

		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>0003038</u></p> <p>Facility Name: <u>Elmhurst Extended Care Center</u></p> <p>Address: <u>200 East Lake Street</u> <u>Elmhurst</u> <u>60126</u> Number City Zip Code</p> <p>County: <u>DuPage</u></p> <p>Telephone Number: <u>(630) 834-4337</u> Fax # <u>(630) 834-4122</u></p> <p>HFS ID Number: <u>362472961000</u></p> <p>Date of Initial License for Current Owners: <u>02/18/1961</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u> </u></td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other <u> </u></td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other <u> </u></td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-4580</u> Please send copies of desk review and audit adjustments to address on this page.</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u> </u>	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other <u> </u>		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other <u> </u>		<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>08/01/2005</u> to <u>07/31/2006</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> <tr> <td colspan="2"> 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 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmhurst Extended Care Center

0003038 Report Period Beginning: 08/01/2005 Ending: 07/31/2006

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	112	Skilled (SNF)	112	40,880	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,880	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	283	2,202	5,984	8,469	8
9	SNF/PED					9
10	ICF	2,650	20,791		23,441	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,933	22,993	5,984	31,910	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.06%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

Non-allowable costs have been eliminated in Schedule V, Column 7.

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 08/09/1960

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 42 and days of care provided 5,753

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 07/31/06 Fiscal Year: 07/31/06

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

Facility Name & ID Number Elmhurst Extended Care Center # 0003038 Report Period Beginning: 08/01/2005 Ending: 07/31/2006

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	223,520	28,110		251,630		251,630	251,630			1
2	Food Purchase		164,937		164,937		164,937	164,937			2
3	Housekeeping	91,977	33,399		125,376		125,376	125,376			3
4	Laundry	25,792	24,555		50,347		50,347	50,347			4
5	Heat and Other Utilities			131,028	131,028		131,028	131,028			5
6	Maintenance	126,309		125,811	252,120		252,120	252,120			6
7	Other (specify):*										7
8	TOTAL General Services	467,598	251,001	256,839	975,438		975,438	975,438			8
	B. Health Care and Programs										
9	Medical Director			27,500	27,500		27,500	27,500			9
10	Nursing and Medical Records	1,957,255	198,873	55,723	2,211,851		2,211,851	2,211,851			10
10a	Therapy	171,014	634	39,612	211,260		211,260	211,260			10a
11	Activities	78,580	447	1,183	80,210		80,210	80,210			11
12	Social Services	49,602		912	50,514		50,514	50,514			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,256,451	199,954	124,930	2,581,335		2,581,335	2,581,335			16
	C. General Administration										
17	Administrative	142,195			142,195		142,195	142,195			17
18	Directors Fees										18
19	Professional Services			58,493	58,493		58,493	(4,255)	54,238		19
20	Dues, Fees, Subscriptions & Promotions			21,160	21,160		21,160		21,160		20
21	Clerical & General Office Expenses	244,930	13,470	16,788	275,188		275,188	245	275,433		21
22	Employee Benefits & Payroll Taxes			435,108	435,108		435,108		435,108		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,780	11,780		11,780	(291)	11,489		24
25	Other Admin. Staff Transportation			6,836	6,836		6,836		6,836		25
26	Insurance-Prop.Liab.Malpractice			92,592	92,592		92,592		92,592		26
27	Other (specify):*										27
28	TOTAL General Administration	387,125	13,470	642,757	1,043,352		1,043,352	(4,301)	1,039,051		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,111,174	464,425	1,024,526	4,600,125		4,600,125	(4,301)	4,595,824		29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number

Elmhurst Extended Care Center

#0003038

Report Period Beginning:

08/01/2005

Ending:

07/31/2006

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			106,592	106,592		106,592	37,227	143,819			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			95,043	95,043		95,043	(5,543)	89,500			32
33	Real Estate Taxes			38,159	38,159		38,159		38,159			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			239,794	239,794		239,794	31,684	271,478			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		191,072		191,072		191,072		191,072			39
40	Barber and Beauty Shops			16,420	16,420		16,420		16,420			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,320	61,320		61,320		61,320			42
43	Other (specify):* Nonallowable Cost			475,043	475,043		475,043	(475,043)				43
44	TOTAL Special Cost Centers		191,072	552,783	743,855		743,855	(475,043)	268,812			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,111,174	655,497	1,817,103	5,583,774		5,583,774	(447,660)	5,136,114			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

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	43,225	30		9
10	Interest and Other Investment Income	(5,543)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11,319)	43		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	(1,412)	43		19
20	Contributions	(15,800)	43		20
21	Owner or Key-Man Insurance	(2,502)	43		21
22	Special Legal Fees & Legal Retainers	(4,255)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,778)	43		24
25	Fund Raising, Advertising and Promotional	(17,407)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(356,700)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(17,542)	43		28
29	Other-Attach Schedule <u>See page 5A</u>	(36,627)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (447,660)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (447,660)		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

Elmhurst Extended Care Center

ID# 0003038

Report Period Beginning: 08/01/2005

Ending: 07/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Board of Directors fees	\$ (3,622)	43	1
2	Lab and x-ray fees	(15,593)	43	2
3	Vending expense	(11,368)	43	3
4	Non-care related depreciation	(5,998)	43	4
5	Offset miscellaneous income	245	21	5
6	Prepaid seminar expense	(291)	24	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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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	(36,627)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmhurst Extended Care Center# 0003038

Report Period Beginning:

08/01/2005

Ending:

07/31/2006

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

	Operating Expenses	PAGES	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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	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	(4,255)	0	0	0	0	0	0	0	0	0	0	(4,255)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	245	0	0	0	0	0	0	0	0	0	0	245	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	(291)	0	0	0	0	0	0	0	0	0	0	(291)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(4,301)	0	(4,301)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,301)	0	(4,301)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmhurst Extended Care Center# 0003038

Report Period Beginning:

08/01/2005 Ending:07/31/2006

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	43,225	0	0	0	0	0	0	0	0	0	0	43,225	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,543)	0	0	0	0	0	0	0	0	0	0	(5,543)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	37,682	0	37,682	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):*	(481,041)	0	0	0	0	0	0	0	0	0	0	(481,041)	43
44	TOTAL Special Cost Centers	(481,041)	0	(481,041)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(447,660)	0	(447,660)	45									

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John Massard	100	N/A		N/A		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V			N/A				3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Elmhurst Extended Care Center # 0003038 Report Period Beginning: 08/01/2005 Ending: 07/31/2006

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	John Massard	President/Owner	Administrator	100.00	None	40	100.00	Salary	\$ 142,195	17(1)	1
2	Peggy Massard	Secretary/Bkpr	Secretary/Bkpr	0.00	None	40	100.00	Salary	91,677	21(1)	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 233,872		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 Elmhurst Extended Care Center

0003038

Report Period Beginning:

08/01/2005

Ending: 7/31/2006

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 N/A

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3			N/A						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

Elmhurst Extended Care Center

0003038

Report Period Beginning:

08/01/2005

Ending:

07/31/2006

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Itasca Bank & Trust Company		X	Mortgage	\$11,039.89	06/14/04	\$ 1,700,000	\$ 1,226,108	06/14/29	various	\$ 91,755	1								
2												2								
3												3								
4							Amortization of mortgage costs				3,288	4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$11,039.89		\$ 1,700,000	\$ 1,226,108			\$ 95,043	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13							Interest income offset				(5,543)	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (5,543)	14								
15	TOTALS (line 9+line14)						\$ 1,700,000	\$ 1,226,108			\$ 89,500	15								

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

* 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, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmhurst Extended Care Center COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0003038

CONTACT PERSON REGARDING THIS REPORT John Massard

TELEPHONE (630) 834-4337 FAX #: (630) 834-4122

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>03-36-309-029</u>	<u>Nursing Home</u>	\$ <u>40,029.24</u>	\$ <u>40,029.24</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>40,029.24</u>	\$ <u>40,029.24</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number Elmhurst Extended Care Center

0003038

Report Period Beginning:

08/01/2005 Ending:

07/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,019 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>41,851</u>	<u>1961</u>	<u>\$ 92,016</u>	<u>1</u>
2	<u>Parking Lot</u>			<u>6,950</u>	<u>2</u>
3	TOTALS	41,851		\$ 98,966	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmhurst Extended Care Center# 0003038

Report Period Beginning:

08/01/2005 Ending: 07/31/2006

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	39	1961	1961	\$ 122,779	\$	40	\$	\$	\$ 122,779	4
5	73	1976	1976	1,174,345	18,386	40	18,878	492	964,909	5
6		1980	1980	46,390	1,056	40	1,160	104	50,255	6
7		1998	1998	700		10	70	70	560	7
8		1998	1998	43,075	2,872	15	2,872		21,538	8
Improvement Type**										
9	Other		1983	7,336		12			7,336	9
10	Other		1984	5,800		15			5,800	10
11	Other		1987	1,630		10			1,630	11
12	Other		1989	7,744		10			7,744	12
13	Front walk		1995	4,900	209	10		(209)	4,900	13
14	Ceiling tile		1996	4,960	279	20	248	(31)	2,536	14
15	New sign		1997	11,049	1,105	10	1,105		10,435	15
16	Retaining wall		1998	6,800	303	10	680	377	5,485	16
17	Fire dampers		1999	6,169	330	10	617	287	4,627	17
18	Rewiring		1999	4,356	234	10	436	202	3,268	18
19	Tile		1999	2,945	204	20	147	(57)	1,104	19
20	Wood fence		2000	1,349	144	10	135	(9)	877	20
21	Parking lot		2000	1,000	103	10	100	(3)	650	21
22	Hand rail		2001	1,813	152	10	181	29	997	22
23	Rail		2001	2,527	206	10	253	47	1,390	23
24	Kitchen air unit		2002	17,790	890	20	890		3,916	24
25	Gates and railing		2002	2,500	205	20	125	(80)	550	25
26	Laundry exhaust ductwork		2003	1,980	173	10	198	25	693	26
27	Basement corridor flooring		2004	3,335	220	20	167	(53)	417	27
28	Tile and cover base		2004	926	61	20	46	(15)	115	28
29	Tile and cover base		2004	2,248	176	20	112	(64)	280	29
30	Outside improvements		2004	91,411	4,062	20	4,571	509	11,427	30
31	Breaker and amp		2005	5,930	1,493	10	593	(900)	840	31
32	Wallpaper, flooring, painting		2004	44,630	4,463	10	4,463		7,846	32
33	Locking system		2005	10,357	1,036	10	1,036		1,507	33
34	Counter top		2005	2,899	690	10	290	(400)	459	34
35	Call light system		2005	33,993	3,399	10	3,399		4,229	35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmhurst Extended Care Center

0003038

Report Period Beginning:

08/01/2005 Ending: 07/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Carpet	2005	\$ 3,913	\$ 1,065	10	\$ 391	\$ (674)	\$ 456	37
38	Flooring	2005	22,881	1,144	20	1,144		1,262	38
39	Alarm system	2005	1,013	101	10	101		143	39
40	Elevator pipe replaced (a)	2005	2,135	214	10	214		285	40
41	Hand rails and bumper guards	2004	6,666	667	20	333	(334)	777	41
42	Ceiling light fixtures	2004	2,347	235	10	235		391	42
43	Privacy curtains	2005	968	97	10	97		129	43
44	Signs	2005	1,697	170	10	170		227	44
45	Ceiling tile	2004	4,117	205	20	205		342	45
46	Door locking system	2005	1,125	113	20	56	(57)	112	46
47	Exhaust fan	2005	835	14	10	14		28	47
48	Thermostat guard	2004	582	58	10	58		102	48
49	Pump in boiler room	2005	1,704	170	10	170		255	49
50	Replace electrical boxes	2005	2,576	129	20	129		150	50
51	Nurses station counter top	2005	1,293	129	10	129		151	51
52	Replace pipes (a)	2005	5,912	591	10	591		788	52
53									53
54	Roof coating	2005	9,800	700	7	700		700	54
55	Baseboards	2005	28,500	2,036	7	2,036		2,036	55
56	Light fixtures	2005	4,097	293	7	293		293	56
57	Tile 1W	2006	7,318	523	7	523		523	57
58	Light fixtures	2006	2,515	180	7	180		180	58
59	Call light system 1W	2006	12,134	867	7	867		867	59
60	Nurses station remodel 1W	2006	4,738	338	7	338		338	60
61	Parking lot pavement	2006	12,000		15				61
62	Dining room renovation	2006	11,055		20				62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,827,587	\$ 52,490		\$ 51,746	\$ (744)	\$ 1,261,634	70

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	\$ 1,011,243	\$ 39,743	\$ 77,714	\$ 37,971	10-20 yrs	\$ 678,016	71
72	Current Year Purchases	145,110	14,359	14,359		5-7 yrs	14,359	72
73	Fully Depreciated Assets	201,212					201,212	73
74								74
75	TOTALS	\$ 1,357,565	\$ 54,102	\$ 92,073	\$ 37,971		\$ 893,587	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	Resident Care	Mini bus	1995	\$ 44,094	\$	\$	\$		\$ 44,094	76
77										77
78										78
79										79
80	TOTALS			\$ 44,094	\$	\$	\$		\$ 44,094	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)	\$ 3,328,212	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 106,592	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 143,819	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 37,227	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,199,315	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	2003 Dodge Ram	\$ 44,099	\$ 5,998	\$ 44,099	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 44,099	\$ 5,998	\$ 44,099	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ N/A 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			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	10A(1), (3)	1892 hrs	\$ 59,693	92	\$ 5,154		1,984	\$ 64,847	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		240	12,480		240	12,480	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1), (2), (3)	3685 hrs	111,321	468	21,978	634	4,153	133,933	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				191,072		191,072	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			\$ 171,014	800	\$ 39,612	\$ 191,706	6,377	\$ 402,332	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmhurst Extended Care Center

0003038

Report Period Beginning: 08/01/2005

Ending: 07/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 07/31/2006

(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	\$ 477,211	\$ 477,211	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 60,000)	332,585	332,585	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	73,022	73,022	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 882,818	\$ 882,818	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	98,966	98,966	13
14	Buildings, at Historical Cost	1,690,739	1,678,052	14
15	Leasehold Improvements, at Historical Cost	149,535	149,535	15
16	Equipment, at Historical Cost	1,289,316	1,401,659	16
17	Accumulated Depreciation (book methods)	(2,531,957)	(2,199,315)	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): <u>See Schedule 17A</u>	22,777	22,777	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 719,376	\$ 1,151,674	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,602,194	\$ 2,034,492	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 86,432	\$ 86,432	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	60,779	60,779	29
30	Accrued Salaries Payable	273,597	273,597	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,500	36,500	32
33	Accrued Interest Payable	4,000	4,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	46,259	46,259	35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	90,727	90,727	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 598,294	\$ 598,294	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,165,329	1,165,329	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)	\$ 1,165,329	\$ 1,165,329	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,763,623	\$ 1,763,623	46
47	TOTAL EQUITY(page 18, line 24)	\$ (161,429)	\$ 270,869	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,602,194	\$ 2,034,492	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Elmhurst Extended Care Center, Inc.
Facility ID#: 0003038
08/01/05 - 07/31/06

Schedule 17A

Balance Sheet - Line 23 - Other

Mortgage fees, net of amortization	9,146
Deposits	<u>13,631</u>
	<u>22,777</u>

Balance Sheet - Line 36 - Other Current Liabilities

401 (k) pension	14,508
Accrued IPAC tax	5,208
Accrued insurance	60,161
Accrued expense payable	<u>10,850</u>
	<u>90,727</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (704,876)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (704,876)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	543,447	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 543,447	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)	\$ (161,429)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 6,028,189	1
2	Discounts and Allowances for all Levels	(1,118,699)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,909,490	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	483,676	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 483,676	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	23,648	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	185,493	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,673	19
20	Radiology and X-Ray	5,028	20
21	Other Medical Services	480,492	21
22	Laundry	6,033	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 713,367	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,543	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,543	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending revenue</u>	15,145	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,145	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,127,221	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	975,438	31
32	Health Care	2,581,335	32
33	General Administration	1,043,352	33
	B. Capital Expense		
34	Ownership	239,794	34
	C. Ancillary Expense		
35	Special Cost Centers	682,535	35
36	Provider Participation Fee	61,320	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,583,774	40
41	Income before Income Taxes (line 30 minus line 40)**	543,447	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 543,447	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.

*** 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 Elmhurst Extended Care Center

0003038

Report Period Beginning: 08/01/2005

Ending: 07/31/2006

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,803	2,000	\$ 87,189	\$ 43.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,862	15,373	438,805	28.54	3
4	Licensed Practical Nurses	16,551	18,355	422,379	23.01	4
5	CNAs & Orderlies	62,244	69,029	844,931	12.24	5
6	CNA Trainees					6
7	Licensed Therapist	5,029	5,577	171,014	30.66	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,876	2,080	36,960	17.77	9
10	Activity Assistants	3,496	3,878	41,620	10.73	10
11	Social Service Workers	2,119	2,350	49,602	21.11	11
12	Dietician	1,876	2,080	46,952	22.57	12
13	Food Service Supervisor					13
14	Head Cook	2,015	2,235	38,222	17.10	14
15	Cook Helpers/Assistants	8,013	8,886	104,281	11.74	15
16	Dishwashers	3,791	4,205	34,065	8.10	16
17	Maintenance Workers	9,838	10,910	126,309	11.58	17
18	Housekeepers	8,346	9,256	91,977	9.94	18
19	Laundry	2,812	3,119	25,792	8.27	19
20	Administrator	1,876	2,080	142,195	68.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,221	8,008	244,930	30.59	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	1,876	2,080	37,149	17.86	31
32	Other Health C: See Sch 20A	3,823	4,240	126,802	29.91	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	158,467	175,741	\$ 3,111,174 *	\$ 17.70	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			35
36	Medical Director	monthly	27,500	9(3) 36
37	Medical Records Consultant	27	1,485	10(3) 37
38	Nurse Consultant	monthly	12,700	10(3) 38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	20	1,183	11(3) 44
45	Social Service Consultant	16	912	12(3) 45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	63	\$ 43,780	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	56	\$ 2,487	10(3) 50
51	Licensed Practical Nurses	274	10,764	10(3) 51
52	Certified Nurse Assistants/Aides	1,101	24,885	10(3) 52
53	TOTAL (lines 50 - 52)	1,431	\$ 38,136	53

SEE ACCOUNTANTS' COMPILATION REPORT

Elmhurst Extended Care Center, Inc.
Facility ID#: 0003038
08/01/05 - 07/31/06

Schedule 20A

Staffing & Salary Cost

<u>Line 32 - Other Healthcare</u>	<u>Hours</u> <u>Worked</u>	<u>Hours</u> <u>Paid</u>	<u>Total</u> <u>Wages</u>	<u>Ave. Hrly.</u> <u>Wage</u>
MDS Coordinator	1,947	2,160	62,702	29.03
Restorative Nurse	1,876	2,080	64,100	30.82
	<u>3,823</u>	<u>4,240</u>	<u>126,802</u>	<u>29.91</u>

Elmhurst Extended Care Center, Inc.
Facility ID#: 0003038
08/01/05 - 07/31/06

Schedule 21A

Schedule 21 (C) - Professional Services

Total agreeing to Schedule V, Line 19, Column 3	58,493
Non allowable legal expenses	<u>(4,255)</u>
Total to Schedule V, Line 19, Column 8	<u><u>54,238</u></u>

Schedule 21 (C) - Professional Services

Additional Services

<u>Vendor</u>	<u>Service</u>	<u>Amount</u>
Hands On Technology	Computer consulting	2,160
Illinois Paper	Computer consulting	621
AdminaStar Federal	Electronic billing consult	25
Corporate Express	Computer consulting	133
ISPINET	Computer consulting	110
Partners in Technology	Computer consulting	960
Midwest Laser Specialists	Computer consulting	491
Sam's Club	Computer consulting	270
Cybercom	Computer consulting	70
	Total to Schedule 21 (C)	<u><u>4,840</u></u>

Schedule 21(G) - Travel & Seminar

Total per attached schedule	11,780
Non-allowable prepaid seminar (07/31/06)	(636)
Non-allowable prepaid seminar (07/31/05) disallowed on prior year cost report	<u>345</u>
Total to Schedule V, Line 24, Column 8	<u><u>11,489</u></u>

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmhurst Extended Care Center# 0003038Report Period Beginning: 08/01/2005Ending: 07/31/2006**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? Yes
If YES, give association name and amount. Illinois Health Care Assn. - 5,873
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (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? 6 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 40,351 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 61,320
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ None Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
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: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (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