2004		\$		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:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Country Club Terrace COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037267

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,200 B. General Construction Type: Exterior ALUMINUM Frame MASONRY Number of Stories ONE

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).

NOT 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Country Club Terrace

0037267

Report Period Beginning:

7/1/04

Ending:

6/30/05

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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10	REFER TO SCH VIII										
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

*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

XI. OWNERSHIP COSTS (continued)

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

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

**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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	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	2	
	Reference	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)	\$	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	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: St. Coletta's of Illinois Foundation
 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>1991</u>	<u>16</u>		\$ <u>55,020</u>	<u>1</u>	<u>20</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>16</u>		\$ <u>55,020</u>			7

10. Effective dates of current rental agreement:
 Beginning 7/1/04
 Ending 6/30/05

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

	Fiscal Year Ending	Annual Rent
12.	<u>6/30/2006</u>	\$ <u>55,020</u>
13.	<u>6/30/2007</u>	\$ <u>55,020</u>
14.	<u>6/30/2008</u>	\$ <u>55,020</u>

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: \$ _____ Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19	<u>NOT APPLICABLE</u>				19
20					20
21	TOTAL		\$ _____	\$ _____	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.

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 checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		33		33
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		566		566
6	Transportation				
7	Contractual Payments			1,260	1,260
8	CNA Competency Tests				
9	TOTALS	\$	\$ 599	\$ 1,260	\$ 1,859
10	SUM OF line 9, col. 1 and 2 (e)	\$	599		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	NOT APPLICABLE	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Country Club Terrace

0037267

Report Period Beginning: 7/1/04

Ending:

6/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/05

(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	\$	\$ 532,567	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance		65,839	6
7 Other Prepaid Expenses		5,440	7
8 Accounts Receivable (owners or related parties)		2,045,645	8
9 Other(specify): due from scif		120,338	9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 2,769,829	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		94,204	15
16 Equipment, at Historical Cost		1,446,878	16
17 Accumulated Depreciation (book methods)		(1,280,055)	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): investments & deposits		30,006	23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 291,033	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 3,060,862	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$	\$ 316,744	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits		76,019	28
29 Short-Term Notes Payable		1,734,995	29
30 Accrued Salaries Payable		605,193	30
31 Accrued Taxes Payable (excluding real estate taxes)			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		43,579	35
Other Current Liabilities(specify):			
36 workers compensation payable		44,182	36
37 accrued vacation payable		74,928	37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 2,895,640	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable		68,204	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)	\$	\$ 68,204	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 2,963,844	46
47 TOTAL EQUITY(page 18, line 24)	\$ 421,505	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 421,505	\$ 2,963,844	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 314,823	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 314,823	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	106,682	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)	\$ 106,682	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)	\$ 421,505	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	\$ 849,682	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 849,682	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	4,464	9
10	Other Government Grants		10
11	CNA Training Reimbursements	2,907	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)	\$ 7,371	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	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)	\$ 857,053	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	116,537	31
32	Health Care	333,430	32
33	General Administration	168,657	33
B. Capital Expense			
34	Ownership	80,387	34
C. Ancillary Expense			
35	Special Cost Centers	1,508	35
36	Provider Participation Fee	49,852	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 750,371	40
41	Income before Income Taxes (line 30 minus line 40)**	106,682	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 106,682	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 Country Club Terrace

0037267

Report Period Beginning: 7/1/04

Ending: 6/30/05

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
2	Assistant Director of Nursing				2
3	Registered Nurses	805	15,335	19.05	3
4	Licensed Practical Nurses	18	426	23.67	4
5	CNAs & Orderlies	23,249	247,816	10.66	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	2,321	23,359	10.06	14
15	Cook Helpers/Assistants	114	1,022	8.96	15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers				18
19	Laundry				19
20	Administrator	1,044	33,133	31.74	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical				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)	27,551	\$ 321,091 *	\$ 11.65	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	\$ 960		35
36	Medical Director	6,000		36
37	Medical Records Consultant	198		37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify) DENTAL&OPT	621		46
47	OUT HOUSEKEEPING	14,400		47
48	OTHER CONSULTANT-SCHVIII	8,709		48
49	TOTAL (lines 35 - 48)	\$ 30,888		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

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? 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? 5YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (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. \$ 49,852
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? N/A 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? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? 0 Indicate the amount. \$ 0
- (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? _____ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ No
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Mulcahy, Pauritsch, Salvador & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes 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.