

Facility Name & ID Number CRESTWOOD TERRACE

0022863 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	126	Intermediate (ICF)	126	45,990	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	126	TOTALS	126	45,990	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	40,343	2,594	589	43,526
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	40,343	2,594	589	43,526

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.64%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ 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: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number **CRESTWOOD TERRACE** # **0022863** Report Period Beginning: **01/01/2005** Ending: **12/31/2005**

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	128,723	11,121	5,940	145,784		145,784		145,784		1
2	Food Purchase		171,083		171,083		171,083	(537)	170,546		2
3	Housekeeping	150,735	16,838		167,573		167,573		167,573		3
4	Laundry	45,075	18,046		63,121		63,121	945	64,066		4
5	Heat and Other Utilities			101,050	101,050		101,050	273	101,323		5
6	Maintenance	48,061	28,886	29,436	106,383		106,383	397	106,780		6
7	Other (specify):*			6,827	6,827		6,827	58	6,885		7
8	TOTAL General Services	372,594	245,974	143,253	761,821		761,821	1,136	762,957		8
	B. Health Care and Programs										
9	Medical Director			5,400	5,400		5,400		5,400		9
10	Nursing and Medical Records	1,059,834	48,317	9,336	1,117,487		1,117,487		1,117,487		10
10a	Therapy	41,592		3,543	45,135		45,135		45,135		10a
11	Activities	107,455	6,999	626	115,080		115,080		115,080		11
12	Social Services	76,067		4,914	80,981		80,981		80,981		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,284,948	55,316	23,819	1,364,083		1,364,083		1,364,083		16
	C. General Administration										
17	Administrative	64,008		179,500	243,508		243,508	(160,016)	83,492		17
18	Directors Fees										18
19	Professional Services			33,514	33,514		33,514	7,599	41,113		19
20	Dues, Fees, Subscriptions & Promotions			15,810	15,810		15,810	(3,802)	12,008		20
21	Clerical & General Office Expenses	66,380	16,964	96,868	180,212		180,212	(59,030)	121,182		21
22	Employee Benefits & Payroll Taxes			236,041	236,041		236,041		236,041		22
23	Inservice Training & Education			1,495	1,495		1,495	18	1,513		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			18,721	18,721		18,721	372	19,093		25
26	Insurance-Prop.Liab.Malpractice			63,427	63,427		63,427	1,790	65,217		26
27	Other (specify):*							4,847	4,847		27
28	TOTAL General Administration	130,388	16,964	645,376	792,728		792,728	(208,222)	584,506		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,787,930	318,254	812,448	2,918,632		2,918,632	(207,086)	2,711,546		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	5,940
	REPAIRS & MAINTENANCE	0
		0
		5,940
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	57,315
	ELECTRICITY	31,165
	WATER	11,783
	CABLE TV - LOBBY	787
		0
		101,050
6	MAINTENANCE	
	GROUNDS MAINTENANCE	4,696
	PAINTING & DECORATING	6,687
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	8,507
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,406
	FIRE SERVICE	7,140
		0
		0
		0
		29,436
7	OTHER	
	SCAVENGER	6,411
	SECURITY SERVICE	416
		6,827
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	5,400
		5,400

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	4,536
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	1,200
	DENTAL	3,600
		0
		9,336
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	2,072
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	1,471
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		3,543
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	626
		0
		626
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	4,914
	SOCIAL WORKER XVIII B 45-2	0
		0
		4,914
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	179,500
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	12,706
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	20,808
		0
		33,514
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	0
	EMPLOYEE WANT ADS XIX F	4,732
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	5,532
	LICENSES & PERMITS XIX F	1,079
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	2,567
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	450
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,450
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
		15,810
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	96
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	66,000
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	16,063
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	14,709
		96,868

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	135,772
	UNEMPLOYMENT COMPENSATION XIX D	26,162
	WORKERS COMPENSATION INSURANCE XIX D	56,798
	HOSPITALIZATION INSURANCE XIX D	12,881
	EMPLOYEE BENEFITS - OTHER XIX D	300
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	4,128
	CHICAGO HEAD TAX XIX D	0
		236,041
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,495
		1,495
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	18,721
		18,721
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	63,427
		63,427
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

812,448

CRESTWOOD TERRACE
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2005

TOTAL FOOD PURCHASE	171,083	PATIENT MEALS	130578
LESS SALES TAX	(537)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	170,546	TOTAL MEALS/YEAR	130578
TOTAL PATIENT CENSUS	43,526	NET FOOD	170546
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	130578

TOTAL PATIENT MEALS	130578	COST PER MEAL	1.31
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number **CRESTWOOD TERRACE**

#0022863

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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			36,019	36,019		36,019	9,078	45,097			30
31	Amortization of Pre-Op. & Org.			696	696		696		696			31
32	Interest			152,457	152,457		152,457	(77,433)	75,024			32
33	Real Estate Taxes			220,943	220,943		220,943	1,344	222,287			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			28,195	28,195		28,195	3,546	31,741			35
36	Other (specify):* OFFICE RENT			9,828	9,828		9,828	(9,828)				36
37	TOTAL Ownership			448,138	448,138		448,138	(73,293)	374,845			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			68,985	68,985		68,985		68,985			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			68,985	68,985		68,985		68,985			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,787,930	318,254	1,329,571	3,435,755		3,435,755	(280,379)	3,155,376			45

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

Facility Name & ID Number **CRESTWOOD TERRACE**

0022863

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	8,039	30		9
10	Interest and Other Investment Income	(78,866)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(537)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(450)	20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(1,450)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,567)	20		28
29	Other-Attach Schedule <u>SEE PAGE 5-A</u>	(16,104)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (91,935)		\$	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)	(188,444)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (188,444)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (280,379)		37

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

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

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

CRESTWOOD TERRACE

ID# 0022863

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (1,395)	6	1
2	STAFF DEVELOPMENT	(14,709)	21	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	(16,104)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CRESTWOOD TERRACE# 0022863

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	(537)	0	0	0	0	0	0	0	0	0	0	(537)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	945	0	0	0	0	0	0	0	0	945	4
5	Heat and Other Utilities	0	0	0	273	0	0	0	0	0	0	0	273	5
6	Maintenance	(1,395)	0	1,251	541	0	0	0	0	0	0	0	397	6
7	Other (specify):*	0	0	28	30	0	0	0	0	0	0	0	58	7
8	TOTAL General Services	(1,932)	0	2,224	844	0	1,136	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	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(165,070)	5,054	0	0	0	0	0	0	0	0	(160,016)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	325	7,229	45	0	0	0	0	0	0	0	7,599	19
20	Fees, Subscriptions & Promotions	(4,467)	0	665	0	0	0	0	0	0	0	0	(3,802)	20
21	Clerical & General Office Expenses	(14,709)	4,722	(49,261)	218	0	0	0	0	0	0	0	(59,030)	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	18	0	0	0	0	0	0	0	0	18	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	54	318	0	0	0	0	0	0	0	0	372	25
26	Insurance-Prop.Liab.Malpractice	0	134	1,491	165	0	0	0	0	0	0	0	1,790	26
27	Other (specify):*	0	1,448	3,399	0	0	0	0	0	0	0	0	4,847	27
28	TOTAL General Administration	(19,176)	(158,387)	(31,087)	428	0	(208,222)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(21,108)	(158,387)	(28,863)	1,272	0	(207,086)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CRESTWOOD TERRACE# 0022863

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

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	8,039	0	175	864	0	0	0	0	0	0	0	9,078	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(78,866)	0	0	1,433	0	0	0	0	0	0	0	(77,433)	32
33	Real Estate Taxes	0	0	0	1,344	0	0	0	0	0	0	0	1,344	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	271	3,082	193	0	0	0	0	0	0	0	3,546	35
36	Other (specify):*	0	0	0	(9,828)	0	0	0	0	0	0	0	(9,828)	36
37	TOTAL Ownership	(70,827)	271	3,257	(5,994)	0	(73,293)	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)	(91,935)	(158,116)	(25,606)	(4,722)	0	(280,379)	45						

Facility Name & ID Number

CRESTWOOD TERRACE

0022863

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 MANAGEMENT FEE	\$ 174,000	EMI ENTERPRISES		\$	\$ (174,000)	1
2	V							2
3	V	17 OFFICERS SALARY				8,930	8,930	3
4	V	19 ACCOUNTING FEES				325	325	4
5	V	21 OFFICE EXPENSE				4,722	4,722	5
6	V	25 TRANSPORTATION				54	54	6
7	V	26 INSURANCE				134	134	7
8	V	27 EMPLOYEE BENEFITS				1,448	1,448	8
9	V	35 AUTO LEASE				271	271	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 174,000			\$ 15,884	\$ * (158,116)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 BOOKKEEPING	\$ 66,000	EKS MANAGEMENT	100.00%	\$	\$ (66,000)
16	V						
17	V	4 HOUSEKEEPING SALARIES				945	945
18	V	6 PAINTERS SALARIES				1,251	1,251
19	V	7 SCAVENGER				28	28
20	V	17 CFO SALARY				5,054	5,054
21	V	19 PROFESSIONAL FEES				7,229	7,229
22	V	20 WANT ADS/BACKGR CKS				665	665
23	V	21 OFFICE EXPENSE				16,739	16,739
24	V	23 SEMINARS				18	18
25	V	25 TRANSPORTATION				318	318
26	V	26 INSURANCE				1,491	1,491
27	V	27 EMPLOYEE BENEFITS				3,399	3,399
28	V	30 DEPRECIATION				175	175
29	V	35 EQUIPMENT RENT				3,082	3,082
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 66,000			\$ 40,394	\$ * (25,606)

* 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	36 OFFICE RENT	\$ 9,828	IME REALTY	100.00%	\$	\$ (9,828)
16	V						
17	V						
18	V	5 UTILITIES				273	273
19	V	6 REPAIR & MAINTENANCE				541	541
20	V	7 ALARM SERVICE				30	30
21	V	19 PROFESSIONAL FEES				45	45
22	V	21 OFFICE EXPENSE				218	218
23	V	26 INSURANCE				165	165
24	V	30 DEPRECIATION				864	864
25	V	32 INTEREST				1,433	1,433
26	V	33 RE TAX				1,344	1,344
27	V	35 STORAGE FEES				193	193
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 9,828			\$ 5,106	\$ * (4,722)

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

Facility Name & ID Number

CRESTWOOD TERRACE

#

0022863

Report Period Beginning:

01/01/2005

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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	MORRIS ESFORMES	GENERAL PARTN	ADMINISTRATION		SEE ATTACHED			SALARY	\$ 8,930	17-7	1
2	AVRUM WEINFELD	CFO						SALARY	5,054	17-7	2
3	PHILIP ESFORMES							MGMT FEE	5,500	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 19,484		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 CRESTWOOD TERRACE

0022863 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization EMI ENTERPRISES
 Street Address 6865 N LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-1946
 Fax Number (847) 674-1962

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	17	OFFICERS SALARY	PATIENT DAYS	901,761	15	\$ 185,000	\$ 43,526	\$ 8,930	1
2	19	ACCOUNTING FEES	PATIENT DAYS	901,761	15	6,725	43,526	325	2
3	21	OFFICE EXPENSE	PATIENT DAYS	901,761	15	97,823	43,526	4,722	3
4	25	TRANSPORTATION	PATIENT DAYS	901,761	15	1,114	43,526	54	4
5	26	INSURANCE	PATIENT DAYS	901,761	15	2,768	43,526	134	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	901,761	15	29,997	43,526	1,448	6
7	35	AUTO LEASE	PATIENT DAYS	901,761	15	5,617	43,526	271	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					\$ 329,044	\$ 264,576	\$ 15,884	25

Facility Name & ID Number CRESTWOOD TERRACE

0022863 Report Period Beginning: 01/01/2005

Ending: 2/31/2005

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 EKS MGMT
 Street Address 6865 N LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-1946
 Fax Number (847) 674-1962

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	4	HOUSEKEEPING SALARIES	PATIENT DAYS	901,761	15	\$ 19,581	\$ 19,441	43,526	\$ 945	1
2	6	PAINTERS SALARIES	PATIENT DAYS	901,761	15	25,925	25,925	43,526	1,251	2
3	7	SCAVENGER	PATIENT DAYS	901,761	15	573		43,526	28	3
4	17	CFO SALARY	PATIENT DAYS	901,761	15	104,714	104,714	43,526	5,054	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	901,761	15	149,759	119,638	43,526	7,229	5
6	20	WANT ADS/BACKGR CKS	PATIENT DAYS	901,761	15	13,787		43,526	665	6
7	21	OFFICE EXPENSE	PATIENT DAYS	901,761	15	346,792	248,929	43,526	16,739	7
8	23	SEMINARS	PATIENT DAYS	901,761	15	380		43,526	18	8
9	25	TRANSPORTATION	PATIENT DAYS	901,761	15	6,593		43,526	318	9
10	26	INSURANCE	PATIENT DAYS	901,761	15	30,900		43,526	1,491	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	901,761	15	70,423		43,526	3,399	11
12	30	DEPRECIATION	PATIENT DAYS	901,761	15	3,617		43,526	175	12
13	35	EQUIPMENT RENT	PATIENT DAYS	901,761	15	63,848		43,526	3,082	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					\$ 836,892	\$ 518,647		\$ 40,394	25

Facility Name & ID Number CRESTWOOD TERRACE

0022863

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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 IME REALTY CORP
 Street Address 6865 N LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-1946
 Fax Number (847) 674-1962

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	RENTAL INCOME	346,361	15	\$ 9,618	\$ 9,828	\$ 273	1
2	6	REPAIR & MAINTENANCE	RENTAL INCOME	346,361	15	19,083	9,828	541	2
3	7	ALARM SERVICE	RENTAL INCOME	346,361	15	1,056	9,828	30	3
4	19	PROFESSIONAL FEES	RENTAL INCOME	346,361	15	1,575	9,828	45	4
5	21	OFFICE EXPENSE	RENTAL INCOME	346,361	15	7,666	9,828	218	5
6	26	INSURANCE	RENTAL INCOME	346,361	15	5,806	9,828	165	6
7	30	DEPRECIATION	RENTAL INCOME	346,361	15	30,446	9,828	864	7
8	32	INTEREST	RENTAL INCOME	346,361	15	50,514	9,828	1,433	8
9	33	RE TAX	RENTAL INCOME	346,361	15	47,364	9,828	1,344	9
10	35	STORAGE FEES	RENTAL INCOME	346,361	15	6,785	9,828	193	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					\$ 179,913	\$	\$ 5,106	25

Facility Name & ID Number

CRESTWOOD TERRACE

0022863

Report Period Beginning:

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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	LASALLE BANK		X	MORTGAGE	\$16,219.00	08/01/95	\$ 3,160,000	\$ 2,268,727	07/31/15		\$ 145,912	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	LASALLE BANK		X	LINE OF CREDIT							6,545	6						
7												7						
8	RELATED PARTY										1,433	8						
9	TOTAL Facility Related				\$16,219.00		\$ 3,160,000	\$ 2,268,727			\$ 153,890	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 3,160,000	\$ 2,268,727			\$ 153,890	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.

\$ **195,700** 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.)

\$ **206,243** 2

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

\$ **10,543** 3

4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **210,400** 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.

\$ **220,943** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	135,738	8
	2001	141,599	9
	2002	188,724	10
	2003	193,741	11
	2004	206,243	12

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

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

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.**

Facility Name & ID Number CRESTWOOD TERRACE

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,623 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>		<u>1976</u>	<u>\$ 100,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 100,000	3

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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	126	1976	1971	\$ 1,233,000	\$	25	\$	\$	\$ 1,233,000	4
5										5
6										6
7										7
8	IME REALTY			28,992	830		830			8
	Improvement Type**									
9	BUILDING IMPROVEMENTS		8083	24,240					24,240	9
10	BUILDING IMPROVEMENTS		1981	954					954	10
11	BUILDING IMPROVEMENTS		1985	1,000		15			1,000	11
12	BUILDING IMPROVEMENTS		1985	1,884		15			1,884	12
13	BUILDING IMPROVEMENTS		1987	6,130	195	15		(195)	6,130	13
14	BUILDING IMPROVEMENTS		1987	750	24	20	38	14	706	14
15	BUILDING IMPROVEMENTS		1988	64,717	2,054	31.5	2,054		36,591	15
16	BUILDING IMPROVEMENTS		1989	2,985	95	31.5	95		1,548	16
17	BUILDING IMPROVEMENTS		1990	10,962	348	31.5	348		5,395	17
18	BUILDING IMPROVEMENTS		1991	14,001	444	31.5	444		6,394	18
19	BUILDING IMPROVEMENTS		1992	26,640	847	31.5	847		11,417	19
20	BUILDING IMPROVEMENTS		1993	4,065	129	31.5	129		1,639	20
21	BUILDING IMPROVEMENTS		1993	5,035	129	39	129		1,629	21
22	BUILDING IMPROVEMENTS		1994	5,220	134	39	134		1,491	22
23	ROOFING		1995	550	14	39	14		151	23
24	ALUMINUM POLES		1995	5,700	146	39	146		1,539	24
25	ROOFING		1995	10,605	272	39	272		2,822	25
26	FURNANCE		1995	764	20	39	20		204	26
27	TILES		1996	9,924	254	39	254		2,439	27
28	BATHROOM IMPROVEMENTS		1997	1,378	35	39	35		290	28
29	NURSE STATIONS		1998	51,911	1,331	39	1,331		10,595	29
30	ROOFING		1999	6,500	167	39	167		1,080	30
31	DOORS, SCUPPER DRAINS		2000	4,750	173	27.5	173		937	31
32	ALARM/SECURITY SYSTEM		2000	27,728	1,008	27.5	1,008		5,499	32
33	COVE BASE/WALLPAPER		2000	9,250	825	20	462	(363)	2,343	33
34	SMOKE DETECTORS		2001	3,571	130	27.5	130		644	34
35	NEW DURO-LAST ROOF		2001	42,450	1,544	27.5	1,544		6,874	35
36	WALLPAPER, BEDBOARD		2001	10,760	391	27.5	391		1,833	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **CRESTWOOD TERRACE**

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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	VINYL FLOORING	2001	\$ 3,000	\$ 109	27.5	\$ 109	\$	\$ 495	37
38	VINYL FLOORING	2002	3,569	130	27.5	130		450	38
39	HEAT/COOL SYSTEM	2002	1,774	64	27.5	64		221	39
40	FIRE SUPPRESSION SYSTEM	2002	1,874	68	27.5	68		235	40
41	STEEL FIRE DOORS	2003	1,077	39	27.5	39		96	41
42	HEAT/COOL SYSTEM	2003	29,936	1,089	27.5	1,089		2,677	42
43	ASPHALT PAVING	2003	20,049	729	27.5	729		1,792	43
44	WOOD FLOORING	2003	30,570	1,112	27.5	1,112		2,734	44
45	SHEET METAL	2003	1,000	36	27.5	36		89	45
46	ASPHALT PAVING	2005	19,015	634	15	634		634	46
47	BUILT IN WARDROBES	2005	29,295	488	27.5	488		488	47
48	WINDOWS, DOORS,CIRCUIT PANEL	2005	63,577	1,060	27.5	1,060		1,060	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,821,152	\$ 17,097		\$ 16,553	\$ (544)	\$ 1,382,239	70

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

Facility Name & ID Number **CRESTWOOD TERRACE**

0022863

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	\$ 276,392	\$ 16,949	\$ 27,634	\$ 10,685	5-10	\$ 178,680	71
72	Current Year Purchases	14,014	2,803	701	(2,102)	10	701	72
73	Fully Depreciated Assets	383,196					383,196	73
74	RELATED PARTY		209	209				74
75	TOTALS	\$ 673,602	\$ 19,961	\$ 28,544	\$ 8,583		\$ 562,577	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,594,754	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 37,058	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 45,097	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,039	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,944,816	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 18,762 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	MAINT/ACTIVITY	03CHEV EXPRESS VAN	\$ 675.85	\$ 8,110	17
18	MAINTENANCE	03 CHEV ASTRO VAN		1,323	18
19					19
20					20
21	TOTAL		\$ 675.85	\$ 9,433	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.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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		visits							6
7	Work Related Program		hrs			N/A				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.

Facility Name & ID Number CRESTWOOD TERRACE

0022863

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(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	\$ 124,387	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	971,704		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	86,699		6
7	Other Prepaid Expenses	59,493		7
8	Accounts Receivable (owners or related parties)	780,814		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,023,097	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable	1,232,470		11
12	Long-Term Investments			12
13	Land	100,000		13
14	Buildings, at Historical Cost	1,233,000		14
15	Leasehold Improvements, at Historical Cost	559,160		15
16	Equipment, at Historical Cost	680,281		16
17	Accumulated Depreciation (book methods)	(2,032,484)		17
18	Deferred Charges	14,265		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)	\$ 1,786,692	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,809,789	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 281,605	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	83,031		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,418		31
32	Accrued Real Estate Taxes(Sch.IX-B)	210,400		32
33	Accrued Interest Payable	13,329		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)	\$ 614,783	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,268,727		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)	\$ 2,268,727	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,883,510	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 926,279	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,809,789	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 706,380	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 706,380	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	\$ 378,490	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	\$ (158,591)	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)	\$ 219,899	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)	\$ 926,279	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,735,379	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,735,379	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	78,866	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 78,866	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,814,245	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	761,821	31
32	Health Care	1,364,083	32
33	General Administration	792,728	33
	B. Capital Expense		
34	Ownership	448,138	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	68,985	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,435,755	40
41	Income before Income Taxes (line 30 minus line 40)**	378,490	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 378,490	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number CRESTWOOD TERRACE

0022863

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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	2,080	\$ 52,942	\$ 25.45	1
2	Assistant Director of Nursing				2
3	Registered Nurses	1,546	38,969	21.72	3
4	Licensed Practical Nurses	15,778	349,756	20.77	4
5	CNAs & Orderlies	57,104	521,499	8.52	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	3,226	41,592	10.64	8
9	Activity Director				9
10	Activity Assistants	11,682	107,455	8.82	10
11	Social Service Workers	5,918	76,067	12.85	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	15,587	128,723	7.81	15
16	Dishwashers				16
17	Maintenance Workers	3,698	48,061	12.80	17
18	Housekeepers	19,221	150,735	7.51	18
19	Laundry	6,095	45,075	6.87	19
20	Administrator	2,080	64,008	30.77	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	8,140	66,380	7.85	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) <u>SEE ATTACHED</u>	6,157	96,668	15.51	33
34	TOTAL (lines 1 - 33)	158,312	\$ 1,787,930 *	\$ 10.67	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	\$ 5,940	1-3	35
36	Medical Director	5,400	9-3	36
37	Medical Records Consultant	0	10-3	37
38	Nurse Consultant	1,200	10-3	38
39	Pharmacist Consultant	4,536	10-3	39
40	Physical Therapy Consultant	2,072	10a-3	40
41	Occupational Therapy Consultant	1,471	10a-3	41
42	Respiratory Therapy Consultant	0	10a-3	42
43	Speech Therapy Consultant	0	10a-3	43
44	Activity Consultant	626	11-3	44
45	Social Service Consultant	4,914	12-3	45
46	Other(specify) <u>DENTAL</u>	3,600	10-3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 29,759		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0	10-3	50
51	Licensed Practical Nurses	0	10-3	51
52	Certified Nurse Assistants/Aides	0	10-3	52
53	TOTAL (lines 50 - 52)	\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
KATHLEEN STEEL	ADMIN	0	\$ 64,008	Workers' Compensation Insurance	\$ 56,798	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	26,162	Advertising: Employee Recruitment	4,732	
				FICA Taxes	135,772	Health Care Worker Background Check	0	
				Employee Health Insurance	12,881	(Indicate # of checks performed)		
				Employee Meals	0	MARKETING/ADV/PROMO	2,567	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,900	
				EMPLOYEE BENEFITS - OTHER	300	LICENSES & PERMITS	84	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	5,532	
				PENSION/PROFIT SHARING PLANS	4,128	MGMT CO ALLOCATION	665	
						TRUST/FRANCHISE/CONTRIB/ETC	(1,900)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 64,008			Less: Public Relations Expense	(0)	
						Non-allowable advertising	(0)	
						Yellow page advertising	(2,567)	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 12,008	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount					
EMI ENTERPRISES	MANAGEMENT FEES		\$ 174,000					
PHILIP ESFORMES			5,500					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 179,500					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	0
							Seminar Expense	0
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
SEE SCHEDULE ATTACHED			33,514	TOTAL		\$	TOTAL	\$
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 33,514					

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13														
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
																	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	
1	PAINT/DECORATING	2002	\$ 6,906	3	\$ 1,151	\$ 2,302	\$ 2,302	\$ 1,151	\$	\$	\$	\$														
2	PAINT/DECORATING	2003	9,082	3		1,514	3,027	3,027	1,514																	
3	PAINT/DECORATING	2005	6,687	3				1,114	2,229	2,229	1,115															
4																										
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18																										
19																										
20	TOTALS		\$ 22,675		\$ 1,151	\$ 3,816	\$ 5,329	\$ 5,292	\$ 3,743	\$ 2,229	\$ 1,115	\$														

Facility Name & ID Number CRESTWOOD TERRACE# 0022863Report Period Beginning: 01/01/2005Ending: 12/31/2005**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE - \$4,674
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 754 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 68,985
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. **Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$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