

		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>I. IDPH Facility ID Number: <u>0046979</u></p> <p>Facility Name: <u>Eastside Terrace</u></p> <p>Address: <u>3850 East Fulton</u> <u>Decatur</u> <u>62521</u> Number City Zip Code</p> <p>County: <u>Macon</u></p> <p>Telephone Number: <u>(217)422-4884</u> Fax # ()</p> <p>HFS ID Number: <u>57-1203464002</u></p> <p>Date of Initial License for Current Owners: <u>01/01/92</u></p> <p>Type of Ownership:</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 _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</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 _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Patrick E. Bell, CPA</u> Telephone Number: <u>(217)465-6494</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 _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/06</u> to <u>12/31/06</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%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Angela Cornell</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>President</u></td> <td></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Patrick E. Bell, CPA</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>Larsson, Woodyard & Henson LLP</u> <u>702 E Court Paris, IL 61944</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(217)465-6494</u> Fax # <u>(217)465-6499</u></td> <td></td> </tr> </table> <p>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>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Angela Cornell</u>			(Title) <u>President</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>Patrick E. Bell, CPA</u>		(Firm Name & Address) <u>Larsson, Woodyard & Henson LLP</u> <u>702 E Court Paris, IL 61944</u>		(Telephone) <u>(217)465-6494</u> Fax # <u>(217)465-6499</u>	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastside Terrace

0046979 Report Period Beginning: 01/01/06 Ending: 12/31/06

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,287			5,287	13
14	TOTALS	5,287			5,287	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.53%

D. How many bed-hold days during this year were paid by the Department? 175 (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 January 1, 1992

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/01/92 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: 12/31/06 Fiscal Year: N/A

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

STATE OF ILLINOIS

Facility Name & ID Number Eastside Terrace # 0046979 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	14,913	1,225	1,104	17,242		17,242		17,242		1
2	Food Purchase		31,990		31,990		31,990	(541)	31,449		2
3	Housekeeping	7,596	3,802		11,398		11,398		11,398		3
4	Laundry		534		534		534		534		4
5	Heat and Other Utilities			13,852	13,852		13,852	494	14,346		5
6	Maintenance	6,814	1,243	8,524	16,581		16,581	178	16,759		6
7	Other (specify):*										7
8	TOTAL General Services	29,323	38,794	23,480	91,597		91,597	131	91,728		8
B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	185,209	1,661	3,020	189,890	(1,272)	188,618		188,618		10
10a	Therapy										10a
11	Activities	11,791	3,513		15,304		15,304	447	15,751		11
12	Social Services			1,215	1,215		1,215		1,215		12
13	CNA Training					1,272	1,272		1,272		13
14	Program Transportation			6,580	6,580		6,580		6,580		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	197,000	5,174	18,015	220,189		220,189	447	220,636		16
C. General Administration											
17	Administrative	13,421		22,500	35,921		35,921		35,921		17
18	Directors Fees										18
19	Professional Services			4,526	4,526		4,526		4,526		19
20	Dues, Fees, Subscriptions & Promotions			942	942		942		942		20
21	Clerical & General Office Expenses	23,696	1,489	24,255	49,440		49,440	(17,902)	31,538		21
22	Employee Benefits & Payroll Taxes			39,206	39,206		39,206	3,900	43,106		22
23	Inservice Training & Education										23
24	Travel and Seminar			639	639		639		639		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			6,731	6,731		6,731	1,004	7,735		26
27	Other (specify):*										27
28	TOTAL General Administration	37,117	1,489	98,799	137,405		137,405	(12,998)	124,407		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	263,440	45,457	140,294	449,191		449,191	(12,420)	436,771		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Eastside Terrace

#0046979

Report Period Beginning: 01/01/06 Ending: 12/31/06

12/31/06

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			747	747		747	12,598	13,345			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			418	418		418	163	581			32
33	Real Estate Taxes			6,952	6,952		6,952		6,952			33
34	Rent-Facility & Grounds			51,000	51,000		51,000	(17,000)	34,000			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			987	987		987	(987)				36
37	TOTAL Ownership			60,104	60,104		60,104	(5,226)	54,878			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,910	36,910		36,910		36,910			42
43	Other (specify):* Resident Supplies		209		209		209	(209)				43
44	TOTAL Special Cost Centers		209	36,910	37,119		37,119	(209)	36,910			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	263,440	45,666	237,308	546,414		546,414	(17,855)	528,559			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastside Terrace

0046979

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	4,683	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(541)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(987)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(19,112)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (16,457)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(17,000)		34
35	Other- Attach Schedule	15,602		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,398)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (17,855)		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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

SEE ACCOUNTANTS' COMPILATION REPORT

Eastside Terrace

ID# 0046979

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Personal Supplies	\$ (209)	43	1
2	Central Office Expense	(18,624)	21	2
3	Gifts	(279)	21	3
4				4
5	Total Line 29	(19,112)		5
6				6
7				7
8	Depreciation - Bldg.-Owned by Related Party	5,324	30	8
9	Central Office Expense Allocation			9
10	C.O. Water and Sewer	15	5	10
11	C.O. Gas and Electric	479	5	11
12	C.O. Maintenance	178	6	12
13	C.O. Activities	447	11	13
14	C.O. Telephone	1,137	21	14
15	C.O. Office Supplies	364	21	15
16	C.O. Employee Insurance	3,900	22	16
17	C.O. General Insurance	1,004	26	17
18	C.O. Depreciation Expense	2,591	30	18
19	C.O. Interest Expense	163	32	19
20				20
21	Total Line 35	15,602		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	(7,020)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eastside Terrace

0046979

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(541)	0	0	0	0	0	0	0	0	0	0	(541)	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	494	0	0	0	0	0	0	0	0	0	0	494	5
6	Maintenance	178	0	0	0	0	0	0	0	0	0	0	178	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	131	0	0	0	0	0	0	0	0	0	0	131	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	447	0	0	0	0	0	0	0	0	0	0	447	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	447	0	0	0	0	0	0	0	0	0	0	447	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(17,902)	0	0	0	0	0	0	0	0	0	0	(17,902)	21
22	Employee Benefits & Payroll Taxes	3,900	0	0	0	0	0	0	0	0	0	0	3,900	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	1,004	0	0	0	0	0	0	0	0	0	0	1,004	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(12,998)	0	0	0	0	0	0	0	0	0	0	(12,998)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(12,420)	0	0	0	0	0	0	0	0	0	0	(12,420)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eastside Terrace# 0046979

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	12,598	0	0	0	0	0	0	0	0	0	0	12,598	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	163	0	0	0	0	0	0	0	0	0	0	163	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(17,000)	0	0	0	0	0	0	0	0	0	(17,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(987)	0	0	0	0	0	0	0	0	0	0	(987)	36
37	TOTAL Ownership	11,774	(17,000)	0	(5,226)	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):* Resident Supplies	(209)	0	0	0	0	0	0	0	0	0	0	(209)	43
44	TOTAL Special Cost Centers	(209)	0	0	0	0	0	0	0	0	0	0	(209)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(855)	(17,000)	0	(17,855)	45								

Facility Name & ID Number Eastside Terrace

0046979

Report Period Beginning: 01/01/06

Ending: 12/31/06

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
Scott Cornell	100%	See Attached	Geneva, FL	Angela Barr-Cornell	Geneva, FL	Empl-Clerical

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	17-3 Admin Management	\$ 22,500	Scott Cornell	100.00%	\$ 22,500		1
2	V	34 Building Rent	17,000	Estate of Scott Cornell 1/3 ownership in lease	100.00%		(17,000)	2
3	V							3
4	V							4
5	V							5
6	V	Sch VIII Central Office	10,278			10,278		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 49,778			\$ 32,778	\$ * (17,000)	14

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

Facility Name & ID Number Eastside Terrace # 0046979 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	Scott Cornell	Owner	Admin. Mgmt	100.00	90,000	6	16.60		\$ 22,500	17-3	1
2	Angela Barr-Cornell	Spouse of Owner	Clerical/Mgmt	100.00	64,980	8	20.00		16,245	21-1	2
3	Jason Cornell	Son of Owner	Maint	0.00	2,080	8	20.00				3
4	Scott Cornell	Officer	Officer	100.00	13,623				3,406	17-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 42,151		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastside Terrace # 0046979 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 Scott Cornell
 Street Address 681 Pine Hill Blvd
 City / State / Zip Code Geneva, FL 32732
 Phone Number ()
 Fax Number ()

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	See Attached								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastside Terrace # 0046979 Report Period Beginning: 01/01/06 Ending: 12/31/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense		
		YES	NO				Original	Balance					7
	A. Directly Facility Related												
	Long-Term												
1	Hickory Point Bank		X	2005 Chevy Van	\$521.00	06/09/05	\$ 14,761	\$ 6,104	12/09/07	4.5000	\$ 418	1	
2												2	
3	Central Office											163	3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related				\$521.00		\$ 14,761	\$ 6,104			\$ 581	9	
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 14,761	\$ 6,104			\$ 581	15	

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

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

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

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,

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eastside Terrace COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0046979

CONTACT PERSON REGARDING THIS REPORT Janet Byers

TELEPHONE (217)422-4725 FAX #: ()

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of total 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>09-13-20-303-010</u>	<u>Nursing Home Facility</u>	<u>\$ 7,465.00</u>	<u>\$ 7,465.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		<u>\$ 7,465.00</u>	<u>\$ 7,465.00</u>

B. Real Estate Tax Cost Allocation:

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,400 B. General Construction Type: Exterior RBB & B/Vinyl Frame Wood Number of Stories 1

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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Per 93 Audit			\$ 44,534	1
2					2
3	TOTALS			\$ 44,534	3

SEE ACCOUNTANTS' COMPILATION REPORT

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				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Landscaping	1991		525	15	10		(15)	525
10	Carpet	1992		361		7			361
11	Landscaping	1992		2,285	135	15	152	17	2,218
12	Carpet	1993		294		10			294
13	Blacktop	1993		1,100		10			1,100
14	Carpet	1993		1,561		10			1,561
15	Carpet	1995		3,704		10			3,704
16	Carpet	1997		998		10	100		998
17	Bathroom Vinyl & Installation	1997		360		10	36	36	360
18	Vinyl Flooring	1998		652		10	65	65	652
19	Bathroom Vinyl	1999		344		10	34	34	344
20	Water Heater	2000		425	38	10	43	5	411
21	Fencing	2003		3,557	137	20	178	41	2,326
22									
23									
24	Central Office						7,915	7,915	
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
37		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70	TOTAL (lines 4 thru 69)	\$ 16,166	\$ 325		\$ 8,523	\$ 8,098	\$ 14,854

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 654	\$ 75	\$ 42	\$ (33)	7	\$ 628	71
72	Current Year Purchases	347	347	20	(327)	7	347	72
73	Fully Depreciated Assets	16,225		1,478	1,478	7	16,225	73
74								74
75	TOTALS	\$ 17,226	\$ 422	\$ 1,540	\$ 1,118		\$ 17,200	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	Transportation	1991 Chevy Pickup	1992	\$ 16,519	\$	\$	\$	5	\$ 16,519	76
77	Transportation	2005 Chevy Van	2005	16,409		3,282	3,282	5	16,409	77
78										78
79										79
80	TOTALS			\$ 32,928	\$	\$ 3,282	\$ 3,282		\$ 32,928	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)	\$ 110,854	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 747	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 13,345	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,598	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 64,982	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	N/A				89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94	N/A		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: Alfred Kreckman, Dewey Barr and Estate of Scott Cornell
 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: <u>1991</u>	<u>16</u>	<u>01/01/92</u>	\$ <u>51,000</u>	<u>15</u>	<u>0</u>	3
4	Additions						4
5							5
6							6
7	TOTAL	16		\$ 51,000			7

10. Effective dates of current rental agreement:
 Beginning 05/14/91
 Ending 05/14/07

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

	Fiscal Year Ending	Annual Rent
12.	<u>12/31/07</u>	\$ <u>51,000</u>
13.	<u>12/31/08</u>	\$ <u>51,000</u>
14.	<u>12/31/09</u>	\$ <u>51,000</u>

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: \$ _____ Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

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

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

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input type="checkbox"/> NO	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER CNA <u>80</u>
		HOURS PER CNA <u>40</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		310		310
4	Clinical Wages (b)		620		620
5	In-House Trainer Wages (c)		342		342
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,272	\$	\$ 1,272
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,272		

- (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.

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts		N/A			#VALUE!		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			\$		\$	\$	#VALUE!	\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Eastside Terrace # 0046979 Report Period Beginning: 01/01/06 Ending: 12/31/06
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/06 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (6,966)	\$ 43,940	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	177,951	722,204	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,180	40,010	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,500	230,942	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 181,665	\$ 1,037,096	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	16,166	246,175	15
16	Equipment, at Historical Cost	50,154	230,549	16
17	Accumulated Depreciation (book methods)	(64,982)	(407,253)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,338	\$ 69,471	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 183,003	\$ 1,106,567	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 18,025	\$ 87,442	26
27	Officer's Accounts Payable		500	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	6,104	19,169	29
30	Accrued Salaries Payable	5,451	37,163	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,684	8,521	31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,464	30,195	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	987	3,085	35
Other Current Liabilities(specify):				
36	<u>Due to Workshop</u>		8,943	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 39,715	\$ 195,018	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		6,276	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)	\$	\$ 6,276	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 39,715	\$ 201,294	46
47	TOTAL EQUITY(page 18, line 24)	\$ 143,288	\$ 905,273	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 183,003	\$ 1,106,567	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 80,802	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 80,802	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	81,443	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	(18,957)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 62,486	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 143,288	24 *

* This must agree with page 17, line 47.

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STATE OF ILLINOIS

Facility Name & ID Number Eastside Terrace

0046979

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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	\$ 626,621	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 626,621	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	1,355	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)	\$ 1,355	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Loss on F.A	(119)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (119)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 627,857	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	91,597	31
32	Health Care	220,189	32
33	General Administration	137,405	33
B. Capital Expense			
34	Ownership	60,104	34
C. Ancillary Expense			
35	Special Cost Centers	209	35
36	Provider Participation Fee	36,910	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 546,414	40
41	Income before Income Taxes (line 30 minus line 40)**	81,443	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 81,443	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number Eastside Terrace

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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			\$	\$	1
2					2
3	289	291	10,401	35.74	3
4					4
5	15,724	16,595	146,988	8.86	5
6					6
7					7
8					8
9					9
10	1,367	1,367	11,791	8.63	10
11					11
12					12
13					13
14					14
15	1,758	1,758	14,913	8.48	15
16					16
17	392	416	6,814	16.38	17
18	888	888	7,596	8.55	18
19					19
20	364	385	13,421	34.86	20
21					21
22					22
23					23
24	729	748	23,696	31.68	24
25					25
26					26
27					27
28	1,960	2,080	27,820	13.38	28
29					29
30					30
31					31
32					32
33					33
34	23,471	24,528	\$ 263,440 *	\$ 10.74	34

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	24	\$ 1,104	1-3	35
36	Mo Fee	7,200	9-3	36
37				37
38	22	550	10-3	38
39	Mo Fee	1,800	10-3	39
40				40
41				41
42				42
43				43
44				44
45	3	1,215	12-3	45
46				46
47	per Visit	670	10-3	47
48				48
49	TOTAL (lines 35 - 48)	\$ 49 12,539		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50		\$		50
51				51
52		N/A		52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

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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		
Pam Rosendrantz	Adm	0	\$ 4,455	Workers' Compensation Insurance	\$ 7,050	IDPH License Fee	\$		
Anna Brackenbush	Adm	0	5,560	Unemployment Compensation Insurance	9,516	Advertising: Employee Recruitment			
Scott Cornell	Officer	100	3,406	FICA Taxes	20,050	Health Care Worker Background Check (Indicate # of checks performed <u>20</u>)	320		
				Employee Health Insurance	3,900	Patient Background Checks			
				Employee Meals		Dues and Subscriptions	197		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses and Fees	425		
				Simple IRA	2,590				
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 13,421	TOTAL (agree to Schedule V, line 22, col.8)		\$ 43,106	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 942
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	
Scott Cornell			\$ 22,500				Out-of-State Travel	\$	
							In-State Travel	60	
							Seminar Expense	579	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 22,500	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 639
C. Professional Services									
Vendor/Payee	Type		Amount						
Larsson, Woodyard & Henson	Accounting		\$ 4,306						
Kreckman & Anderson	Legal		220						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 4,526						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**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	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8		N/A										
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political 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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (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. \$ 36,910
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? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
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? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? _____
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT