

		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020842

Facility Name: Halsted Terrace Nursing Ctr

Address: 10935 South Halsted Street Chicago 60628
 Number City Zip Code

County: Cook

Telephone Number: (773) 928-2000 **Fax #** (773) 928-9154

HFS ID Number: 362877032001

Date of Initial License for Current Owners: 05/01/76

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Noshir R. Daruwalla, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

MAIL TO: BUREAU OF HEALTH FINANCE
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842 Report Period Beginning: 01/01/05 Ending: 12/31/05

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>300</u>	Skilled (SNF)	<u>300</u>	<u>109,500</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>300</u>	TOTALS	<u>300</u>	<u>109,500</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>41,854</u>	<u>1,647</u>	<u>5,490</u>	<u>48,991</u>	8
9	SNF/PED					9
10	ICF	<u>29,188</u>	<u>34</u>	<u>643</u>	<u>29,865</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>71,042</u>	<u>1,681</u>	<u>6,133</u>	<u>78,856</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.01%

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

None (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 5/1/76

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 300 and days of care provided 5,298

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number Halsted Terrace Nursing Ctr # 0020842 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	312,979	91,148	10,560	414,687		414,687	5,146	419,833			1
2	Food Purchase		287,049		287,049	(26,098)	260,952	(61)	260,891			2
3	Housekeeping	343,070	59,100		402,170		402,170	14,491	416,661			3
4	Laundry	90,344	32,938		123,282		123,282		123,282			4
5	Heat and Other Utilities			224,734	224,734		224,734	4,741	229,475			5
6	Maintenance	93,389	25,752	128,316	247,457		247,457	(1,520)	245,937			6
7	Other (specify):*											7
8	TOTAL General Services	839,782	495,987	363,610	1,699,379	(26,098)	1,673,282	22,797	1,696,079			8
	B. Health Care and Programs											
9	Medical Director			63,300	63,300		63,300		63,300			9
10	Nursing and Medical Records	3,763,713	168,690	116,210	4,048,613		4,048,613	(6,581)	4,042,032			10
10a	Therapy	152,443		2,809	155,252		155,252		155,252			10a
11	Activities	208,559	6,730	2,729	218,018		218,018		218,018			11
12	Social Services	133,239		3,179	136,418		136,418		136,418			12
13	CNA Training											13
14	Program Transportation			1,645	1,645		1,645		1,645			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,257,954	175,420	189,872	4,623,246		4,623,246	(6,581)	4,616,665			16
	C. General Administration											
17	Administrative	179,621		20,000	199,621		199,621	64,921	264,542			17
18	Directors Fees											18
19	Professional Services			727,977	727,977		727,977	(427,613)	300,364			19
20	Dues, Fees, Subscriptions & Promotions			207,694	207,694		207,694	(102,472)	105,222			20
21	Clerical & General Office Expenses	384,263	4,703	693,101	1,082,067		1,082,067	(475,907)	606,160			21
22	Employee Benefits & Payroll Taxes			1,037,442	1,037,442	26,098	1,063,540	(76,883)	986,657			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,742	5,742		5,742	1,974	7,716			24
25	Other Admin. Staff Transportation			1,989	1,989		1,989		1,989			25
26	Insurance-Prop.Liab.Malpractice			491,058	491,058		491,058	41,707	532,765			26
27	Other (specify):*							74,719	74,719			27
28	TOTAL General Administration	563,884	4,703	3,185,003	3,753,590	26,098	3,779,688	(899,554)	2,880,134			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,661,620	676,110	3,738,485	10,076,215		10,076,215	(883,338)	9,192,877			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Halsted Terrace Nursing Ctr #0020842 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			152,973	152,973		152,973	571,692	724,665			30
31	Amortization of Pre-Op. & Org.							214	214			31
32	Interest			232,544	232,544		232,544	361,347	593,891			32
33	Real Estate Taxes							291,518	291,518			33
34	Rent-Facility & Grounds			961,002	961,002		961,002	(958,125)	2,877			34
35	Rent-Equipment & Vehicles			60,524	60,524		60,524	(24,694)	35,830			35
36	Other (specify):*			1,647	1,647		1,647	3,038	4,685			36
37	TOTAL Ownership			1,408,690	1,408,690		1,408,690	244,990	1,653,680			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	197,339	213,580	51,126	462,045		462,045		462,045			39
40	Barber and Beauty Shops			1,040	1,040		1,040		1,040			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,250	164,250		164,250		164,250			42
43	Other (specify):*	104,859		496	105,355		105,355	(105,355)				43
44	TOTAL Special Cost Centers	302,198	213,580	216,912	732,690		732,690	(105,355)	627,335			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,963,818	889,690	5,364,087	12,217,595		12,217,595	(743,703)	11,473,892			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	348,778	30		9
10	Interest and Other Investment Income	(27,931)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(61)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(28,795)	21		18
19	Entertainment				19
20	Contributions	(15,572)	20		20
21	Owner or Key-Man Insurance	(76,883)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(398,336)	21		24
25	Fund Raising, Advertising and Promotional	(25,456)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(949)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(640,831)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (866,036)		\$	30

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)	122,333		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 122,333		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (743,703)		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

OHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line
1 Therapy Settlement	\$ (157,743)	21
2 Wage Assignment Fees	(1,234)	10
3 Veteran Pharmacy Expense	(2,499)	10
4 Bank Charges	(6,193)	21
5 Collection Fees	(150)	21
6 Franchise Tax	(561)	21
7 Public Relations	(64,443)	20
8		
9 Building Company - Accounting Fees	(8,078)	19
10 Building Company - Trust Fees	(430)	21
11 Non-Allowable Professional Fees	(24,400)	19
12 Misc. Income	961	23
13 Duty Duty Income	(172)	10
14 Non-Allowable Auto Leases	(29,330)	35
15 Non-Allowable Interest Expense	(19,299)	34
16 Auto Reimbursement	(2,675)	19
17 Capitalized R&M	(8,897)	6
18 Non-Allowable Legal Fees	(26,401)	19
19 Marketing Salaries	(168,859)	43
20 Marketing Auto Expense	(496)	43
21 Non-Allowable Expense	(131,495)	21
22 Seminar - Marketing	(113)	24
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101 Total	(640,831)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending:

12/31/05

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				5,146								5,146	1
2	Food Purchase	(61)											(61)	2
3	Housekeeping				14,491								14,491	3
4	Laundry													4
5	Heat and Other Utilities				4,741								4,741	5
6	Maintenance	(8,897)			7,377								(1,520)	6
7	Other (specify):*													7
8	TOTAL General Services	(8,958)			31,755								22,797	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(6,581)											(6,581)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(6,581)											(6,581)	16
	C. General Administration													
17	Administrative			18,849		1,489	44,583						64,921	17
18	Directors Fees													18
19	Professional Services	(58,879)	8,078	(22,174)	(356,543)	91	1,814						(427,613)	19
20	Fees, Subscriptions & Promotions	(105,471)		254	2,745								(102,472)	20
21	Clerical & General Office Expenses	(724,713)	430	1,746	246,455	175							(475,907)	21
22	Employee Benefits & Payroll Taxes	(76,883)											(76,883)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(113)		171	1,916								1,974	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice		40,537		1,170								41,707	26
27	Other (specify):*			3,815	67,388	165	3,351						74,719	27
28	TOTAL General Administration	(966,059)	49,045	2,661	(36,869)	1,920	49,748						(899,554)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(981,598)	49,045	2,661	(5,114)	1,920	49,748						(883,338)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05 Ending:

12/31/05

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	348,778	207,762		15,152								571,692	30
31	Amortization of Pre-Op. & Org.				214								214	31
32	Interest	(98,523)	433,398		26,472								361,347	32
33	Real Estate Taxes		280,423		11,095								291,518	33
34	Rent-Facility & Grounds		(958,125)										(958,125)	34
35	Rent-Equipment & Vehicles	(29,338)			4,644								(24,694)	35
36	Other (specify):*		3,038										3,038	36
37	TOTAL Ownership	220,917	(33,504)		57,577								244,990	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													42
43	Other (specify):*	(105,355)											(105,355)	43
44	TOTAL Special Cost Centers	(105,355)											(105,355)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(866,036)	15,541	2,661	52,463	1,920	49,748						(743,703)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Halsted Assoc. Limited Partnership		Building Company

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	34 Rent	\$ 958,125	Halsted Associates Limited Partnership	100.00%	\$	\$ (958,125)	1
2	V	32 Interest	4,638	Halsted Associates Limited Partnership	100.00%	438,036	433,398	2
3	V	26 Insurance		Halsted Associates Limited Partnership	100.00%	40,537	40,537	3
4	V	19 Accounting		Halsted Associates Limited Partnership	100.00%	8,078	8,078	4
5	V	21 Trust Fees		Halsted Associates Limited Partnership	100.00%	430	430	5
6	V	33 Real Estate Taxes		Halsted Associates Limited Partnership	100.00%	280,423	280,423	6
7	V	30 Depreciation		Halsted Associates Limited Partnership	100.00%	207,762	207,762	7
8	V	36 Amortization of Loan Costs		Halsted Associates Limited Partnership	100.00%	3,038	3,038	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 962,763			\$ 978,304	\$ * 15,541	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr # 0020842 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 18,849	\$ 18,849	15
16	V	19 PROFESSIONAL FEES				538	538	16
17	V	20 FEES, SUBSCRIPTIONS				254	254	17
18	V	21 CLERICAL AND GENERAL				1,746	1,746	18
19	V	24 SEMINARS				171	171	19
20	V	27 GEN ADMIN.- EMP. BEN.				3,815	3,815	20
21	V							21
22	V							22
23	V							23
24	V							24
25	V	19 BOOKKEEPING FEES	22,712				(22,712)	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 22,712			\$ 25,373	\$ * 2,661	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr # 0020842 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	1 DIETARY	\$	ITEX / AK CARE COMPANY	100.00%	\$ 5,146	\$ 5,146	15
16	V	3 HOUSEKEEPING				14,491	14,491	16
17	V	5 UTILITIES				4,741	4,741	17
18	V	6 REPAIRS AND MAINT.				7,377	7,377	18
19	V	19 PROFESSIONAL FEES				8,893	8,893	19
20	V	20 FEES, SUBSCRIPTIONS				2,745	2,745	20
21	V	21 CLERICAL AND GENERAL				29,519	29,519	21
22	V	24 EDUCATION/SEMINARS				1,916	1,916	22
23	V	26 INSURANCE				1,170	1,170	23
24	V	27 EMPLOYEE BENEFITS				2,266	2,266	24
25	V	30 DEPRECIATION				15,152	15,152	25
26	V	31 AMORTIZATION				214	214	26
27	V	32 INTEREST				26,472	26,472	27
28	V	33 REAL ESTATE TAXES				11,095	11,095	28
29	V	35 EQUIPMENT RENTAL				4,644	4,644	29
30	V							30
31	V							31
32	V	21 CLERICAL SALARIES				216,936	216,936	32
33	V	27 GEN ADMIN. - EMP. BEN.				65,122	65,122	33
34	V							34
35	V	19 BOOKKEEPING FEES	365,436				(365,436)	35
36	V							36
37	V							37
38	V							38
39	Total		\$ 365,436			\$ 417,899	\$ * 52,463	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	J. RAJCHENBACH-COMP.	\$	JLR MANAGEMENT CORP.	100.00%	\$ 1,489	\$ 1,489	15
16	V	19	PROFESSIONAL FEES				91	91	16
17	V	21	OFFICE				175	175	17
18	V	27	PAYROLL TAXES				165	165	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 1,920	\$ * 1,920	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	BERNIE HOLLANDER-SAL.	\$	SHAYMARK MANAGEMENT CORP.	100.00%	\$ 64,583	\$ 64,583	15
16	V	19	PROFESSIONAL FEES				1,814	1,814	16
17	V	27	PAYROLL TAXES				3,351	3,351	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V	17	MANAGEMENT FEES	20,000				(20,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 20,000			\$ 69,748	\$ * 49,748	39

* 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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* 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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr # 0020842 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	Bernard Hollander	President	Management	83.33%	see attached	20.00	30.77%	Shaymark	\$ 64,583	17-7	1
2	Jack Rajchenbach	Vice President	Management	10.00%	see attached	1.00	1.54%	JLR alloc	1,489	17-7	2
3	Mark Hollander	Relative	Executive	0.00%	see attached	20.00	33.33%	Salary	49,000	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 115,072		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending: 12/31/05

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

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

Name of Related Organization CAREPATH HEALTH NETWORK
 Street Address 6633 N LINCOLN AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (888) 707-6700
 Fax Number (847) 679-2150

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	17	ADMINISTRATIVE	CARE PATH FEES	305,641	9	\$ 253,650	\$ 22,712	\$ 18,849	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	305,641	9	7,234	22,712	538	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	305,641	9	3,415	22,712	254	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	305,641	9	23,496	22,712	1,746	4
5	24	SEMINARS	CARE PATH FEES	305,641	9	2,300	22,712	171	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	305,641	9	51,334	22,712	3,815	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					\$ 341,429	\$ 253,650	\$ 25,373	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending: 12/31/05

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 ITEX / AK CARE COMPANY
 Street Address 6633 N. LINCOLN AVE.
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 679-9141
 Fax Number (847) 679-1820

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	1	DIETARY	AVAILABLE BED DAYS	464,645	5	\$ 21,836	\$ 109,500	\$ 5,146	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	464,645	5	61,490	109,500	14,491	2
3	5	UTILITIES	AVAILABLE BED DAYS	464,645	5	20,118	109,500	4,741	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	464,645	5	31,302	109,500	7,377	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	464,645	5	37,736	109,500	8,893	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	464,645	5	11,649	109,500	2,745	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	464,645	5	125,259	109,500	29,519	7
8	24	EDUCATION/SEMINARS	AVAILABLE BED DAYS	464,645	5	8,131	109,500	1,916	8
9	26	INSURANCE	AVAILABLE BED DAYS	464,645	5	4,965	109,500	1,170	9
10	27	EMPLOYEE BENEFITS	AVAILABLE BED DAYS	464,645	5	9,614	109,500	2,266	10
11	30	DEPRECIATION	AVAILABLE BED DAYS	464,645	5	64,296	109,500	15,152	11
12	31	AMORTIZATION	AVAILABLE BED DAYS	464,645	5	908	109,500	214	12
13	32	INTEREST	AVAILABLE BED DAYS	464,645	5	112,329	109,500	26,472	13
14	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	464,645	5	47,080	109,500	11,095	14
15	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	464,645	5	19,705	109,500	4,644	15
16									16
17									17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		6	689,164	689,164	216,936	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		6	206,879		65,122	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,472,461	\$ 689,164	\$ 417,899	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning: 01/01/05

Ending: 12/31/05

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

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

Name of Related Organization JLR MANAGEMENT CORP.
 Street Address 6633 NORTH LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 679-9141
 Fax Number (847) 679-1820

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	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	55	10	\$ 81,900	\$ 81,900	1	\$ 1,489	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	55	10	5,000		1	91	2
3	21	OFFICE	AVG. HOURS WORKED	55	10	9,614	9,614	1	175	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED	55	10	9,055		1	165	4
5										5
6										6
7	17	MARVIN NEEDLE-CONS. FEES	AVG. HOURS WORKED	40	1	36,296				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					\$ 141,865	\$ 91,514		\$ 1,920	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning: 01/01/05

Ending: 12/31/05

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

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

Name of Related Organization SHAYMARK MANAGEMENT CORP.
 Street Address 6633 NORTH LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 679-9141
 Fax Number (847) 679-1820

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	17	BERNIE HOLLANDER-SAL.	AVG. HOURS WORKED	48	5	\$ 155,000	\$ 155,000	20	\$ 64,583	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	48	5	4,353		20	1,814	2
3	27	PAYROLL TAXES	AVG. HOURS WORKED	48	5	8,043		20	3,351	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	TOTALS					\$ 167,396	\$ 155,000		\$ 69,748	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending: 12/31/05

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending: 12/31/05

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending: 12/31/05

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending: 12/31/05

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending: 12/31/05

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr # 0020842 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	Cambridge		X	Mortgage	\$43,906.00	07/01/03	\$ 8,276,700	\$ 8,070,848	7/1/38	5.4000	\$ 438,036	1
2	Hill Rom / TCF Leasing		X	Video Equipment				5,200			412	2
3	ABB Business Finance		X	Paging System				3,152			645	3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Bank Leumi		X	Line of Credit				1,800,000			148,820	6
7	A.I. Credit		X	Insurance Financing							12,076	7
8	See Supplemental Schedule							1,630,241			26,472	8
9	TOTAL Facility Related				\$43,906.00		\$ 8,276,700	\$ 11,509,441			\$ 626,461	9
	B. Non-Facility Related*											
10	Interest Income										(27,931)	10
11	Interest Income (Bldg Co)										(4,638)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			(32,569)	14
15	TOTALS (line 9+line14)						\$ 8,276,700	\$ 11,509,441			\$ 593,892	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 Halsted Terrace Nursing Ctr # 0020842 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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							\$	\$			\$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											
	Working Capital											
8	Due to Owners	X		Working Capital			\$	\$ 1,630,241			\$	8
9	Allocated from ITEX		X								26,472	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											
								1,630,241			26,472	14
	B. Non-Facility Related*											
15							\$	\$			\$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											

* 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2004 report.		\$ 281,682	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.)		\$ 285,292	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 3,610	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 287,907	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.		\$ 291,517	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	256,659	8
	2001	263,375	9
	2002	266,212	10
	2003	268,268	11
	2004	274,197	12
<u>2005 Accrual = 2004 Tax \$274,197 x 1.05 = \$287,907</u>			
<u>Allocated RE Tax from ITEX \$11,095</u>			
	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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 Halsted Terrace Nursing Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0020842

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

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. <u>25-16-316-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>27,296.46</u>	\$ <u>27,296.46</u>
2. <u>25-16-316-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>26,211.78</u>	\$ <u>26,211.78</u>
3. <u>25-16-332-012-0000</u>	<u>Long Term Care Property</u>	\$ <u>89,409.38</u>	\$ <u>89,409.38</u>
4. <u>25-16-332-013-0000</u>	<u>Long Term Care Property</u>	\$ <u>131,279.69</u>	\$ <u>131,279.69</u>
5. <u>10-35-312-022-0000</u>	<u>Home Office Allocation</u>	\$ <u>47,110.51</u>	\$ <u>11,102.24</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>321,307.82</u>	\$ <u>285,299.55</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X 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.

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 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 Halsted Terrace Nursing Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0020842

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842 Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,068 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

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).

None

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: 214 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>855,000</u>	1
2					2
3	TOTALS			\$ 855,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various			1978	750		20			750	9
10	Various			1979	12,807		20			12,749	10
11	Various			1980	35,915		20			35,915	11
12	Various			1981	13,910		20			13,910	12
13	Various			1982	8,814		20			8,814	13
14	Various			1983	12,936		20			12,936	14
15	Various			1984	20,560		20			20,560	15
16	Various			1985	18,883		20			18,874	16
17	Various			1986	2,456		20	114	114	2,456	17
18	Various			1987	4,000		20	127	127	2,336	18
19	Various			1988	82,596		20	2,621	2,621	45,142	19
20	Various			1989	1,225		20	39	39	639	20
21	Various			1990	91,597		20	3,783	3,783	52,592	21
22	Various			1993	53,620		20	2,681	2,681	36,561	22
23	Various			1995	137,959		20	6,981	6,981	73,114	23
24	Various			1996	538,107		20	26,907	26,907	270,788	24
25	Various			1997	76,548		20	3,910	3,910	33,534	25
26	Various			1998	77,488		20	3,875	3,875	29,113	26
27	Various			1999	278,572		20	13,997	13,997	94,992	27
28	Various			2000	48,393		20	2,248	2,248	12,784	28
29	Various			2001	97,460		20	4,936	4,936	21,263	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending:

12/31/05

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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		8,125,379	207,762		406,751	198,989	4,828,957	67
68		467,462	11,867		15,227	3,360	186,419	68
69			45,000			(45,000)		69
70		\$ 10,207,437	\$ 264,629		\$ 494,197	\$ 229,568	\$ 5,815,198	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 10,207,437	\$ 264,629		\$ 494,197	\$ 229,568	\$ 5,815,198	1
2	Carpeting	2002	4,550		20	650	650	2,167	2
3	Border Patient'S Room	2002	1,173		20			1,173	3
4	Paint	2002	713		20	71	71	267	4
5	Sink	2002	642		20	64	64	214	5
6	Paint	2002	532		20	53	53	173	6
7	Copper Drain	2002	1,400		20	140	140	560	7
8	Roof Repair	2002	974		20	97	97	357	8
9	Cable Connectors/Outlets (Electric)	2002	1,100		20	110	110	376	9
10	Cable Connectors/Outlets (Electric)	2002	990		20	99	99	330	10
11	Fixtures	2002	705		20	71	71	217	11
12	Expansion Coupler	2002	1,405		20	141	141	562	12
13	Electrical & Fixtures	2002	590		20	59	59	236	13
14	Cable & Lines	2002	528		20	53	53	198	14
15	Chiller	2002	2,932		20	293	293	1,051	15
16	Chiller	2002	1,697		20	170	170	594	16
17	Flow Switches	2002	1,185		20	119	119	405	17
18	Carrier Unit	2002	759		20	76	76	253	18
19	Electrical Lines	2002	585		20	59	59	195	19
20	Air Conditioner Repair	2002	1,731		20	173	173	563	20
21	Boiler & Pump	2002	1,089		20	109	109	345	21
22	Wallcoverings	2003	5,601		20			5,601	22
23	Window Treatmens	2003	451		20	23	23	68	23
24	Flooring	2003	14,743		20	1,474	1,474	4,423	24
25	Flooring	2003	2,488		20	249	249	746	25
26	Flooring	2003	14,743		20	1,474	1,474	4,423	26
27	Flooring	2003	2,488		20	249	249	746	27
28	Light Fixtures	2003	3,685		20	184	184	537	28
29	Window Treatments	2003	5,305		20	265	265	774	29
30	Carpeting	2003	3,146		20	157	157	459	30
31	Flooring	2003	21,810		20	2,181	2,181	6,361	31
32	Flooring	2003	4,550		20	455	455	1,327	32
33	Draperly And Rods	2003	5,882		20	294	294	833	33
34	TOTAL (lines 1 thru 33)		\$ 10,317,609	\$ 264,629		\$ 503,809	\$ 239,180	\$ 5,851,732	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 10,317,609	\$ 264,629		\$ 503,809	\$ 239,180	\$ 5,851,732	1
2	Cleanout Covers	2003	1,700		20	170	170	468	2
3	Carpeting	2003	15,447		20	772	772	2,060	3
4	Insulation	2003	1,208		20	121	121	322	4
5	Insulation	2003	7,422		20	742	742	1,979	5
6	Roof Compressor	2003	14,394		20	720	720	1,859	6
7	Water Pump	2003	1,626		20	81	81	210	7
8	Compressor	2003	2,637		20	132	132	330	8
9	Carpeting	2003	2,663		20	133	133	333	9
10	Wallcovering	2003	21,003		20	1,050	1,050	2,538	10
11	Roof Repairs	2003	6,044		20	604	604	1,511	11
12	Flooring	2003	7,564		20	756	756	1,828	12
13	Flooring	2003	5,600		20	373	373	902	13
14	Flooring	2003	66,858		20	4,457	4,457	10,771	14
15	Light Fixtures	2003	780		20	39	39	94	15
16	Computer Cabeling	2003	1,669		20	334	334	807	16
17	Flooring	2003	6,113		20	611	611	1,375	17
18	Water Heater Repairs	2003	2,004		20	100	100	225	18
19	Light Fixtures	2003	1,300		20	65	65	146	19
20	Flooring	2003	553		20	55	55	124	20
21	Flooring	2003	8,559		20	856	856	1,926	21
22	Flooring	2003	24,530		20	2,453	2,453	5,519	22
23	Light Fixtures	2003	520		20	26	26	56	23
24	Flooring	2003	7,564		20	756	756	1,576	24
25	Flooring	2003	5,600		20	560	560	1,167	25
26	Flooring	2003	66,858		20	6,686	6,686	13,929	26
27	Flooring	2003	8,559		20	856	856	1,783	27
28	Flooring	2003	553		20	55	55	115	28
29	Flooring	2003	6,113		20	611	611	1,273	29
30	Flooring	2003	7,780		20	778	778	1,621	30
31	Flooring	2003	41,155		20	4,116	4,116	8,574	31
32	Room Renovation	2003	10,670		20	1,067	1,067	2,223	32
33	Light Fixtures	2003	2,795		20	140	140	291	33
34	TOTAL (lines 1 thru 33)		\$ 10,675,450	\$ 264,629		\$ 534,084	\$ 269,455	\$ 5,919,667	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,675,450	\$ 264,629		\$ 534,084	\$ 269,455	\$ 5,919,667	1
2	Dialysis Room Plumbing	2003	12,984		20	1,298	1,298	2,705	2
3	Hood Duct	2003	595		20	60	60	174	3
4	Nurse Call Unit	2003	515		20	103	103	300	4
5	Sprinkler System Drain	2003	516		20	52	52	142	5
6	Valves	2003	1,211		20	121	121	313	6
7	Gas Saftey Valve	2003	542		20	54	54	136	7
8	Connector & Insulation	2003	500		20	50	50	129	8
9	Plate Assembly	2003	741		20	74	74	179	9
10	Air Conditioner Motor	2003	1,351		20	135	135	281	10
11	Wiring	2004	1,194		20	119	119	239	11
12	Electric Installation	2004	6,090		20	609	609	1,218	12
13	Cables And Wiring	2004	2,100		20	210	210	298	13
14	Air Conditioning	2004	3,806		20	381	381	476	14
15	Air Conditioners	2004	4,046		20	809	809	1,281	15
16	Pipes And Electrical	2004	4,950		20	990	990	1,320	16
17	Room Fixtures And Outlets	2004	1,165		20	233	233	466	17
18	Flooring	2004	9,400		20	1,880	1,880	3,760	18
19	Painting And Kitchen Installation	2004	2,425		20	485	485	970	19
20	Wall Covering	2004	7,763		20	1,553	1,553	2,847	20
21	Bathroom Sewer Line Repair	2004	4,800		20	480	480	820	21
22	Paint	2004	990		20	99	99	198	22
23	Water Valve And Circulating Pump	2004	1,282		20	128	128	182	23
24	Hvac	2004	986		20	99	99	148	24
25	Roof Repair	2004	1,820		20	182	182	288	25
26	Roof Repair	2004	2,252		20	225	225	375	26
27	Wallpaper	2004	950		20	95	95	166	27
28	Heater Pump	2004	653		20	65	65	120	28
29	Sprinkler Heads	2004	938		20	94	94	188	29
30	Insulation	2004	2,198		20	220	220	256	30
31	Roof Repair	2004	817		20	82	82	89	31
32	Walk-In Cooler Repair	2004	945		20	95	95	102	32
33	Paint	2004	576		20	58	58	62	33
34	TOTAL (lines 1 thru 33)		\$ 10,756,551	\$ 264,629		\$ 545,222	\$ 280,593	\$ 5,939,895	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 10,756,551	\$ 264,629		\$ 545,222	\$ 280,593	\$ 5,939,895	1
2	Plastered Walls	2005	7,100		20	2,367	2,367	2,367	2
3	Plastered Walls	2005	12,700		20	2,117	2,117	2,117	3
4	Sign	2005	5,615		20	281	281	281	4
5	Signs	2005	13,217		20	441	441	441	5
6	Wallpaper	2005	3,288		20	438	438	438	6
7	Wallpaper	2005	8,984		20	599	599	599	7
8	Window Treatments	2005	10,661		20	533	533	533	8
9	Wallcovering	2005	337		20	22	22	22	9
10	Blinds	2005	373		20	6	6	6	10
11	Floor Covering	2005	48,040		20	1,068	1,068	1,068	11
12	Doors	2005	3,245		20	270	270	270	12
13	Doors	2005	5,550		20	463	463	463	13
14	Exhaust Fan	2005	7,912		20	791	791	791	14
15	Closets	2005	6,300		20	158	158	158	15
16	Phone System	2005	7,130		20	654	654	654	16
17	Phone System	2005	4,170		20	174	174	174	17
18	Security System	2005	5,738		20	273	273	273	18
19	Boiler	2005	2,489		20	69	69	69	19
20	Walk- In Cooler	2005	3,585		20	299	299	299	20
21	Walk-In Cooler	2005	4,963		20	414	414	414	21
22	Electrical Work	2005	6,800		20	170	170	170	22
23	Water Heater	2005	6,377		20	531	531	531	23
24	Roofing	2005	3,000		20	25	25	25	24
25	Flooring Adjustment	2005	(95,245)		20	(6,350)	(6,350)	(6,350)	25
26	Door	2005	1,544		20	19	19	19	26
27	Fixture Installation	2005	1,514		20	13	13	13	27
28	Roof Top Unit Repair	2005	3,479		20	15	15	15	28
29	Chiller Fan Repair	2005	2,359		20	20	20	20	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,847,776	\$ 264,629		\$ 551,102	\$ 286,473	\$ 5,945,775	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 10,847,776	\$ 264,629		\$ 551,102	\$ 286,473	\$ 5,945,775		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
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16									16
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,847,776	\$ 264,629		\$ 551,102	\$ 286,473	\$ 5,945,775		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 10,847,776	\$ 264,629		\$ 551,102	\$ 286,473	\$ 5,945,775		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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,847,776	\$ 264,629		\$ 551,102	\$ 286,473	\$ 5,945,775		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 10,847,776	\$ 264,629		\$ 551,102	\$ 286,473	\$ 5,945,775		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
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18									18
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,847,776	\$ 264,629		\$ 551,102	\$ 286,473	\$ 5,945,775		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12H, Carried Forward	\$ 10,847,776	\$ 264,629		\$ 551,102	\$ 286,473	\$ 5,945,775		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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,847,776	\$ 264,629		\$ 551,102	\$ 286,473	\$ 5,945,775		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12I, Carried Forward	\$ 10,847,776	\$ 264,629		\$ 551,102	\$ 286,473	\$ 5,945,775		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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,847,776	\$ 264,629		\$ 551,102	\$ 286,473	\$ 5,945,775		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	
1		\$ 10,847,776	\$ 264,629		\$ 551,102	\$ 286,473	\$ 5,945,775	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	TOTAL (lines 1 thru 33)	\$ 10,847,776	\$ 264,629		\$ 551,102	\$ 286,473	\$ 5,945,775	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	300		1994	1976	\$ 7,334,294	\$ 188,059		\$ 366,715	\$ 178,656	\$ 4,370,020	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Halsted Associates		1994		791,085	19,703		40,036	20,333	458,937	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
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending:

12/31/05

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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 8,125,379	\$ 207,762		\$ 406,751	\$ 198,989	\$ 4,828,957	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending:

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XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocation from ITEX		1993	1993	\$ 378,017	\$ 9,693	35	\$ 10,800	\$ 1,107	\$ 135,905	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Allocation from ITEX		1993	1993	47,565	575	20	2,378	1,803	30,219	9
10	Allocation from ITEX		1994	1994	25,548	665	20	1,277	612	14,411	10
11	Allocation from ITEX		1995	1995	4,354	11	20	218	207	2,220	11
12	Allocation from ITEX		1996	1996	246		20	12	(12)	124	12
13	Allocation from ITEX		1997	1997	7,345	188	20	367	179	3,121	13
14	Allocation from ITEX		1999	1999	816	21	20	41	20	285	14
15	Allocation from ITEX		2005	2005	3,571	714	20	134	(580)	134	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/05

Ending:

12/31/05

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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 467,462	\$ 11,867		\$ 15,227	\$ 3,336	\$ 186,419	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr # 0020842 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	\$ 1,120,718	\$ 74,887	\$ 135,937	\$ 61,050	10	\$ 756,245	71
72	Current Year Purchases	115,648	36,372	37,627	1,255	10	37,627	72
73	Fully Depreciated Assets	1,568,169				10	1,568,169	73
74								74
75	TOTALS	\$ 2,804,535	\$ 111,259	\$ 173,564	\$ 62,305		\$ 2,362,041	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)	\$ 14,507,311	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 375,888	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 724,666	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 348,778	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,307,816	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	Storage				2,877			6
7	TOTAL				\$ 2,877			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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: \$ 28,913 Description: See Attached Schedule

(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	Facility	2003 Ford Explorer	\$ 576.39	\$ 6,917	17
18					18
19					19
20					20
21	TOTAL		\$ 576.39	\$ 6,917	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 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>
--	---	--

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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 73,384		\$			\$ 73,384	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	123,955					123,955	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				162,749		162,749	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>					51,126	50,831		101,957	13
14	TOTAL			\$ 197,339		\$ 51,126	\$ 213,580		\$ 462,045	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr # 0020842 Report Period Beginning: 01/01/05 Ending: 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 44,566	\$ 164,527	1
2	Cash-Patient Deposits	90,150	90,150	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	990,303	990,303	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	253,343	273,491	6
7	Other Prepaid Expenses	57,940	57,940	7
8	Accounts Receivable (owners or related parties)	(589,375)	(589,375)	8
9	Other(specify): <u>See Attached Schedule</u>	43,507	440,095	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 890,434	\$ 1,427,131	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		855,000	13
14	Buildings, at Historical Cost		7,998,898	14
15	Leasehold Improvements, at Historical Cost	1,698,021	1,742,391	15
16	Equipment, at Historical Cost	2,313,252	3,209,420	16
17	Accumulated Depreciation (book methods)	(2,512,971)	(5,872,830)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	1,830	108,160	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,830)	(9,425)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	695,501	695,501	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,193,803	\$ 8,727,115	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,084,237	\$ 10,154,246	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,074,619	\$ 1,074,618	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	105,976	105,976	28
29	Short-Term Notes Payable	3,437,641	3,530,979	29
30	Accrued Salaries Payable	441,575	441,575	30
31	Accrued Taxes Payable (excluding real estate taxes)	57,849	57,849	31
32	Accrued Real Estate Taxes(Sch.IX-B)		287,907	32
33	Accrued Interest Payable	12,119	48,438	33
34	Deferred Compensation	10,000	10,000	34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>		21,379	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,139,779	\$ 5,578,721	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	952	952	39
40	Mortgage Payable		7,977,510	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 952	\$ 7,978,462	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,140,731	\$ 13,557,183	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,056,494)	\$ (3,402,937)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,084,237	\$ 10,154,246	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (512,477)	1
2	Restatements (describe):		2
3	Depreciation	304,062	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (208,415)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,848,079)	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)	\$ (1,848,079)	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)	\$ (2,056,494)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr# 0020842Report Period Beginning: 01/01/05Ending: 12/31/05**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	\$ 9,154,427	1
2	Discounts and Allowances for all Levels	64,372	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,218,799	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	778,623	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 778,623	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	959	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	257,887	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	81,174	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 340,020	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	27,931	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 27,931	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	4,143	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,143	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,369,516	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,699,379	31
32	Health Care	4,623,246	32
33	General Administration	3,753,590	33
B. Capital Expense			
34	Ownership	1,408,690	34
C. Ancillary Expense			
35	Special Cost Centers	568,440	35
36	Provider Participation Fee	164,250	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,217,595	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,848,079)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,848,079)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? not complete 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning: 01/01/05

Ending:

12/31/05

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	1,142	1,231	\$ 47,904	\$ 38.91	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,148	19,637	547,487	27.88	3
4	Licensed Practical Nurses	75,078	81,429	1,744,882	21.43	4
5	CNAs & Orderlies	136,740	147,731	1,385,575	9.38	5
6	CNA Trainees					6
7	Licensed Therapist	6,898	7,391	197,339	26.70	7
8	Rehab/Therapy Aides	10,508	12,718	152,443	11.99	8
9	Activity Director	1,204	1,246	17,842	14.32	9
10	Activity Assistants	18,458	20,235	190,717	9.43	10
11	Social Service Workers	7,269	7,928	133,239	16.81	11
12	Dietician					12
13	Food Service Supervisor	1,880	2,140	29,220	13.65	13
14	Head Cook	60	60	435	7.25	14
15	Cook Helpers/Assistants	32,990	34,871	283,324	8.12	15
16	Dishwashers					16
17	Maintenance Workers	6,065	6,533	93,389	14.29	17
18	Housekeepers	35,544	38,679	343,070	8.87	18
19	Laundry	10,572	11,178	90,344	8.08	19
20	Administrator	1,294	1,436	49,723	34.63	20
21	Assistant Administrator	2,080	2,080	47,015	22.60	21
22	Other Administrative	3,069	3,202	82,883	25.88	22
23	Office Manager					23
24	Clerical	17,997	19,858	384,263	19.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,933	2,086	33,642	16.13	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,048	3,161	109,082	34.51	33
34	TOTAL (lines 1 - 33)	391,977	424,830	\$ 5,963,818 *	\$ 14.04	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	monthly	\$ 10,560	01-03	35
36	Medical Director	monthly	63,300	09-03	36
37	Medical Records Consultant	monthly	4,224	10-03	37
38	Nurse Consultant	Fee	95,275	10-03	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	61	2,809	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	monthly	2,729	11-03	44
45	Social Service Consultant	57	3,179	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	118	\$ 182,076		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	446	16,711	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	446	\$ 16,711		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

Report Period Beginning: 01/01/05 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

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. ICLTC \$16,055
- (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 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 47,153 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 164,250
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. \$ 26,098 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
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? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT