

Facility Name & ID Number BOURBONNAIS TERRACE

0021550 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	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3	97	Intermediate (ICF)	97	35,405	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	71,905	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	13,362	910		14,272	8
9	SNF/PED					9
10	ICF	53,448	449		53,897	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,810	1,359		68,169	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.80%

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

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

NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/01/06

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/01/06 NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number **BOURBONNAIS TERRACE** # **0021550** 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
	A. General Services										
1	Dietary	317,441	21,561	10,080	349,082		349,082	0	349,082		1
2	Food Purchase		261,436		261,436	(6,789)	254,647	(266)	254,381		2
3	Housekeeping	259,209	25,143	0	284,352		284,352	0	284,352		3
4	Laundry	91,899	16,035	4,430	112,364	0	112,364	1,539	113,903		4
5	Heat and Other Utilities			137,700	137,700		137,700	464	138,164		5
6	Maintenance	109,594	15,994	34,981	160,569		160,569	9,008	169,577		6
7	Other (specify):*			10,917	10,917		10,917	112	11,029		7
8	TOTAL General Services	778,143	340,169	198,108	1,316,420	(6,789)	1,309,631	10,857	1,320,488		8
	B. Health Care and Programs										
9	Medical Director	0		5,776	5,776		5,776	0	5,776		9
10	Nursing and Medical Records	1,875,017	41,096	17,841	1,933,954		1,933,954	0	1,933,954		10
10a	Therapy	57,754		2,966	60,720		60,720	0	60,720		10a
11	Activities	99,209	7,580	2,178	108,967		108,967	0	108,967		11
12	Social Services	153,314		2,709	156,023		156,023	0	156,023		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	2,185,294	48,676	31,470	2,265,440	0	2,265,440	0	2,265,440		16
	C. General Administration										
17	Administrative	75,207		456,894	532,101		532,101	(423,235)	108,866		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			65,524	65,524		65,524	1,489	67,013		19
20	Dues, Fees, Subscriptions & Promotions			14,959	14,959		14,959	3,019	17,978		20
21	Clerical & General Office Expenses	104,603	25,800	130,618	261,021		261,021	(80,801)	180,220		21
22	Employee Benefits & Payroll Taxes			519,107	519,107	6,789	525,896	0	525,896		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			3,533	3,533		3,533	9	3,542		24
25	Other Admin. Staff Transportation			8,040	8,040		8,040	838	8,878		25
26	Insurance-Prop.Liab.Malpractice			91,600	91,600		91,600	702	92,302		26
27	Other (specify):*			106,894	106,894		106,894	(93,691)	13,203		27
28	TOTAL General Administration	179,810	25,800	1,397,169	1,602,779	6,789	1,609,568	(591,670)	1,017,898		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,143,247	414,645	1,626,747	5,184,639	0	5,184,639	(580,813)	4,603,826		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	10,080
	REPAIRS & MAINTENANCE	0
		0
		10,080
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	4,430
		0
		4,430
5	HEAT & OTHER UTILITIES	
	GAS HEAT	16,576
	ELECTRICITY	63,330
	WATER	48,977
	CABLE TV - LOBBY	8,817
		0
		137,700
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,909
	PAINTING & DECORATING	711
	BUILDING REPAIRS	1,500
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	23,275
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,052
	FIRE SERVICE	3,534
		0
		0
		0
		0
		34,981
7	OTHER	
	SCAVENGER	10,174
	SECURITY SERVICE	743
		0
		0
		10,917
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	5,776
		5,776

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	814
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	7,410
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	300
	PHARMACY CONSULTANT XVIII B 39-2	7,692
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL	1,625
		0
		17,841
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	2,966
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		2,966
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,178
		0
		2,178
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	2,709
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,709
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	456,894
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	14,498
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	51,026
		0
		65,524
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	0
	EMPLOYEE WANT ADS XIX F	2,400
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	7,458
	LICENSES & PERMITS XIX F	2,300
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,591
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,210
	PATIENT BACKGROUND CHECKS XIX F	0
		14,959
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,854
	EQUIPMENT REPAIR & MAINTENANCE	110
	OUTSIDE CLERICAL SERVICES	116,000
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	12,654
	MESSENGER SERVICE	0
		0
		130,618

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	238,079
	UNEMPLOYMENT COMPENSATION XIX D	38,671
	WORKERS COMPENSATION INSURANC XIX D	117,182
	HOSPITALIZATION INSURANCE XIX D	96,753
	EMPLOYEE BENEFITS - OTHER XIX D	850
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	27,572
	CHICAGO HEAD TAX XIX D	0
		0
		519,107
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	3,533
	TRAVEL XIX G	0
		3,533
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	8,040
		8,040
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	91,600
		91,600
27	OTHER	
	BAD DEBTS VI 24	106,894
		106,894

GRAND TOTAL COLUMN 3 OTHER

1,626,747

BOURBONNAIS TERRACE
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	261,436	PATIENT MEALS	204507
LESS SALES TAX	(266)	ADD EMPLOYEE MEALS	5475
	-----		-----
NET FOOD	261,170	TOTAL MEALS/YEAR	209982
TOTAL PATIENT CENSUS	68,169	NET FOOD	261170
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	209982

TOTAL PATIENT MEALS	204507	COST PER MEAL	1.24
		TIME EMPLOYEE MEALS	5475
ADD # EMPLOYEE MEALS/DAY	15		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	6789
	-----		=====
TOTAL EMPLOYEE MEALS	5475		

Facility Name & ID Number

BOURBONNAIS TERRACE

#0021550

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	
	D. Ownership											
30	Depreciation			31,442	31,442		31,442	29,579	61,021			30
31	Amortization of Pre-Op. & Org.			17,890	17,890		17,890	0	17,890			31
32	Interest			258,248	258,248		258,248	(113,026)	145,222			32
33	Real Estate Taxes			69,847	69,847		69,847	1,959	71,806			33
34	Rent-Facility & Grounds			205,874	205,874		205,874	0	205,874			34
35	Rent-Equipment & Vehicles			34,594	34,594		34,594	4,553	39,147			35
36	Other (specify):* IME rent, amort software			15,768	15,768		15,768	(15,366)	402			36
37	TOTAL Ownership			633,663	633,663	0	633,663	(92,301)	541,362			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			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			107,858	107,858		107,858	0	107,858			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	107,858	107,858	0	107,858	0	107,858			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,143,247	414,645	2,368,268	5,926,160	0	5,926,160	(673,114)	5,253,046			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 **BOURBONNAIS TERRACE**

0021550

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	27,662	30		9
10	Interest and Other Investment Income	(115,758)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(266)	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	0	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(10,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(106,894)	27		24
25	Fund Raising, Advertising and Promotional	0	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,591)	20		28
29	Other-Attach Schedule	(22,119)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (228,966)		\$ 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)	(444,148)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (444,148)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (673,114)		37

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

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

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

BOURBONNAIS TERRACE

ID# 0021550

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 3,993	6	1
2	MARKETING SALARIES	(2,785)	21	2
3	MANAGEMENT FEES - 6865 FINANCIAL INC	(23,327)	17	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(22,119)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **BOURBONNAIS TERRACE**# **0021550**

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	(266)	0	0	0	0	0	0	0	0	0	0	(266)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	1,539	0	0	0	0	0	0	0	0	1,539	4
5	Heat and Other Utilities	0	0	0	464	0	0	0	0	0	0	0	464	5
6	Maintenance	3,993	2,121	2,048	846	0	0	0	0	0	0	0	9,008	6
7	Other (specify):*	0	0	65	47	0	0	0	0	0	0	0	112	7
8	TOTAL General Services	3,727	2,121	3,652	1,357	0	10,857	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(23,327)	(409,523)	9,615	0	0	0	0	0	0	0	0	(423,235)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,000)	1,211	10,208	70	0	0	0	0	0	0	0	1,489	19
20	Fees, Subscriptions & Promotions	(1,591)	0	4,610	0	0	0	0	0	0	0	0	3,019	20
21	Clerical & General Office Expenses	(2,785)	12,286	(90,389)	87	0	0	0	0	0	0	0	(80,801)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	9	0	0	0	0	0	0	0	0	9	24
25	Other Admin. Staff Transportation	0	334	504	0	0	0	0	0	0	0	0	838	25
26	Insurance-Prop.Liab.Malpractice	0	194	312	196	0	0	0	0	0	0	0	702	26
27	Other (specify):*	(106,894)	5,906	7,297	0	0	0	0	0	0	0	0	(93,691)	27
28	TOTAL General Administration	(144,597)	(389,592)	(57,834)	353	0	(591,670)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(140,870)	(387,471)	(54,182)	1,710	0	(580,813)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	27,662	253	306	1,358	0	0	0	0	0	0	0	29,579	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(115,758)	0	0	2,732	0	0	0	0	0	0	0	(113,026)	32
33	Real Estate Taxes	0	0	0	1,959	0	0	0	0	0	0	0	1,959	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	479	3,625	449	0	0	0	0	0	0	0	4,553	35
36	Other (specify):*	0	0	0	(15,366)	0	0	0	0	0	0	0	(15,366)	36
37	TOTAL Ownership	(88,096)	732	3,931	(8,868)	0	(92,301)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(228,966)	(386,739)	(50,251)	(7,158)	0	(673,114)	45						

Facility Name & ID Number **BOURBONNAIS TERRACE**

0021550

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
				EMI ENTERPRISES	LINCOLNWOOD	MANGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				
				EKS MANAGEMENT	LICOLNWOOD	BOOKKEEPING
				IME REALTY	LICOLNWOOD	HOME OFFICE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 MANAGEMENT FEES	\$ 423,067	EMI ENTERPRISES, INC		\$	(423,067)	1
2	V	6 DRIVER SALARY				2,121	2,121	2
3	V	17 OFFICER SALARY				13,544	13,544	3
4	V	19 ACCOUNTING FEES				1,211	1,211	4
5	V	21 OFFICE EXPENSE				12,286	12,286	5
6	V	25 TRANSPORTATION				334	334	6
7	V	26 INSURANCE				194	194	7
8	V	27 EMPLOYEE BENEFITS				5,906	5,906	8
9	V	30 DEPRECIATION				253	253	9
10	V	35 AUTO LEASE				479	479	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 423,067			\$ 36,328	\$ * (386,739)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 BOOKKEEPING FEES	\$ 116,000	EKS MANAGEMENT		\$	\$ (116,000)
16	V	4 HOUSEKEEPING SALARIES				1,539	1,539
17	V	6 PAINTERS SALRIES				2,048	2,048
18	V	7 SCAVENGER				65	65
19	V	17 CFO SALARY				9,615	9,615
20	V	19 PROFESSIONAL FEES				10,208	10,208
21	V	20 WANT ADS / BACKGR CKS				4,610	4,610
22	V	21 OFFICE EXPENSE				25,611	25,611
23	V	24 IN- STATE TRAVEL				9	9
24	V	25 TRANSPORTATION				504	504
25	V	26 INSURANCE				312	312
26	V	27 EMPLOYEE BENEFITS				7,297	7,297
27	V	30 DEPRECIATION S.L.				306	306
28	V	35 EQUIPMENT RENT				3,625	3,625
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 116,000			\$ 65,749	\$ * (50,251)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	36 OFFICE RENT	\$ 15,366	IME REALTY		\$	\$ (15,366)
16	V	5 UTILITIES				464	464
17	V	6 REPAIRS / MAINT				846	846
18	V	7 ALARM SERVICE				47	47
19	V	19 PROFESSIONAL FEES				70	70
20	V	21 OFFICE EXPENSE				87	87
21	V	26 INSURANCE				196	196
22	V	30 DEPRECIATION S.L.				1,358	1,358
23	V	32 INTEREST				2,732	2,732
24	V	33 R.E. TAX				1,959	1,959
25	V	35 STORAGE FEES				449	449
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		\$ 15,366			\$ 8,208	\$ * (7,158)

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

Facility Name & ID Number

BOURBONNAIS TERRACE

0021550

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	MORRIS ESFORMES	GEN PARTNER	ADMIN.		SEE ATTACHED			SALARY	\$ 13,544	17-7	1
2											2
3											3
4	AVRUM WEINFELD	CFO						SALARY	9,615	17-7	4
5											5
6											6
7											7
8	PHILIP ESFORMES							MGMT FEE	10,500	17-8	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 33,659		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 **BOURBONNAIS TERRACE**

0021550 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 EMI ENTERPRISES
 Street Address 6865 N. LINCOLN AVE
 City / State / Zip Code LICOLNWOOD, IL. 60712
 Phone Number (847)674-5795
 Fax Number (847)674-5794

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	6	DRIVER SALARY	PATIENT DAYS	778,042	14	\$ 28,965	\$ 56,961	\$ 2,121	1
2	17	OFFICER SALARY	PATIENT DAYS	778,042	14	185,000	56,961	13,544	2
3	19	ACCOUNTING FEES	PATIENT DAYS	778,042	14	16,537	56,961	1,211	3
4	21	OFFICE EXPENSE	PATIENT DAYS	778,042	14	167,811	56,961	12,286	4
5	25	TRANSPORTATION	PATIENT DAYS	778,042	14	4,565	56,961	334	5
6	26	INSURANCE	PATIENT DAYS	778,042	14	2,648	56,961	194	6
7	27	EMPLOYEE BENEFITS	PATIENT DAYS	778,042	14	80,669	56,961	5,906	7
8	30	DEPRECIATION	PATIENT DAYS	778,042	14	3,451	56,961	253	8
9	35	AUTO LEASE	PATIENT DAYS	778,042	14	6,544	56,961	479	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					\$ 496,190	\$ 345,993	\$ 36,328	25

Facility Name & ID Number **BOURBONNAIS TERRACE**

0021550 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

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

Name of Related Organization EKS MANAGEMENT
 Street Address 6865 N. LINCOLN AVE.
 City / State / Zip Code LICOLNWOOD,IL.60712
 Phone Number (847)674-5795
 Fax Number (847)674-5794

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	4	HOUSEKEEPING SALARIES	PATIENT DAYS	863,827	14	\$ 19,500	\$ 68,169	\$ 1,539	1
2	6	PAINTERS SALARIES	PATIENT DAYS	863,827	14	25,953	68,169	2,048	2
3	7	SCAVENGER	PATIENT DAYS	863,827	14	825	68,169	65	3
4	17	CFO SALARY- A WEINFELD	PATIENT DAYS	863,827	14	121,844	68,169	9,615	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	863,827	14	129,352	68,169	10,208	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	863,827	14	58,423	68,169	4,610	6
7	21	OFFICE EXPENSE	PATIENT DAYS	863,827	14	324,544	68,169	25,611	7
8	24	IN- STATE TRAVEL	PATIENT DAYS	863,827	14	112	68,169	9	8
9	25	TRANSPORTATION	PATIENT DAYS	863,827	14	6,388	68,169	504	9
10	26	INSURANCE	PATIENT DAYS	863,827	14	3,958	68,169	312	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	863,827	14	92,462	68,169	7,297	11
12	30	DEPRECIATION S.L.	PATIENT DAYS	863,827	14	3,880	68,169	306	12
13	35	EQUIPMENT RENT	PATIENT DAYS	863,827	14	45,937	68,169	3,625	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					\$ 833,178	\$ 496,665	\$ 65,749	25

Facility Name & ID Number **BOURBONNAIS TERRACE**

0021550 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

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

Name of Related Organization IME REALTY
 Street Address 6865 N. LINCOLN AVE
 City / State / Zip Code LICOLNWOOD, IL. 60712
 Phone Number (847)674-5795
 Fax Number (847)674-5794

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	INCOME	344,402	15	\$ 10,404	\$ 15,366	\$ 464	1
2	6	REPAIRS / MAINT	INCOME	344,402	15	18,957	15,366	846	2
3	7	ALARM SERVICE	INCOME	344,402	15	1,056	15,366	47	3
4	19	PROFESSIONAL FEES	INCOME	344,402	15	1,575	15,366	70	4
5	21	OFFICE EXPENSE	INCOME	344,402	15	1,942	15,366	87	5
6	26	INSURANCE	INCOME	344,402	15	4,387	15,366	196	6
7	30	DEPRECIATION S.L.	INCOME	344,402	15	30,446	15,366	1,358	7
8	32	INTEREST	INCOME	344,402	15	61,229	15,366	2,732	8
9	33	R.E. TAX	INCOME	344,402	15	43,904	15,366	1,959	9
10	35	STORAGE FEES	INCOME	344,402	15	10,073	15,366	449	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					\$ 183,973	\$	\$ 8,208	25

Facility Name & ID Number

BOURBONNAIS TERRACE

0021550

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		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	LASALLE BANK		X	MORTGAGE	\$27,208.00	11/01/01	\$ 4,004,402	\$ 0			\$ 209,851	1						
2												2						
3	Related Party- IME										2,732	3						
4												4						
5												5						
Working Capital																		
6	LASALLE BANK		X	LINE OF CREDIT	INTEREST	REVOLV		580,000	REVOLV	PRIME +	48,397	6						
7												7						
8												8						
9	TOTAL Facility Related				\$27,208.00		\$ 4,004,402	\$ 580,000			\$ 260,980	9						
B. Non-Facility Related*																		
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)						\$ 4,004,402	\$ 580,000			\$ 260,980	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.		\$	68,058	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	126,395	2
3. Under or (over) accrual (line 2 minus line 1).		\$	58,337	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	11,510	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	69,847	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	68,535	8
	2002	68,333	9
	2003	66,677	10
	2004	68,058	11
	2005	69,063	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON 2/12 OF 2005 REAL ESTATE BILL

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

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

NOTES:

- 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.**

Facility Name & ID Number BOURBONNAIS TERRACE

0021550

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,232 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

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

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

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

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>165,000</u>		\$ <u>187,600</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	165,000		\$ 187,600	3

Facility Name & ID Number BOURBONNAIS TERRACE

0021550

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	197	1975	1975	\$ 1,838,000	\$		\$	\$	\$ 1,838,000	4
5										5
6	Related									6
7	Party			45,329	1,305	39	1,305			7
8	Office									8
	Improvement Type**									
9	LEASEHOLD IMPROVEMENT		1981	54,211		10			54,211	9
10	LEASEHOLD IMPROVEMENT		1982	17,608		10			17,608	10
11	ROOFING		1983	1,875		15			1,875	11
12	ROOFING		1984	6,215	520	18		(520)	6,215	12
13	IMPROVEMENTS		1987	21,900	579	31.5	695	116	13,900	13
14	STONE DRIVE		1990	7,800	206	31.5	248	42	4,061	14
15	IMPROVEMENTS		1991	26,075	689	31.5	828	139	12,592	15
16	IMPROVEMENTS		1992	38,485	1,018	31.5	1,222	204	17,719	16
17	ROOFING		1993	21,500	459	39	551	92	8,773	17
18	GUTTERS		1994	7,248	155	39	186	31	2,348	18
19	CONCRETE		1994	7,967	170	39	204	34	2,525	19
20	FLOOR		1995	766	16	39	20	4	239	20
21	TILES		1995	1,580	34	39	40	6	480	21
22	FLOOR		1995	934	20	39	24	4	285	22
23	CONCRETE		1995	2,500	53	39	64	11	712	23
24	TILES		1996	5,820	124	39	149	25	1,583	24
25	SEWERS		1996	10,000	214	39	256	42	2,699	25
26	TILES		1996	16,056	343	39	412	69	4,343	26
27	ROOF		1996	21,650	462	39	555	93	5,805	27
28	CONCRETE		1996	7,949	170	39	204	34	2,117	28
29	SCREENS		1996	1,424	30	39	37	7	381	29
30	DISPOSER BASE UNIT		1996	732	16	39	19	3	191	30
31	FLOORING IMPROVEMENTS		1997	16,979	363	39	435	72	4,151	31
32	WINDOWS		1998	1,680	36	39	43	7	387	32
33	INSTALL NEW SIGN		1998	2,643	56	39	68	12	547	33
34	NURSES STATION		1999	3,520	75	39	90	15	702	34
35	KITCHEN UNIT		1999	6,696	143	39	172	29	1,283	35
36	FURNISHING - CARPET/WALLPAPER		1999	16,384	350	7		(350)	16,384	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number BOURBONNAIS TERRACE

0021550

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	
37	FENCE	2000	\$ 2,800	\$ 155	15	\$ 187	\$ 32	\$ 1,270	37
38	DUCT WORK	2000	14,000	424	27.5	509	85	3,118	38
39	IN WALL HEATERS	2000	12,407	376	27.5	451	75	3,138	39
40	IN WALL HEATERS	2000	4,378	133	27.5	159	26	701	40
41	FURNISHINGS	2000	23,248	1,038	7	3,321	2,283	23,248	41
42	DOORS	2000	881	27	27.5	32	5	223	42
43	BATHROOM	2001	2,782	84	27.5	101	17	560	43
44	HVAC UNNITS	2001	15,737	477	27.5	572	95	3,170	44
45	BUILT IN CLOSETS	2001	60,000	1,818	27.5	2,182	364	12,092	45
46	WINDOWS	2001	2,995	91	27.5	109	18	654	46
47	FURNISHINGS	2001	5,208	150	5	1	(149)	5,208	47
48	ROOF	2002	52,300	1,584	27.5	1,902	318	8,955	48
49	HEATING & AIR CON	2002	27,923	846	27.5	1,015	169	4,610	49
50	HEAT/COOL WALL UNITS	2003	2,764	84	27.5	101	17	383	50
51	VINYL FLOORING	2003	10,087	306	27.5	367	61	1,392	51
52	NURSES STATION	2003	27,711	840	27.5	1,008	168	3,234	52
53	ROOF	2003	27,000	818	27.5	982	164	3,151	53
54	DOOR ALARM	2003	1,412	43	27.5	51	8	155	54
55	FURNISHINGS - DRAPES & CARPETS	2003	11,358	458	5	2,272	1,814	9,088	55
56	CUBICLE CURTAINS	2004	16,747	804	5	3,349	2,545	10,047	56
57	SMOKE DETECTORS	2004	15,656	474	27.5	569	95	1,446	57
58	DOORS	2004	9,141	277	27.5	332	55	844	58
59	FLOOR TILE	2004	3,491	106	27.5	127	21	270	59
60	ROOM LIGHT FIXTURES	2005	3,173	96	27.5	116	20	169	60
61	FLOOR TILE	2005	13,646	414	27.5	496	82	723	61
62	ROOF TOP AIR CONDITIONER	2005	8,081	244	27.5	294	50	429	62
63	DOORS	2006	73,082	996	27.5	1,329	333	1,329	63
64	WATER HEATER	2006	3,946	54	27.5	72	18	72	64
65	TERMINAL AIR CONDITIONERS	2006	8,111	110	27.5	147	37	147	65
66	SIDEWALK LIGHTING	2006	7,525	103	27.5	137	34	137	66
67	REFRIGERATION SYSTEM	2006	4,070	56	27.5	74	18	74	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,683,186	\$ 21,092		\$ 30,191	\$ 9,099	\$ 2,122,153	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 302,203	\$ 11,655	\$ 30,218	\$ 18,563	10 YRS	\$ 199,769	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets	498,633			0	10 YRS	498,633	73
74	Related Party		612	612	0			74
75	TOTALS	\$ 800,836	\$ 12,267	\$ 30,830	\$ 18,563		\$ 698,402	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	TOTALS			\$ 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)	\$ 3,671,622	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 33,359	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 61,021	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 27,662	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,820,555	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **GRANITE BOURBONNAIS TERRACE ,LLC**

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:	197		\$ 205,874	5.5	5	3
4	Additions						4
5							5
6							6
7	TOTAL	197		\$ 205,874			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: \$ **23,018** Description: **SEE SCHEDULE ATTACHED**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	MAINT/ACTIVITIES	2006 FORD E350 WAGON	\$ 695.00	\$ 9,109	17
18	PAINTERS	2006 TOWN & COUNTRY	645.00	1,290	18
19	MARKETING	2003 MERCEDES	#####	1,177	19
20					20
21	TOTAL		\$ #####	\$ 11,576	21

10. Effective dates of current rental agreement:

Beginning 11/01/06

Ending 4/30/12

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

Fiscal Year Ending Annual Rent

12. /2007 \$ 1,253,770

13. /2008 \$ 1,264,218

14. /2009 \$ 1,316,458

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 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

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 0	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			0				2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			0				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			0				9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number BOURBONNAIS TERRACE

0021550

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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,280	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 21,435)	788,960		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	133,996		6
7	Other Prepaid Expenses	24,487		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 948,723	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	320,302		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 320,302	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,269,025	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 251,299	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	134,000		29
30	Accrued Salaries Payable	125,515		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,173		31
32	Accrued Real Estate Taxes(Sch.IX-B)	11,510		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 536,497	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 536,497	\$ 0	46
47	TOTAL EQUITY (page 18, line 24)	\$ 732,528	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,269,025	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 0	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	32,528	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) CAPITAL CONTRIBUTED	700,000	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 732,528	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 732,528	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,301,007	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,301,007	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	115,758	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 115,758	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	REALIZED GAIN	7,236,248	28
28a	PRIOR YEAR EXP	(14,258)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,221,990	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,638,755	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,316,420	31
32	Health Care	2,265,440	32
33	General Administration	1,602,779	33
	B. Capital Expense		
34	Ownership	633,663	34
	C. Ancillary Expense		
35	Special Cost Centers	0	35
36	Provider Participation Fee	107,858	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,926,160	40
41	Income before Income Taxes (line 30 minus line 40)**	7,712,595	41
42	Income Taxes	(7,743)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 7,704,852	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 BOURBONNAIS TERRACE

0021550

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	2,086	2,166	\$ 63,829	\$ 29.47	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,160	3,247	73,431	22.62	3
4	Licensed Practical Nurses	23,025	25,114	509,116	20.27	4
5	CNAs & Orderlies	69,687	88,047	1,092,663	12.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,293	4,079	57,754	14.16	8
9	Activity Director					9
10	Activity Assistants	9,466	10,419	99,209	9.52	10
11	Social Service Workers	12,308	12,808	153,314	11.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,398	25,077	317,441	12.66	15
16	Dishwashers					16
17	Maintenance Workers	6,847	7,604	109,594	14.41	17
18	Housekeepers	22,035	25,604	259,209	10.12	18
19	Laundry	5,190	6,995	91,899	13.14	19
20	Administrator	2,086	2,206	75,207	34.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,488	11,211	104,603	9.33	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	1,403	1,482	16,189	10.92	31
32	Other Health C: <u>MDS</u>	6,131	6,330	119,789	18.92	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	196,603	232,389	\$ 3,143,247 *	\$ 13.53	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	\$ 10,080	1-3	35
36	Medical Director	O	5,776	9-3	36
37	Medical Records Consultant	N	300	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	7,692	10-3	39
40	Physical Therapy Consultant	L	2,966	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,178	11-3	44
45	Social Service Consultant	E	2,709	12-3	45
46	Other(specify) <u>DENTAL</u>	S	1,625	10-3	46
47	<u>Psycho Social Consultant</u>		7,410	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 40,736		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	
DEBRA WOOD	ADMINISTRATOR		\$ 75,207	Workers' Compensation Insurance	\$ 117,182	IDPH License Fee	\$	
	ASST ADMIN		0	Unemployment Compensation Insurance	38,671	Advertising: Employee Recruitment	2,400	
				FICA Taxes	238,079	Health Care Worker Background Check	1,210	
				Employee Health Insurance	96,753	(Indicate # of checks performed)		
				Employee Meals	6,789	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	850	MARKETING/ADV/PROMO	1,591	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	9,758	
				PENSION/PROFIT SHARING PLANS	27,572	MGMT CO ALLOC	4,610	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	0	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(0)	
						Yellow page advertising	(1,591)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 75,207	TOTAL (agree to Schedule V, line 22, col.8)	\$ 525,896	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,978	
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
EMI ENTERPRISES MANAGEMENT FEE			\$ 423,067			\$	Out-of-State Travel	\$
PHILIP ESFORMES, INC MANAGEMENR FEE			10,500					
6865 FINANCIAL INC MANAGEMENT FEE			23,327				In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 456,894				Seminar Expense	3,533
							MGMT ALLOC	9
C. Professional Services							Entertainment Expense	()
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
			\$				TOTAL	\$ 3,542
SEE SCHEDULE ATTACHED			65,524					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 65,524	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13													
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
																	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	PAINT/DECORATING	2003	\$ 8,641	3	\$ 1,441	\$ 2,880	\$ 2,880	\$ 1,440	\$	\$	\$	\$	\$												
2	PAINT/DECORATING	2004	3,258	3		543	1,086	1,086	543																
3	PAINT/DECORATING	2005	4,402	3			734	1,467	1,467	734															
4																									
5																									
6																									
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14																									
15																									
16																									
17																									
18																									
19																									
20	TOTALS		\$ 16,301		\$ 1,441	\$ 3,423	\$ 4,700	\$ 3,993	\$ 2,010	\$ 734	\$	\$	\$												

Facility Name & ID Number BOURBONNAIS TERRACE

0021550

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 COUNCIL LONG TERM CARE \$6899
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 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? YES
If YES, give effective date of lease. 11/01/06
- (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 _____ 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. \$ 107,858
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. \$ 6,789 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