

		FOR BHF USE					

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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.

<p><b>I. IDPH Facility ID Number:</b> <u>0033340</u></p> <p><b>Facility Name:</b> <u>AVENUE CARE CENTER</u></p> <p><b>Address:</b> <u>4505 SOUTH DREXEL</u> <u>CHICAGO</u> <u>60653</u>          Number City Zip Code</p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>(847) 329-1555</u> Fax # <u>(847) 329-9555</u></p> <p><b>HFS ID Number:</b> <u>36-3558590</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>2/1/1988</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>          </u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other <u>          </u></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other <u>          </u></td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>BOB KAGDA</u> <b>Telephone Number:</b> <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>          </u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other <u>          </u>		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other <u>          </u>		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2006</u> to <u>12/31/2006</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>SHERWIN I. RAY</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>PRESIDENT</u></td> </tr> <tr> <td rowspan="4" style="width: 15%;"><b>Paid Preparer</b></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">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</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>SHERWIN I. RAY</u> (Date) _____		(Title) <u>PRESIDENT</u>	<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number AVENUE CARE CENTER

# 0033340 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,575	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	155	TOTALS	155	56,575	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			3,021	3,021	8
9	SNF/PED					9
10	ICF	46,368	1,007		47,375	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,368	1,007	3,021	50,396	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.08%

D. How many bed-hold days during this year were paid by the Department? 1,030 (Do not include bed-hold days in Section B.)

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

NONE

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 02/01/88

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/01/88 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 21 and days of care provided 3,021

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

**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	183,344	22,506	11,081	216,931		216,931	0	216,931		1
2	Food Purchase		190,441		190,441	(18,560)	171,881	(891)	170,990		2
3	Housekeeping	130,318	38,063	0	168,381		168,381	0	168,381		3
4	Laundry	53,911	15,154	0	69,065	0	69,065	0	69,065		4
5	Heat and Other Utilities			138,601	138,601		138,601	37	138,638		5
6	Maintenance	59,434	28,376	49,830	137,640		137,640	(194)	137,446		6
7	Other (specify):*			17,807	17,807		17,807	18	17,825		7
8	<b>TOTAL General Services</b>	427,007	294,540	217,319	938,866	(18,560)	920,306	(1,030)	919,276		8
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		6,000	6,000		6,000	0	6,000		9
10	Nursing and Medical Records	1,411,399	49,103	67,393	1,527,895		1,527,895	(19,505)	1,508,390		10
10a	Therapy	75,335	5,925	91,975	173,235		173,235	(8,066)	165,169		10a
11	Activities	95,418	13,096	1,927	110,441		110,441	0	110,441		11
12	Social Services	136,189		0	136,189		136,189	0	136,189		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			35	35		35	0	35		14
15	Other (specify):*				0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	1,718,341	68,124	167,330	1,953,795	0	1,953,795	(27,571)	1,926,224		16
	<b>C. General Administration</b>										
17	Administrative	99,995		330,000	429,995		429,995	(228,435)	201,560		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			234,876	234,876		234,876	(176,622)	58,254		19
20	Dues, Fees, Subscriptions & Promotions			55,157	55,157		55,157	(6,385)	48,772		20
21	Clerical & General Office Expenses	63,283	17,234	187,275	267,792		267,792	(87,420)	180,372		21
22	Employee Benefits & Payroll Taxes			418,589	418,589	18,560	437,149	0	437,149		22
23	Inservice Training & Education			0	0		0	2,012	2,012		23
24	Travel and Seminar			606	606		606	1,076	1,682		24
25	Other Admin. Staff Transportation			7,010	7,010		7,010	2,966	9,976		25
26	Insurance-Prop.Liab.Malpractice			220,351	220,351		220,351	1,436	221,787		26
27	Other (specify):*			0	0		0	56,417	56,417		27
28	<b>TOTAL General Administration</b>	163,278	17,234	1,453,864	1,634,376	18,560	1,652,936	(434,955)	1,217,981		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,308,626	379,898	1,838,513	4,527,037	0	4,527,037	(463,556)	4,063,481		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	9,347
	REPAIRS & MAINTENANCE	1,734
		0
		11,081
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	62,498
	ELECTRICITY	44,621
	WATER	22,249
	CABLE TV - LOBBY	9,233
		0
		138,601
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	1,647
	PAINTING & DECORATING	8,150
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	21,668
	ELEVATOR MAINTENANCE & REPAIR	6,072
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	7,020
	FIRE SERVICE	5,273
		0
		0
		0
		0
		49,830
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	17,807
	SECURITY SERVICE	0
		0
		0
		17,807
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,440
	PHARMACY CONSULTANT XVIII B 39-2	1,440
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	PROGRAM CONSULTANT	64,513
		0
		67,393
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	5,054
	SPEECH THERAPY SERVICES	1,692
	OCCUPATIONAL THERAPY SERVICES	2,430
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	5,400
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	5,400
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	THERAPY CONTRACT SERVICES	71,999
		91,975
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,927
		0
		1,927
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	35
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	330,000
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	25,820
	ADMINISTRATIVE CONSULTANTS XIX C	168,000
	PROFESSIONAL FEES XIX C	41,056
		0
		234,876
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	3,344
	EMPLOYEE WANT ADS XIX F	36,820
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	1,619
	LICENSES & PERMITS XIX F	7,539
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	5,198
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	300
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	184
	PATIENT BACKGROUND CHECKS XIX F	153
		55,157
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	
	EQUIPMENT REPAIR & MAINTENANCE	5,015
	OUTSIDE CLERICAL SERVICES	149,275
	PENALTIES / OVERDRAFT CHARGES VI 18	7,685
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	162
	TELEPHONE	23,347
	MESSENGER SERVICE	1,791
		0
		187,275

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	174,906
	UNEMPLOYMENT COMPENSATION XIX D	96,166
	WORKERS COMPENSATION INSURANC XIX D	64,072
	HOSPITALIZATION INSURANCE XIX D	51,545
	EMPLOYEE BENEFITS - OTHER XIX D	1,587
	EMPLOYEE PHYSICAL EXAMS XIX D	144
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	26,457
	CHICAGO HEAD TAX XIX D	3,712
		0
		418,589
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	606
	TRAVEL XIX G	0
		606
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	7,010
		7,010
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	220,351
		220,351
27	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,838,513

AVENUE CARE CENTER  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2006

TOTAL FOOD PURCHASE	190,441	PATIENT MEALS	151188
LESS SALES TAX	(891)	ADD EMPLOYEE MEALS	16425
	-----		-----
NET FOOD	189,550	TOTAL MEALS/YEAR	167613
TOTAL PATIENT CENSUS	50,396	NET FOOD	189550
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	167613
	-----		
TOTAL PATIENT MEALS	151188	COST PER MEAL	1.13
		TIME EMPLOYEE MEALS	16425
ADD # EMPLOYEE MEALS/DAY	45		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	18560
	-----		=====
TOTAL EMPLOYEE MEALS	16425		

Facility Name &amp; ID Number AVENUE CARE CENTER

#0033340

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			43,004	43,004		43,004	120,899	163,903			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			8,521	8,521		8,521	324,653	333,174			32
33	Real Estate Taxes			179,862	179,862		179,862	4,539	184,401			33
34	Rent-Facility & Grounds			510,370	510,370		510,370	(510,370)	0			34
35	Rent-Equipment & Vehicles			47,636	47,636		47,636	(20,173)	27,463			35
36	Other (specify):*			0	0		0	0	0			36
37	<b>TOTAL Ownership</b>			789,393	789,393	0	789,393	(80,452)	708,941			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		72,760	166,658	239,418		239,418	(20,130)	219,288			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			84,863	84,863		84,863	0	84,863			42
43	Other (specify):*				0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	72,760	251,521	324,281	0	324,281	(20,130)	304,151			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,308,626	452,658	2,879,427	5,640,711	0	5,640,711	(564,138)	5,076,573			45

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

Facility Name & ID Number AVENUE CARE CENTER

# 0033340

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	782	30		9
10	Interest and Other Investment Income	(75,440)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(891)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(7,685)	21		18
19	Entertainment	0	20		19
20	Contributions	(300)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(3,344)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,198)	20		28
29	Other-Attach Schedule	(6,291)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (98,367)		\$ 0	30

BHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(465,771)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (465,771)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (564,138)		37

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

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

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

AVENUE CARE CENTER

ID# 0033340

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ (6,291)	6
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	(6,291)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number AVENUE CARE CENTER

# 0033340

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(891)	0	0	0	0	0	0	0	0	0	0	(891)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	37	0	0	0	0	0	0	0	0	0	37	5
6	Maintenance	(6,291)	6,097	0	0	0	0	0	0	0	0	0	(194)	6
7	Other (specify):*	0	0	18	0	0	0	0	0	0	0	0	18	7
8	<b>TOTAL General Services</b>	<b>(7,182)</b>	<b>6,134</b>	<b>18</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,030)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(64,513)	45,008	0	0	0	0	0	0	0	0	(19,505)	10
10a	Therapy	0	0	3,043	(11,109)	0	0	0	0	0	0	0	(8,066)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>(64,513)</b>	<b>48,051</b>	<b>(11,109)</b>	<b>0</b>	<b>(27,571)</b>	<b>16</b>						
	<b>C. General Administration</b>													
17	Administrative	0	(330,000)	101,565	0	0	0	0	0	0	0	0	(228,435)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(180,000)	3,378	0	0	0	0	0	0	0	0	(176,622)	19
20	Fees, Subscriptions & Promotions	(8,842)	0	2,457	0	0	0	0	0	0	0	0	(6,385)	20
21	Clerical & General Office Expenses	(7,685)	(149,275)	69,540	0	0	0	0	0	0	0	0	(87,420)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	2,012	0	0	0	0	0	0	0	0	2,012	23
24	Travel and Seminar	0	0	1,076	0	0	0	0	0	0	0	0	1,076	24
25	Other Admin. Staff Transportation	0	0	2,966	0	0	0	0	0	0	0	0	2,966	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,436	0	0	0	0	0	0	0	0	1,436	26
27	Other (specify):*	0	(10,877)	67,294	0	0	0	0	0	0	0	0	56,417	27
28	<b>TOTAL General Administration</b>	<b>(16,527)</b>	<b>(670,152)</b>	<b>251,724</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(434,955)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(23,709)</b>	<b>(728,531)</b>	<b>299,793</b>	<b>(11,109)</b>	<b>0</b>	<b>(463,556)</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number AVENUE CARE CENTER# 0033340

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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	782	0	11,279	108,838	0	0	0	0	0	0	0	120,899	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(75,440)	0	32,779	367,314	0	0	0	0	0	0	0	324,653	32
33	Real Estate Taxes	0	0	4,539	0	0	0	0	0	0	0	0	4,539	33
34	Rent-Facility & Grounds	0	0	0	(510,370)	0	0	0	0	0	0	0	(510,370)	34
35	Rent-Equipment & Vehicles	0	0	8,420	(28,593)	0	0	0	0	0	0	0	(20,173)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(74,658)</b>	<b>0</b>	<b>57,017</b>	<b>(62,811)</b>	<b>0</b>	<b>(80,452)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(20,130)	0	0	0	0	0	0	0	(20,130)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(20,130)</b>	<b>0</b>	<b>(20,130)</b>	<b>44</b>						
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(98,367)</b>	<b>(728,531)</b>	<b>356,810</b>	<b>(94,050)</b>	<b>0</b>	<b>(564,138)</b>	<b>45</b>						

Facility Name & ID Number AVENUE CARE CENTER

# 0033340

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

**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
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHAB	SKOKIE	THERAPY
SEE ATTACHED SCHEDULE				AVENUE ASSOC.		
				LLC	SKOKIE	REAL ESTATE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10 PROGRAM CONS. FEES	\$ 64,513	CAREPLUS MANAGEMENT, INC.		\$	\$ (64,513)	1
2	V	17 MANAGEMENT FEES	330,000	" " "			(330,000)	2
3	V	19 ADMIN. CONSULT. FEES	168,000	" " "			(168,000)	3
4	V	19 DATA PROCESS FEES	12,000	" " "			(12,000)	4
5	V	21 CLERICAL FEES	149,275	" " "			(149,275)	5
6	V	27 W/C INSURANCE	10,877	" " "			(10,877)	6
7	V			" " "				7
8	V			" " "				8
9	V			" " "				9
10	V			" " "				10
11	V	5 UTILITIES		" " "		37	37	11
12	V	6 MAINT & REPAIRS		" " "		1,523	1,523	12
13	V	6 MAINTENANCE SALARIES		" " "		4,574	4,574	13
14	Total		\$ 734,665			\$ 6,134	\$ * (728,531)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	7 SECURITY	\$	CAREPLUS MANAGEMENT, INC.		\$ 18	\$	18	15
16	V	10 NURSING SALARIES		" "		45,008		45,008	16
17	V	10A THERAPY SALARIES		" "		3,043		3,043	17
18	V	17 ADMIN. SALARIES		" "		101,565		101,565	18
19	V	19 PROFESSIONAL FEES		" "		3,378		3,378	19
20	V	20 ADVERTISING		" "		2,457		2,457	20
21	V	21 TOTAL OFFICE		" "		14,987		14,987	21
22	V	21 CLERICAL SALARIES		" "		54,553		54,553	22
23	V	23 SEMINARS		" "		2,012		2,012	23
24	V	24 TRAVEL		" "		1,076		1,076	24
25	V	25 TRANSPORTATION		" "		2,966		2,966	25
26	V	26 INSURANCE		" "		1,436		1,436	26
27	V	27 EMPLOYEE BENEFITS		" "		67,294		67,294	27
28	V	30 DEPRECIATION ( SL )		" "		11,279		11,279	28
29	V	33 REAL ESTATE TAX		" "		4,539		4,539	29
30	V	32 INTEREST		" "		28,702		28,702	30
31	V	32 INTEREST-TAG 18 PPTY-MTG		" "		3,807		3,807	31
32	V	32 INTEREST-CP REHAB-EQ LOAN		" "		270		270	32
33	V	35 EQUIPMENT RENT		" "		8,420		8,420	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 356,810	\$ *	356,810	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10A THERAPY SERVICES	\$ 91,974	CAREPLUS REHABILITATIVE SERVICES		\$ 80,865	\$ (11,109)
16	V	39 ANCILLARY THERAPY	166,658	" " "		146,528	(20,130)
17	V	35 EQUIPMENT RENTAL	28,593	" " "			(28,593)
18	V	30 SL DEPRECIATION		" " "		5,092	5,092
19	V	32 INTEREST		" " "		3,228	3,228
20	V						
21	V						
22	V						
23	V	34 RENT	510,370	AVENUE ASSOCIATES, LLC			(510,370)
24	V	30 SL DEPRECIATION		" " "		103,746	103,746
25	V	32 INTEREST		" " "		364,086	364,086
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 797,595			\$ 703,545	\$ * (94,050)

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

Facility Name &amp; ID Number

AVENUE CARE CENTER

# 0033340

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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	CAREPLUS MGMT ALLOCATIONS								\$		1
2	SHERWIN I. RAY	PRESIDENT	ADMINISTRAT.	19.70	SEE	5.5		SALARY	18,220	17-7	2
3			FINANCE		ATTACHED						3
4					SCHEDULE						4
5	ROSLYN INDICH	CLERICAL	CLERICAL	10.25		5.5		SALARY	4,488	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 22,708		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number AVENUE CARE CENTER

# 0033340

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

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 CAREPLUS MANAGEMENT, INC.  
 Street Address 8320 SKOKIE BLVD.  
 City / State / Zip Code SKOKIE, IL 60077  
 Phone Number ( 847 ) 329-1555  
 Fax Number ( 847 ) 329-9555

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	CENSUS DAYS	553,205	13	\$ 408	\$ 50,396	\$ 37	1
2	6	MAINT & REPAIRS	CENSUS DAYS	553,205	13	16,722	50,396	1,523	2
3	6	MAINTENANCE SALARIES	CENSUS DAYS	553,205	13	50,215	50,396	4,574	3
4	7	SECURITY	CENSUS DAYS	553,205	13	194	50,396	18	4
5	10	NURSING SALARIES	CENSUS DAYS	553,205	13	494,063	50,396	45,008	5
6	10A	THERAPY SALARIES	CENSUS DAYS	553,205	13	33,400	50,396	3,043	6
7	17	ADMIN. SALARIES	CENSUS DAYS	553,205	13	1,114,897	50,396	101,565	7
8	19	PROFESSIONAL FEES	CENSUS DAYS	553,205	13	37,085	50,396	3,378	8
9	20	ADVERTISING	CENSUS DAYS	553,205	13	26,974	50,396	2,457	9
10	21	TOTAL OFFICE	CENSUS DAYS	553,205	13	164,515	50,396	14,987	10
11	21	CLERICAL SALARIES	CENSUS DAYS	553,205	13	598,842	50,396	54,553	11
12	23	SEMINARS	CENSUS DAYS	553,205	13	22,090	50,396	2,012	12
13	24	TRAVEL	CENSUS DAYS	553,205	13	11,815	50,396	1,076	13
14	25	TRANSPORTATION	CENSUS DAYS	553,205	13	32,553	50,396	2,966	14
15	26	INSURANCE	CENSUS DAYS	553,205	13	15,760	50,396	1,436	15
16	27	EMPLOYEE BENEFITS	CENSUS DAYS	553,205	13	738,700	50,396	67,294	16
17	30	DEPRECIATION ( SL )	CENSUS DAYS	553,205	13	123,804	50,396	11,279	17
18	33	REAL ESTATE TAX	CENSUS DAYS	553,205	13	49,822	50,396	4,539	18
19	32	INTEREST	CENSUS DAYS	553,205	13	315,063	50,396	28,702	19
20	32	INTEREST-TAG 18 PPTY-MTG	CENSUS DAYS	553,205	13	41,794	50,396	3,807	20
21	32	INTEREST-CP REHAB-EQ LOAN	CENSUS DAYS	553,205	13	2,962	50,396	270	21
22	35	EQUIPMENT RENT	CENSUS DAYS	553,205	13	92,424	50,396	8,420	22
23									23
24									24
25	TOTALS				\$ 3,984,102	\$ 2,291,417		\$ 362,944	25

Facility Name & ID Number AVENUE CARE CENTER

# 0033340

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1	RELATED PARTY: AVENUE ASSOCIATES LLC						\$	\$			\$	1
2	PACIFICMUTUAL		X	MORTGAGE		12/95	4,657,452	3,820,354	01/08	0.0888	349,614	2
3	LOAN COSTS		X	LOAN COSTS	W/O OVER 12 YEARS		118,077	9,069			9,840	3
4	CIB BANK		X	CAPITAL IMPROVEMENTS		01/04	315,000	45,044	01/09	PRIME+	4,632	4
5	CAREPLUS MGMT. ALLOCATION										32,779	5
<b>Working Capital</b>												
6												6
7	A.I. IMPERIAL CREDIT		X	INSURANCE FINANCE							8,521	7
8	CAREPLUS REHAB ALLOCATION : EQUIPMENT LOANS										3,228	8
9	TOTAL Facility Related						\$ 5,090,529	\$ 3,874,467			\$ 408,614	9
<b>B. Non-Facility Related*</b>												
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14
15	TOTALS (line 9+line14)						\$ 5,090,529	\$ 3,874,467			\$ 408,614	15

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

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

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

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2005 report.		\$	<b>178,017</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>178,049</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>32</b>	<b>3</b>
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>179,830</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>179,862</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2001</b>	<b>166,364</b>	<b>8</b>
	<b>2002</b>	<b>168,229</b>	<b>9</b>
	<b>2003</b>	<b>172,425</b>	<b>10</b>
	<b>2004</b>	<b>176,255</b>	<b>11</b>
	<b>2005</b>	<b>178,049</b>	<b>12</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.**

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2005	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME AVENUE CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0033340

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>20-02-312-001-0000</u>	<u>NURSING HOME</u>	\$ <u>178,049.35</u>	\$ <u>178,049.35</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>178,049.35</u>	\$ <u>178,049.35</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number AVENUE CARE CENTER

# 0033340

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 43,293 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

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

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

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

N/A

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

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

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>	<u>51,736</u>	<u>1995</u>	<u>\$ 100,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>51,736</b>		<b>\$ 100,000</b>	<b>3</b>

Facility Name &amp; ID Number AVENUE CARE CENTER

# 0033340

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	155	1995	1971	\$ 4,046,250	\$ 103,746	39	\$ 103,746	\$	\$ 1,232,125	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	SPRINKLER SYSTEM		1988	5,400	171	25	216	45	4,014	9
10	LEASEHOLD IMPROVEMENTS		1989	1,035	33	20	52	19	884	10
11	LEASEHOLD IMPROVEMENTS		1990	5,400	171	20	270	99	4,477	11
12	LEASEHOLD IMPROVEMENTS		1991	14,414	458	20	721	263	11,176	12
13	LEASEHOLD IMPROVEMENTS		1992	42,003	1,384	31.5	1,384		19,807	13
14	LEASEHOLD IMPROVEMENTS		1993	16,403	431	31.5	431		6,763	14
15	LEASEHOLD IMPROVEMENTS		1993	1,081	72	15	72		972	15
16	LEASEHOLD IMPROVEMENTS		1994	15,686	402	39	402		5,093	16
17	LEASEHOLD IMPROVEMENTS		1994	9,604		20	480	480	6,000	17
18	ELEVATOR REPAIR & DOOR		1995	44,614	1,144	39	1,144		12,918	18
19	PAVING		1995	3,600	240	15	240		2,760	19
20	ALARM SYSTEM		1996	1,820	47	39	47		503	20
21	PLUMBING		1996	2,737	70	39	70		744	21
22	WALK-IN COOLER		1996	9,998	256	39	256		2,631	22
23	DOORS AND ROOF REPAIR		1997	5,110	131	39	131		1,290	23
24	FENCE		1997	19,800	508	39	508		4,847	24
25	FLOORING/BUMPER GUARDRAILS/HANDRAILS		1997	30,579	784	39	784		7,365	25
26	BUILT-IN NURSES' STATION & WARDROBES		1997	26,176	671	39	671		6,376	26
27	SMOKE & FIRE DAMPERS		1998	7,100	182	39	182		1,493	27
28	ELEVATOR REPAIR AND LAUNDRY ROOM ELECTRICAL/CIRCU		1998	5,931	152	39	152		1,314	28
29	PARKING LOT PAVING AND LANDSCAPING		1998	53,109	3,139	15	3,541	402	30,236	29
30	FLOORING		1998	11,516	295	39	295		2,496	30
31	FIRE SAFETY UPGRADE/LIGHTING/EXHAUST/ROOF		1999	57,028	1,462	39	1,462		11,025	31
32	ONE SUMP PUMP ASSEMBLY		2000	4,200	153	27.5	153		937	32
33	RELOCATION OF A/C UNIT		2000	3,015	109	27.5	109		679	33
34	INSTALL PULL STATION & REWIRE BLDG		2000	5,878	214	27.5	214		1,311	34
35	CONCRETE STAIRS & RAMP REPLACEMENT		2001	20,000	727	27.5	727		4,029	35
36	REPLACEMENT CARPET-1ST FLOOR		2001	2,422	140	20	121	(19)	726	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number AVENUE CARE CENTER

# 0033340

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	LANDSCAPE INSTALLATION	2001	\$ 2,910	\$ 181	15	\$ 194	\$ 13	\$ 1,328	37
38	REPAIR PASSENGER & SMALL SERVICE ELEVATORS	2001	11,654	424	27.5	424		2,244	38
39	DECK	2001	12,170	758	15	811	53	5,556	39
40	SECOND FLOOR RESIDENT ROOMS-CLOSETS	2001	26,075	948	27.5	948		4,938	40
41	REPLACE PUMP MOTOR ON THE PASSENGER ELEVATOR	2002	2,580	94	27.5	94		466	41
42	BATHROOMS - INSTALLATION OF NEW SHEET VINYL	2002	1,297	47	27.5	47		190	42
43	RESIDENT BATHROOMS-NEW FLOOR	2003	3,274	119	27.5	119		461	43
44	INSTALLATION OF FIRE SPRINKLERS	2003	3,454	126	27.5	126		488	44
45	INSTALL NEW FRAMES FOR SLIDING DOORS	2003	2,765	101	27.5	101		357	45
46	BASEMENT CORRIDOR - FLOORING	2003	7,286	265	27.5	265		894	46
47	REPLACEMENT OF SEWER PIPES	2003	13,436	488	27.5	488		1,718	47
48	RECOVERY EXISTING CANOPY	2004	2,500	91	27.5	91		254	48
49	REMODELING BATHROOMS	2004	14,490	527	27.5	526	(1)	1,072	49
50	PAINTING HALLWAY	2005	15,280	5,195	20	764	(4,431)	1,528	50
51	INSTALL NEW SIGNS	2006	4,100	160	15	273	113	273	51
52	NEW LANDSCAPING	2006	26,080	1,014	15	1,739	725	1,739	52
53	REPLACED HOT WATER HEATER	2006	5,185	87	27.5	87		87	53
54	INSTALL SMOKE DETECTORS & FIRE ALARM SYSTEM	2006	10,239	171	27.5	171		171	54
55	INSTALL NEW ROOF DRAINS	2006	2,850	47	27.5	47		47	55
56	INSTALL EMERGENCY LIGHTS	2006	3,552	59	27.5	59		59	56
57	INSTALL NEW SHRUB ZONE	2006	2,125	35	27.5	35		35	57
58	3RD FLOOR SHOWERS	2006	22,568	377	27.5	377		377	58
59	RELATED PARTY ALLOCATION								59
60	CAREPLUS REHAB								60
61	NEW ROOF VENTILATOR	2003	909	23	39	23			61
62									62
63	CAREPLUS MGMT								63
64	BUILDING-TAG-18 PROPERTIES	2004	58,370	1,462	39	1,462			64
65	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES	2004	22,931	866	39	866			65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,749,989	\$ 130,957		\$ 128,718	\$ (2,239)	\$ 1,409,273	70

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

Facility Name & ID Number AVENUE CARE CENTER

# 0033340

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	\$ 201,487	\$ 13,899	\$ 20,103	\$ 6,204		\$ 125,078	71
72	Current Year Purchases	21,224	4,245	1,062	(3,183)		1,062	72
73	Fully Depreciated Assets	89,227			0		89,227	73
74	<b>RELATED PARTY SL DEPRECIATION</b>		14,020	14,020	0			74
75	<b>TOTALS</b>	\$ 311,938	\$ 32,164	\$ 35,185	\$ 3,021		\$ 215,367	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	<b>TOTALS</b>			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,161,927	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 163,121	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 163,903	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 782	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,624,640	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	<b>TOTALS</b>	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A - RELATED PARTY

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

If NO, see instructions.  YES  NO

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

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 43,382 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	CAREPLUS MGMT		\$ SEE ATTACHED	\$ 4,254	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 4,254	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	<b>TOTALS</b>	\$ 0	\$ 0	\$ 0	\$ 0
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 0			

**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**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 55,962	\$		\$ 55,962	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			554			554	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			110,142			110,142	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				69,246		69,246	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Radiology, laboratory Other (specify): <u>Med. Supplies</u>	39-2 39-2					2,794 720		2,794 720	13
14	<b>TOTAL</b>			\$		\$ 166,658	\$ 72,760		\$ 239,418	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number AVENUE CARE CENTER

# 0033340

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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	\$ 499	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 206,391 )	2,197,803		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	94,596		6
7	Other Prepaid Expenses	23,104		7
8	Accounts Receivable (owners or related parties)	1,329,422		8
9	Other(specify): Real Estate Tax Escrow	108,444		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,753,868	\$ 0	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	611,926		15
16	Equipment, at Historical Cost	321,542		16
17	Accumulated Depreciation (book methods)	(457,754)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	270,548		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 746,262	\$ 0	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,500,130	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 638,790	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,426		28
29	Short-Term Notes Payable	65,176		29
30	Accrued Salaries Payable	140,356		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,637		31
32	Accrued Real Estate Taxes(Sch.IX-B)	179,830		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,092,215	\$ 0	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 0	\$ 0	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,092,215	\$ 0	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,407,915	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,500,130	\$ 0	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 3,402,219	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>POST CLOSING ADJ</b>	(393,691)	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 3,008,528	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	399,387	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 399,387	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ 0	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 3,407,915	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 5,959,858	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,959,858	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 0	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	4,800	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 4,800	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	75,440	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 75,440	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 0	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,040,098	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	938,866	31
32	Health Care	1,953,795	32
33	General Administration	1,634,376	33
	<b>B. Capital Expense</b>		
34	Ownership	789,393	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	239,418	35
36	Provider Participation Fee	84,863	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,640,711	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	399,387	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 399,387	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number AVENUE CARE CENTER

# 0033340

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**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	1,900	2,051	\$ 64,349	\$ 31.37	1
2	Assistant Director of Nursing	1,358	1,465	45,975	31.38	2
3	Registered Nurses	1,788	1,803	44,467	24.66	3
4	Licensed Practical Nurses	27,272	27,985	601,274	21.49	4
5	CNAs & Orderlies	66,234	70,743	637,829	9.02	5
6	CNA Trainees					6
7	Licensed Therapist	314	390	9,435	24.19	7
8	Rehab/Therapy Aides	5,799	6,391	65,900	10.31	8
9	Activity Director	1,902	2,035	24,549	12.06	9
10	Activity Assistants	7,607	8,199	70,869	8.64	10
11	Social Service Workers	6,481	6,916	136,189	19.69	11
12	Dietician					12
13	Food Service Supervisor	2,005	2,128	33,649	15.81	13
14	Head Cook	5,377	5,775	46,601	8.07	14
15	Cook Helpers/Assistants	11,025	12,171	103,094	8.47	15
16	Dishwashers					16
17	Maintenance Workers	5,620	5,946	59,434	10.00	17
18	Housekeepers	14,427	15,214	130,318	8.57	18
19	Laundry	5,297	5,806	53,911	9.29	19
20	Administrator	1,516	1,656	56,969	34.40	20
21	Assistant Administrator	1,731	1,838	43,026	23.41	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,535	5,849	63,283	10.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,792	1,889	17,505	9.27	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	174,980	186,250	\$ 2,308,626 *	\$ 12.40	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	M	\$ 9,347	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	1,440	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,440	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,927	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) <u>Program Consultant</u>	S	64,513	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 95,467		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
MARYANN WRIGHT	ADMINISTRATOR	0.00%	\$ 18,960	Workers' Compensation Insurance	\$ 64,072	IDPH License Fee	\$	
DARNELL FORTNEY	ADMINISTRATOR	0.00%	11,144	Unemployment Compensation Insurance	96,166	Advertising: Employee Recruitment	36,820	
ELI RAY	ADMINISTRATOR	0.00%	26,865	FICA Taxes	174,906	Health Care Worker Background Check	184	
MILA JEFFREY	ASST ADMIN	0.00%	43,026	Employee Health Insurance	51,545	(Indicate # of checks performed <u>18</u> )		
				Employee Meals	18,560	Patient Background Checks	15	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	300	
				EMPLOYEE BENEFITS - OTHER	1,587	MARKETING/ADV/PROMO	8,542	
				EMPLOYEE PHYSICAL EXAMS	144	LICENSES/DUES/SUBSCRIPTIONS	9,158	
				PENSION/PROFIT SHARING PLANS	26,457	MGMT CO ALLOC	2,457	
				CHICAGO HEAD TAX	3,712	TRUST/FRANCHISE/CONTRIB/ETC	(300)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	( 0 )	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(3,344)	
						Yellow page advertising	(5,198)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 99,995	TOTAL (agree to Schedule V, line 22, col.8)	\$ 437,149	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 48,772	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
CAREPLUS MGMT MANAGEMENT FEES			\$ 330,000			\$	Out-of-State Travel	\$
							In-State Travel	
								0
							MGMT CO ALLOC	1,076
							Seminar Expense	
								606
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 330,000	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 1,682
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			234,876					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 234,876					

\* Attach copy of IMRF notifications

\*\*See instructions.

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 Amount of Expense Amortized Per Year								
					6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010	14 FY2011
1	PAINT/DECORATING	07/05	\$ 1,500	3 YRS	\$	\$	\$ 250	\$ 500	\$ 500	\$ 250	\$	\$	\$
2	PAINT/DECORATING	07/06	8,150	3 YRS				1,359	2,716	2,716	1,359		
3													
4													
5													
6													
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16													
17													
18													
19													
20	<b>TOTALS</b>		\$ 9,650		\$	\$	\$ 250	\$ 1,859	\$ 3,216	\$ 2,966	\$ 1,359	\$	\$

Facility Name &amp; ID Number AVENUE CARE CENTER

# 0033340

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL ASSOC. OF HEALTHCARE \$1085
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 887 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 84,863  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 18,560 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees