

		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:** 0041343

**Facility Name:** Oakwood Terrace

**Address:** 1300 Oak Avenue Evanston 60201  
 Number City Zip Code

**County:** Cook

**Telephone Number:** (847) 869-1300 **Fax #** (847) 869-1378

**HFS ID Number:** 364041095001

**Date of Initial License for Current Owners:** 01/01/96

**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
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg &amp; 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 Oakwood Terrace# 0041343 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>57</u>	Skilled (SNF)	<u>57</u>	<u>20,805</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>57</u>	TOTALS	<u>57</u>	<u>20,805</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>896</u>	<u>151</u>	<u>1,815</u>	<u>2,862</u>	8
9	SNF/PED					9
10	ICF	<u>11,050</u>	<u>2,011</u>	<u>553</u>	<u>13,614</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,946</u>	<u>2,162</u>	<u>2,368</u>	<u>16,476</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.19%

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

6 (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)

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

G. Do pages 3 &amp; 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 01/01/96

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

YES  Date 010196 NO 

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

YES  NO  If YES, enter number of beds certified 57 and days of care provided 1,815Medicare Intermediary AdminaStar Federal - Kentucky

## 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakwood Terrace # 0041343 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
	<b>A. General Services</b>										
1	Dietary	113,992	18,911	7,817	140,720		140,720	(1,514)	139,206		1
2	Food Purchase		98,659		98,659	(4,803)	93,856	(128)	93,728		2
3	Housekeeping	39,298	6,555		45,853		45,853	(184)	45,669		3
4	Laundry	16,777	10,295		27,072		27,072		27,072		4
5	Heat and Other Utilities			57,795	57,795		57,795	(1,969)	55,826		5
6	Maintenance	30,193	6,726	51,150	88,069		88,069	(3,004)	85,065		6
7	Other (specify):*							3,407	3,407		7
8	<b>TOTAL General Services</b>	<b>200,260</b>	<b>141,146</b>	<b>116,762</b>	<b>458,168</b>	<b>(4,803)</b>	<b>453,365</b>	<b>(3,392)</b>	<b>449,973</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,500	2,500		2,500		2,500		9
10	Nursing and Medical Records	738,800	67,841	28,889	835,530		835,530	(14,494)	821,036		10
10a	Therapy	10,478		2,080	12,558		12,558		12,558		10a
11	Activities	23,690	3,288	2,301	29,279		29,279		29,279		11
12	Social Services	27,470		4,370	31,840		31,840		31,840		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							1,058	1,058		15
16	<b>TOTAL Health Care and Programs</b>	<b>800,438</b>	<b>71,129</b>	<b>40,140</b>	<b>911,707</b>		<b>911,707</b>	<b>(13,436)</b>	<b>898,271</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	60,761			60,761		60,761	19,796	80,557		17
18	Directors Fees										18
19	Professional Services			46,958	46,958	(273)	46,685	(24,746)	21,939		19
20	Dues, Fees, Subscriptions & Promotions			34,991	34,991		34,991	(16,720)	18,271		20
21	Clerical & General Office Expenses	18,043	28,434	50,017	96,494		96,494	(21,300)	75,194		21
22	Employee Benefits & Payroll Taxes			166,259	166,259	4,803	171,062		171,062		22
23	Inservice Training & Education										23
24	Travel and Seminar			536	536		536	91	627		24
25	Other Admin. Staff Transportation			685	685		685	752	1,437		25
26	Insurance-Prop.Liab.Malpractice			60,956	60,956		60,956	233	61,189		26
27	Other (specify):*							6,125	6,125		27
28	<b>TOTAL General Administration</b>	<b>78,804</b>	<b>28,434</b>	<b>360,402</b>	<b>467,640</b>	<b>4,531</b>	<b>472,171</b>	<b>(35,769)</b>	<b>436,402</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,079,502</b>	<b>240,709</b>	<b>517,304</b>	<b>1,837,515</b>	<b>(273)</b>	<b>1,837,242</b>	<b>(52,596)</b>	<b>1,784,646</b>		<b>29</b>

\*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 Oakwood Terrace #0041343 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	
	<b>D. Ownership</b>											
30	Depreciation			29,882	29,882		29,882	66,585	96,467			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			167,576	167,576		167,576	139,843	307,419			32
33	Real Estate Taxes			102,929	102,929	273	103,202	1,751	104,953			33
34	Rent-Facility & Grounds			194,000	194,000		194,000	(194,000)				34
35	Rent-Equipment & Vehicles			1,360	1,360		1,360	1,157	2,517			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			495,747	495,747	273	496,020	15,336	511,356			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,004	78,235	128,239		128,239		128,239			39
40	Barber and Beauty Shops			4,018	4,018		4,018	(3,696)	322			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,208	31,208		31,208		31,208			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		50,004	113,461	163,465		163,465	(3,696)	159,769			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,079,502	290,713	1,126,512	2,496,727	(0)	2,496,727	(40,956)	2,455,771			45

**THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT**

\*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 Oakwood Terrace

# 0041343

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	(2,604)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,900)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(128)	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				18
19	Entertainment				19
20	Contributions	(177)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(41,111)	21		24
25	Fund Raising, Advertising and Promotional	(3,081)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(13,509)	20		28
29	Other-Attach Schedule	(31,367)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (96,877)		\$	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)	55,921		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 55,921		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (40,956)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

OHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Oakwood Terrace  
 ID# 0041343  
 Report Period Beginning: 01/01/05  
 Ending: 12/31/05

	Amount	Sch. V Line
<b>NON-ALLOWABLE EXPENSES</b>		
1 Barber & Beauty Income	\$ (3,696)	40
2 Divorce Income	(3,459)	19
3 Supplemental Income	(300)	01
4 Travel Fees	(305)	21
5 Non-Allowable Legal	470	19
6 Members Loan	(5,357)	32
7 Filing Fees (Bldg. Company)	(250)	21
8 Print Period Nursing Supplies	(11,457)	10
9 Collection Fees	(983)	21
10 Loan Fees (Bldg.Co)	(5,199)	19
11		11
12		12
13		13
14		14
15		15
16		16
17		17
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19		19
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92		92
93		93
94		94
95		95
96		96
97		97
98		98
99		99
100		100
101 Total	(31,367)	101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Oakwood Terrace

# 0041343

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)	
	<b>A. General Services</b>													
1	Dietary	(300)				1,707	(2,921)						(1,514)	1
2	Food Purchase	(128)											(128)	2
3	Housekeeping			195					(379)				(184)	3
4	Laundry													4
5	Heat and Other Utilities	(2,604)		270	365								(1,969)	5
6	Maintenance			321	1,771		(5,096)						(3,004)	6
7	Other (specify):*				249	349	2,809						3,407	7
8	<b>TOTAL General Services</b>	<b>(3,032)</b>		<b>786</b>	<b>2,385</b>	<b>2,056</b>	<b>(5,208)</b>		<b>(379)</b>				<b>(3,392)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(14,907)			5,301				(4,888)				(14,494)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				1,058								1,058	15
16	<b>TOTAL Health Care and Programs</b>	<b>(14,907)</b>			<b>6,359</b>				<b>(4,888)</b>				<b>(13,436)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			4,974	2,441	12,381							19,796	17
18	Directors Fees													18
19	Professional Services	(5,669)	5,199	(28,375)	236	3,863							(24,746)	19
20	Fees, Subscriptions & Promotions	(16,767)		21	26								(16,720)	20
21	Clerical & General Office Expenses	(42,549)	250	17,502	3,497								(21,300)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			32	59								91	24
25	Other Admin. Staff Transportation			186	566								752	25
26	Insurance-Prop.Liab.Malpractice			107	126								233	26
27	Other (specify):*			3,198	989	1,938							6,125	27
28	<b>TOTAL General Administration</b>	<b>(64,985)</b>	<b>5,449</b>	<b>(2,355)</b>	<b>7,940</b>	<b>18,182</b>							<b>(35,769)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(82,924)</b>	<b>5,449</b>	<b>(1,569)</b>	<b>16,684</b>	<b>20,238</b>	<b>(5,208)</b>		<b>(5,266)</b>				<b>(52,596)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Oakwood Terrace

# 0041343

Report Period Beginning:

01/01/05

Ending:

Summary B

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	(4,900)	70,390	474	621								66,585	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,357)	145,330	(88)	(42)								139,843	32
33	Real Estate Taxes			676	1,075								1,751	33
34	Rent-Facility & Grounds		(194,000)										(194,000)	34
35	Rent-Equipment & Vehicles			721	436								1,157	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(10,257)</b>	<b>21,720</b>	<b>1,783</b>	<b>2,090</b>								<b>15,336</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(3,696)											(3,696)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>	<b>(3,696)</b>											<b>(3,696)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(96,877)</b>	<b>27,169</b>	<b>214</b>	<b>18,774</b>	<b>20,238</b>	<b>(5,208)</b>		<b>(5,266)</b>				<b>(40,956)</b>	<b>45</b>

Facility Name & ID Number Oakwood Terrace

# 0041343

Report Period Beginning:

01/01/05

Ending:

12/31/05

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		Oakwood Care RE 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 194,000	Oakwood Care Real Estate LLC		\$	\$ (194,000)	1
2	V	30 Depreciation		Oakwood Care Real Estate LLC		70,390	70,390	2
3	V	19 Fees - Loan		Oakwood Care Real Estate LLC		5,199	5,199	3
4	V	21 Filing Fees		Oakwood Care Real Estate LLC		250	250	4
5	V	32 Interest		Oakwood Care Real Estate LLC		145,330	145,330	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 194,000			\$ 221,169	\$ * 27,169	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakwood Terrace# 0041343Report Period Beginning: 01/01/05Ending: 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	3 HOUSEKEEPING	\$	PREFERRED BOOKKEEPING	100.00%	\$ 195	\$ 195	15	
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	270	270	16	
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	321	321	17	
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	4,974	4,974	18	
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	455	455	19	
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	21	21	20	
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	17,502	17,502	21	
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	32	32	22	
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	186	186	23	
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	107	107	24	
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	3,198	3,198	25	
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	474	474	26	
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	(88)	(88)	27	
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	676	676	28	
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	721	721	29	
30	V							30	
31	V							31	
32	V	19 ACCOUNT./BOOKKEEPING	28,830	PREFERRED BOOKKEEPING	100.00%		(28,830)	32	
33	V	19 COMPUTER	1,368	PREFERRED BOOKKEEPING	100.00%	1,368		33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$ 30,198			\$ 30,412	\$ *	214	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakwood Terrace# 0041343Report Period Beginning: 01/01/05Ending: 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 365	\$ 365	15
16	V	6 REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,771	1,771	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	249	249	17
18	V	10 NURSING		S.I.R. MANAGEMENT, INC.	100.00%	5,301	5,301	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,058	1,058	19
20	V	17 ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	2,441	2,441	20
21	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	236	236	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	26	26	22
23	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	3,497	3,497	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	59	59	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	566	566	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	126	126	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	989	989	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	621	621	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(42)	(42)	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	1,075	1,075	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	436	436	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 18,774	\$ * 18,774	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakwood Terrace# 0041343Report Period Beginning: 01/01/05Ending: 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 SALARIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,707	\$ 1,707	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	349	349	16
17	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	12,381	12,381	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	3,863	3,863	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	1,938	1,938	19
20	V								20
21	V	17	ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			21
22	V	6	REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			22
23	V	21	CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			23
24	V	26	AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			24
25	V	27	EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			25
26	V	35	AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			26
27	V								27
28	V	17	ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			28
29	V	21	CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			29
30	V	26	AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			30
31	V	27	EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			31
32	V	35	AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$ 20,238	\$ * 20,238	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakwood Terrace# 0041343Report Period Beginning: 01/01/05Ending: 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	10A SPECIAL REHAB		S.I.R. MANAGEMENT, INC.	100.00%		\$	15
16	V	15 EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%			16
17	V							17
18	V	6 REPAIRS AND MAINT.	14,544	S.I.R. MANAGEMENT, INC.	100.00%	9,448	(5,096)	18
19	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,933	1,933	19
20	V							20
21	V							21
22	V	1 DIETICIAN SALARIES	7,200	S.I.R. MANAGEMENT, INC.	100.00%	4,279	(2,921)	22
23	V	7 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	876	876	23
24	V							24
25	V	19 LEGAL FEES		S.I.R. MANAGEMENT, INC.	100.00%			25
26	V							26
27	V	17 FEES		S.I.R. MANAGEMENT, INC.	100.00%			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		\$ 21,744			\$ 16,536	\$ * (5,208)	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	22	EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 37,735	\$ 37,735	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	37,735	CCS EMPLOYEE BENEFIT GROUP	100.00%		(37,735)	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			\$ 37,735			\$ 37,735	\$ *	39

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

Facility Name & ID Number Oakwood Terrace# 0041343Report Period Beginning: 01/01/05Ending: 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	01 DIETARY	\$	XCEL MEDICAL SUPPLY, LLC	100.00%	\$		15
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03 HOUSEKEEPING	3,819	XCEL MEDICAL SUPPLY, LLC	100.00%	3,440	(379)	17
18	V	04 LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06 REPAIRS & MAINTENANCE		XCEL MEDICAL SUPPLY, LLC	100.00%			19
20	V	10 NURSING	49,302	XCEL MEDICAL SUPPLY, LLC	100.00%	44,414	(4,888)	20
21	V	11 ACTIVITIES		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	20 DUES, FEES, SUBSCRIPTIONS & PROM		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22 EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%			24
25	V	39 ANCILLARY		XCEL MEDICAL SUPPLY, LLC	100.00%			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		\$ 53,121			\$ 47,854	\$ * (5,266)	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.

Facility Name & ID Number Oakwood Terrace

# 0041343

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			\$			\$		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 Oakwood Terrace # 0041343 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	Louise Bergthold	Owner	Administrative	3.51%	See Attached	1.42	2.58%	Alloc. Salary	\$ 4,934	17-7	1
2	Tom Winter	Owner	Administrative	3.51%	See Attached	1.85	3.08%	Alloc. Salary	4,974	17-7	2
3	Nenita Guzman	Relative	Dietary		See Attached	1.29	2.58%	Alloc. Salary	1,707	1-7	3
4	Adam Vales	Relative	Clerical		See Attached	0.25	0.62%	Alloc. Salary	308	22-7	4
5	Kim Rudolph	Relative	Clerical		See Attached	0.19	0.54%	Alloc. Salary	186	22-7	5
6	Eric Rothner	Relative	Administrative		See Attached	0.19	0.41%	Alloc. Salary	2,423	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 14,532		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 Oakwood Terrace

# 0041343 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 Oakwood Terrace

# 0041343

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 PREFERRED BOOKKEEPING SERVICES  
 Street Address 4100 WEST PRATT AVE.  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 674-5200  
 Fax Number ( 847) 674-5267

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	3	HOUSEKEEPING	BOOK./ACCNT.INCOME 936,008	10	\$ 6,321	\$	28,830	\$ 195	1
2	5	UTILITIES	BOOK./ACCNT.INCOME 936,008	10	8,775		28,830	270	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME 936,008	10	10,437		28,830	321	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME 936,008	10	161,494	161,494	28,830	4,974	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME 936,008	10	14,763		28,830	455	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME 936,008	10	685		28,830	21	6
7	21	CLERICAL	BOOK./ACCNT.INCOME 936,008	10	568,241	511,444	28,830	17,502	7
8	24	SEMINARS	BOOK./ACCNT.INCOME 936,008	10	1,042		28,830	32	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME 936,008	10	6,051		28,830	186	9
10	26	INSURANCE	BOOK./ACCNT.INCOME 936,008	10	3,462		28,830	107	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME 936,008	10	103,823		28,830	3,198	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME 936,008	10	15,373		28,830	474	12
13	32	INTEREST	BOOK./ACCNT.INCOME 936,008	10	(2,849)		28,830	(88)	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME 936,008	10	21,946		28,830	676	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME 936,008	10	23,404		28,830	721	15
16									16
17									17
18									18
19	19	COMPUTER	DIRECT ALLOCATION					1,368	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 942,968	\$ 672,937		\$ 30,412	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakwood Terrace

# 0041343

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 S.I.R. MANAGEMENT, INC.  
 Street Address 6840 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 675 -7979  
 Fax Number ( 847) 675 -0555

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PATIENT DAYS	636,443	10	\$ 14,105	\$ 16,476	\$ 365	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	636,443	10	68,426	46,969	16,476	1,771	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	636,443	10	9,610		16,476	249	3
4	10	NURSING	PATIENT DAYS	636,443	10	204,773	204,773	16,476	5,301	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	636,443	10	40,863		16,476	1,058	5
6	17	ADMINISTRATIVE	PATIENT DAYS	636,443	10	94,293	94,293	16,476	2,441	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	636,443	10	9,125		16,476	236	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	636,443	10	999		16,476	26	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	636,443	10	135,090	96,485	16,476	3,497	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	636,443	10	2,293		16,476	59	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	636,443	10	21,870		16,476	566	11
12	26	INSURANCE	PATIENT DAYS	636,443	10	4,867		16,476	126	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	636,443	10	38,192		16,476	989	13
14	30	DEPRECIATION	PATIENT DAYS	636,443	10	23,979		16,476	621	14
15	32	INTEREST	PATIENT DAYS	636,443	10	(1,613)		16,476	(42)	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	636,443	10	41,530		16,476	1,075	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	636,443	10	16,852		16,476	436	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 725,254	\$ 442,521	\$ 18,774		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakwood Terrace

# 0041343

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 S.I.R. MANAGEMENT, INC.  
 Street Address 6840 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 675 -7979  
 Fax Number ( 847) 675 -0555

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 SALARIES	PATIENT DAYS	636,443	10	\$ 65,932	\$ 16,476	\$ 1,707	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	636,443	10	13,490	16,476	349	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	636,443	10	478,274	478,274	12,381	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	636,443	10	149,224	16,476	3,863	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	636,443	10	74,875	16,476	1,938	5
6									6
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	20	4	16,008	16,008		7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	20	4	789			8
9	21	CLERICAL & GEN.-B. BARRIS	AVG HRS WKD	20	4	1,626			9
10	26	AUTO INSURANCE-B. BARRIS	AVG HRS WKD	20	4	1,444			10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	20	4	24,215			11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	20	4	5,400			12
13									13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	4	10,035	10,035		14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	4	457			15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	4	662			16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	4	23,622			17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	4	5,242			18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 871,295	\$ 570,249	\$ 20,238	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakwood Terrace

# 0041343

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 S.I.R. MANAGEMENT, INC.  
 Street Address 6840 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 675 -7979  
 Fax Number ( 847) 675 -0555

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	10A	SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	\$ 65,110	\$ 65,110		1	
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	13,322			2	
3									3	
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	144,648	10	93,966	93,966	14,544	9,448	
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	144,648	10	19,226	14,544	1,933	5	
6									6	
7									7	
8	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	74,533	74,533	7,200	4,279	
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	15,250	7,200	876	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					\$ 281,405	\$ 233,608		\$ 16,536	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakwood Terrace

# 0041343

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 CCS EMPLOYEE BENEFITS GROUP, INC.  
 Street Address 4101 W. MAIN ST.  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

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	<u>22</u>	<u>EMPLOYEE HEALTH INSURANCE</u>	<u>DIRECT ALLOCATION</u>		\$	\$		\$ <u>37,735</u>	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	<b>TOTALS</b>				\$	\$		\$ <u>37,735</u>	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakwood Terrace

# 0041343

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 XCEL MEDICAL SUPPLY, LLC  
 Street Address 2201 W. MAIN STREET  
 City / State / Zip Code EVANSTON, IL 60202  
 Phone Number ( 847)328-7600  
 Fax Number ( 847)328-7615

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	01	DIETARY	Direct Allocation		\$	\$		\$	1
2	02	FOOD	Direct Allocation						2
3	03	HOUSEKEEPING	Direct Allocation					3,440	3
4	04	LAUNDRY	Direct Allocation						4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						5
6	10	NURSING	Direct Allocation					44,414	6
7	11	ACTIVITIES	Direct Allocation						7
8	20	DUES, FEES, SUBSCRIPTIONS	Direct Allocation						8
9	21	CLERICAL & GENERAL OFFICE	Direct Allocation						9
10	22	EMPLOYEE BENEFITS	Direct Allocation						10
11	39	ANCILLARY	Direct Allocation						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				\$	\$		\$ 47,854	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakwood Terrace

# 0041343

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 Oakwood Terrace

# 0041343

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 Oakwood Terrace

# 0041343

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

**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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	First Bank		X	Mortgage	\$17,898.00		\$ 1,744,600	\$ 2,343,716		5.2500	\$ 145,330	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
<b>Working Capital</b>																				
6	Lake Forest Bank		X	Working Capital				2,230,000			162,219	6								
7												7								
8	See Supplemental Schedule										(130)	8								
9	<b>TOTAL Facility Related</b>				\$17,898.00		\$ 1,744,600	\$ 4,573,716			\$ 307,419	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13	See Supplemental Schedule											13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 1,744,600	\$ 4,573,716			\$ 307,419	15								

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

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

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 Oakwood Terrace # 0041343 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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>									7										
<b>Working Capital</b>																				
8	<b>Preferred Alloc.</b>		X							(88) 8										
9	<b>SIR Alloc.</b>		X							(42) 9										
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Working Capital</b>									(130) 14										
<b>B. Non-Facility Related*</b>																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	<b>TOTAL Non-Facility Related</b>									20										

\* 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.)



**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 Oakwood Terrace COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041343

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>11-18-326-011-0000</u>	<u>Long Term Care</u>	\$ <u>108,929.35</u>	\$ <u>108,929.35</u>
2. <u>See Attached</u>	<u>Allocation SIR Property</u>	\$ <u>86,511.09</u>	\$ <u>1,686.32</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>195,440.44</u>	\$ <u>110,615.67</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.

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**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 Oakwood Terrace COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041343

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

**A. Summary of Real Estate Tax Cost**

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(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. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ _____	\$ _____

**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 Oakwood Terrace

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**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 18,609 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, 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: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1996</u>	<u>\$ 150,000</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 150,000</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakwood Terrace

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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 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
		<b>Improvement Type**</b>									
9	Various			1996	101,705		20	5,087	5,087	48,787	9
10	Various			1997	88,164		20	4,412	4,412	39,035	10
11	Various			1998	11,669		20	583	583	4,546	11
12	Various			1999	3,800		20	190	190	1,251	12
13	Various			2000	12,034		20	602	602	3,174	13
14	Various			2001	23,253		20	1,164	1,164	5,210	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakwood Terrace

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**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	Related Building Company (Pages 12-BLDG & 12A-BLDG)	2,751,924	70,390		52,500	(17,890)	474,573	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)	23,065	783		911	128	9,541	68
69	Financial Statement Depreciation		29,882			(29,882)		69
70	TOTAL (lines 4 thru 69)	\$ 3,015,614	\$ 101,055		\$ 65,449	\$ (35,606)	\$ 586,117	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Oakwood Terrace

# 0041343

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**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,015,614	\$ 101,055		\$ 65,449	\$ (35,606)	\$ 586,117	1
2	Ejector Pump	2002	6,100		20	610	610	2,237	2
3	Windows	2002	925		20	93	93	324	3
4	Hydrojet Sewer	2002	3,200		20	320	320	1,120	4
5	Shower Repairs	2002	1,360		20	68	68	227	5
6	Painting	2003	2,019		20	101	101	303	6
7	Flooring	2003	6,022		20	301	301	778	7
8	Repair Freezer	2003	1,091		20	55	55	164	8
9	Install Bathroom Tile	2003	665		20	33	33	100	9
10	Replace Pipe, Create Manifold	2003	1,050		20	53	53	149	10
11	Phone System & Camera	2003	1,502		20	75	75	188	11
12	Install Ejector Pump	2003	1,032		20	52	52	129	12
13	Plumbing Work	2004			20				13
14	Plumbing Work	2004	2,067		20	103	103	181	14
15	Electrical Work	2004			20				15
16	Electrical Work	2004	1,655		20	83	83	124	16
17	Plumbing Work	2004			20				17
18	Plumbing Work	2004	13,157		20	658	658	767	18
19	Sprinkler Pipes	2004	3,066		20	153	153	166	19
20	Elevator Cylinder 50%	2005	12,929		20	539	539	539	20
21	Hot Water Pump	2005	1,229		20	102	102	102	21
22	Boiler Pump	2005	1,071		20	89	89	89	22
23	Shower Base	2005	2,450		20	102	102	102	23
24	Hot Water Heater	2005	15,860		20	463	463	463	24
25	Fire System Equipment	2005	3,716		20	77	77	77	25
26	Window Panels	2005	5,850		20	195	195	195	26
27	Electrical Work	2005	3,193		20	40	40	40	27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oakwood Terrace

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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		\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681	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)	\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oakwood Terrace

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Report Period Beginning:

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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		\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681	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)	\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oakwood Terrace

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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		\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681	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)	\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oakwood Terrace

# 0041343

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	\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681		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
19									19
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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)	\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oakwood Terrace

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Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681	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)		\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oakwood Terrace

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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		\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681	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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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)		\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oakwood Terrace

# 0041343

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		\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681	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)		\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oakwood Terrace

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Report Period Beginning:

01/01/05

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681	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)		\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oakwood Terrace

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Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681	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)		\$ 3,106,823	\$ 101,055		\$ 69,814	\$ (31,241)	\$ 594,681	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oakwood Terrace

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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	57		1996	1996	\$ 1,757,500	\$ 44,893		\$ 52,500	\$ 7,607	\$ 474,573	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	Various			2000	994,424	25,497			(25,497)		9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oakwood Terrace

# 0041343

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)	\$ 2,751,924	\$ 70,390		\$ 52,500	\$ (17,890)	\$ 474,573	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oakwood Terrace

**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		SIR Properties - Preferred Bookkeeping		1993	\$ 4,349	\$ 138	35	\$ 124	\$ (14)	\$ 1,553	4
5		SIR Properties - SIR Management		1993	6,917	220	35	198	(22)	2,470	5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9											9
10		Allocation Preferred Bookkeeping		1997	5,432	122	20	272	150	2,392	10
11		Allocation Preferred Bookkeeping		1999	43	-	20	2	2	14	11
12		Allocation Preferred Bookkeeping		2000	272	-	20	14	(14)	74	12
13											13
14		SIR Properties - Preferred Bookkeeping		2002	17	-	20	1	1	3	14
15		SIR Properties - Preferred Bookkeeping		1999	551	55	20	28	(27)	179	15
16		SIR Properties - Preferred Bookkeeping		1998	263	26	20	13	(13)	99	16
17		SIR Properties - Preferred Bookkeeping		1997	16	2	20	1	(1)	8	17
18		SIR Properties - Preferred Bookkeeping		1994	41	1	20	2	1	24	18
19		SIR Properties - Preferred Bookkeeping		1993	71	-	20	4	4	44	19
20											20
21		SIR Management		1993	2,971	83	20	147	64	1,915	21
22		SIR Management		1994	9	-	20	-		9	22
23		SIR Management		1995	68	-	20	3	3	35	23
24		SIR Management		1999	323	-	20	16	16	100	24
25		SIR Management		2000	195	-	20	10	10	55	25
26											26
27		SIR Properties - SIR Management		2002	27	-	20	1	1	5	27
28		SIR Properties - SIR Management		1999	877	88	20	44	(44)	285	28
29		SIR Properties - SIR Management		1998	419	42	20	21	(21)	157	29
30		SIR Properties - SIR Management		1997	26	3	20	1	(2)	12	30
31		SIR Properties - SIR Management		1994	66	2	20	3	1	38	31
32		SIR Properties - SIR Management		1993	112	1	20	6	5	70	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 Oakwood Terrace

# 0041343

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	<b>TOTAL (lines 4 thru 69)</b>	\$	23,065	\$	783	\$	911	\$	100	\$	9,541	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oakwood Terrace # 0041343 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	\$ 269,541	\$ 265	\$ 26,079	\$ 25,814	10	\$ 215,579	71
72	Current Year Purchases	9,881	49	576	527	10	576	72
73	Fully Depreciated Assets	150,010				10	150,010	73
74								74
75	TOTALS	\$ 429,432	\$ 314	\$ 26,655	\$ 26,341		\$ 366,165	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)	\$ 3,686,255	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 101,369	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 96,469	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,900)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 960,846	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: \_\_\_\_\_

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

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	<b>TOTAL</b>				\$ _____			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: \$ 2,517 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			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	<b>TOTAL</b>		\$ _____	\$ _____	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)	
<b>TOTAL TRAINED</b>	

- (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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 16,201	\$		\$ 16,201	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			1,131			1,131	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			60,903			60,903	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				36,550		36,550	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <a href="#">See Supplemental</a>						13,454		13,454	13
14	<b>TOTAL</b>			\$		\$ 78,235	\$ 50,004		\$ 128,239	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 Oakwood Terrace# 0041343Report 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	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 96,546	\$ 97,058	1
2	Cash-Patient Deposits	18,408	18,408	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	654,832	654,832	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,562	12,562	6
7	Other Prepaid Expenses	1,990	1,990	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <a href="#">See Attached Schedule</a>			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 784,338	\$ 784,850	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		1,837,500	14
15	Leasehold Improvements, at Historical Cost	193,757	1,188,181	15
16	Equipment, at Historical Cost	375,284	525,284	16
17	Accumulated Depreciation (book methods)	(358,970)	(1,172,188)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Attached Schedule</a>	1,575	1,575	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 211,646	\$ 2,530,352	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 995,984	\$ 3,315,202	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 80,043	\$ 80,043	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,459	27,459	28
29	Short-Term Notes Payable	2,230,000	2,230,000	29
30	Accrued Salaries Payable	47,235	47,235	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,887	6,887	31
32	Accrued Real Estate Taxes(Sch.IX-B)	112,200	112,200	32
33	Accrued Interest Payable		5,513	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See Attached Schedule</a>			36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,503,824	\$ 2,509,337	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,343,716	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See Attached Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 2,343,716	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,503,824	\$ 4,853,053	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,507,840)	\$ (1,537,851)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 995,984	\$ 3,315,202	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,891,513)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,891,513)	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(186,327)	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)	\$ (186,327)	17
	<b>B. Transfers (Itemize):</b>		
18	Contributed Capital	570,000	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 570,000	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,507,840)	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakwood Terrace# 0041343Report 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,930,893	1
2	Discounts and Allowances for all Levels	93,983	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,024,876</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	222,720	6
7	Oxygen	50	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 222,770</b>	8
<b>C. Other Operating Revenue</b>			
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	3,696	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	35,313	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,824	19
20	Radiology and X-Ray	2,157	20
21	Other Medical Services	13,685	21
22	Laundry	2,475	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 60,150</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	2,604	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 2,604</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,310,400</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	458,168	31
32	Health Care	911,707	32
33	General Administration	467,640	33
<b>B. Capital Expense</b>			
34	Ownership	495,747	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	132,257	35
36	Provider Participation Fee	31,208	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,496,727</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(186,327)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (186,327)</b>	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? See Attached 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 Oakwood Terrace

# 0041343

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	1,947	2,128	\$ 60,033	\$ 28.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,124	2,127	49,809	23.42	3
4	Licensed Practical Nurses	9,976	10,385	221,930	21.37	4
5	CNAs & Orderlies	34,694	36,386	323,557	8.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,075	1,146	10,478	9.14	8
9	Activity Director					9
10	Activity Assistants	3,007	3,087	23,690	7.67	10
11	Social Service Workers	1,821	2,033	27,470	13.51	11
12	Dietician					12
13	Food Service Supervisor	1,945	2,062	29,912	14.51	13
14	Head Cook	3,809	4,001	39,033	9.76	14
15	Cook Helpers/Assistants	5,723	5,981	45,047	7.53	15
16	Dishwashers					16
17	Maintenance Workers	1,792	2,078	30,193	14.53	17
18	Housekeepers	5,104	5,210	39,298	7.54	18
19	Laundry	2,143	2,355	16,777	7.12	19
20	Administrator	1,912	2,067	60,761	29.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,111	2,161	18,043	8.35	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	3,384	3,721	83,471	22.43	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	82,567	86,928	\$ 1,079,502 *	\$ 12.42	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	\$ 7,817	01-03	35
36	Medical Director	Monthly	2,500	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	831	10-03	39
40	Physical Therapy Consultant	40	1,952	10a-03	40
41	Occupational Therapy Consultant	3	128	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,301	11-03	44
45	Social Service Consultant	Monthly	3,770	12-03	45
46	Other(specify)				46
47	<u>Psycho Social Consultant</u>	Monthly	600	12-03	47
48					48
49	TOTAL (lines 35 - 48)	43	\$ 24,123		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	456	\$ 21,885	10-03	50
51	Licensed Practical Nurses	15	551	10-03	51
52	Certified Nurse Assistants/Aides	64	1,398	10-03	52
53	TOTAL (lines 50 - 52)	535	\$ 23,834		53

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Oakwood Terrace

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													
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11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Oakwood Terrace

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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. \$ 10,304 Line 10-02
- (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. \$ 31,208  
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? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 4,803 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? \_\_\_\_\_  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ No**
- (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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**