

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842 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	300	Skilled (SNF)	300	109,500	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	300	TOTALS	300	109,500	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	44,173	2,135	5,850	52,158	8
9	SNF/PED					9
10	ICF	26,607	299	380	27,286	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	70,780	2,434	6,230	79,444	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.55%

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

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 5/1/76

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 300 and days of care provided 5,689

Medicare Intermediary Mutual of Omaha

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: 12/31/06

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

Facility Name & ID Number Halsted Terrace Nursing Ctr # 0020842 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				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	328,415	78,774	12,930	420,119		420,119	4,815	424,934			1
2	Food Purchase		293,772		293,772	(26,335)	267,437	(89)	267,348			2
3	Housekeeping	340,371	44,897		385,268		385,268	14,545	399,813			3
4	Laundry	95,514	18,403		113,917		113,917		113,917			4
5	Heat and Other Utilities			198,793	198,793		198,793	4,904	203,697			5
6	Maintenance	98,358	62,158	143,715	304,231		304,231	1,850	306,081			6
7	Other (specify):*											7
8	TOTAL General Services	862,658	498,004	355,438	1,716,100	(26,335)	1,689,765	26,025	1,715,790			8
	B. Health Care and Programs											
9	Medical Director			52,960	52,960		52,960		52,960			9
10	Nursing and Medical Records	4,107,289	252,698	93,707	4,453,694		4,453,694	(7,001)	4,446,693			10
10a	Therapy	186,910		2,859	189,769		189,769		189,769			10a
11	Activities	223,620	10,660	2,448	236,728		236,728		236,728			11
12	Social Services	313,134		3,152	316,286		316,286		316,286			12
13	CNA Training											13
14	Program Transportation			703	703		703		703			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,830,953	263,358	155,829	5,250,140		5,250,140	(7,001)	5,243,139			16
	C. General Administration											
17	Administrative	241,751			241,751		241,751	64,025	305,776			17
18	Directors Fees											18
19	Professional Services			877,179	877,179		877,179	(556,927)	320,252			19
20	Dues, Fees, Subscriptions & Promotions			222,690	222,690		222,690	(123,657)	99,033			20
21	Clerical & General Office Expenses	179,103	2,469	511,471	693,043		693,043	(143,141)	549,902			21
22	Employee Benefits & Payroll Taxes			1,014,052	1,014,052	26,335	1,040,387	17,860	1,058,247			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,627	10,627		10,627	1,684	12,311			24
25	Other Admin. Staff Transportation			3,340	3,340		3,340	(1,587)	1,753			25
26	Insurance-Prop.Liab.Malpractice			206,551	206,551		206,551	1,177	207,728			26
27	Other (specify):*							103,946	103,946			27
28	TOTAL General Administration	420,854	2,469	2,845,910	3,269,233	26,335	3,295,568	(636,620)	2,658,948			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,114,465	763,831	3,357,177	10,235,473		10,235,473	(617,596)	9,617,877			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 Halsted Terrace Nursing Ctr #0020842 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			185,065	185,065		185,065	548,027	733,092			30
31	Amortization of Pre-Op. & Org.							214	214			31
32	Interest			428,948	428,948		428,948	253,610	682,558			32
33	Real Estate Taxes							291,270	291,270			33
34	Rent-Facility & Grounds			960,884	960,884		960,884	(958,125)	2,759			34
35	Rent-Equipment & Vehicles			67,317	67,317		67,317	(22,251)	45,066			35
36	Other (specify):*							43,099	43,099			36
37	TOTAL Ownership			1,642,214	1,642,214		1,642,214	155,844	1,798,058			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	151,717	201,227	155	353,099		353,099		353,099			39
40	Barber and Beauty Shops			993	993		993	(993)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,250	164,250		164,250		164,250			42
43	Other (specify):*	102,198		7,745	109,943		109,943	(109,943)				43
44	TOTAL Special Cost Centers	253,915	201,227	173,143	628,285		628,285	(110,936)	517,349			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,368,380	965,058	5,172,534	12,505,972		12,505,972	(572,689)	11,933,283			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 Halsted Terrace Nursing Ctr

0020842

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	324,949	30		9
10	Interest and Other Investment Income	(23,853)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(89)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(35,256)	21		18
19	Entertainment				19
20	Contributions	(12,550)	20		20
21	Owner or Key-Man Insurance	17,860	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(365,818)	21		24
25	Fund Raising, Advertising and Promotional	(51,478)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(626,266)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (772,502)		\$	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)	199,813		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 199,813		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (572,689)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line
1 Auto Reimbursement	\$ (272)	25
2 Misc. Income	(234)	21
3 Wage Assignment Fees	(101)	10
4 Veteran expenses - pharmacy	(6,337)	10
5 Bank Charges	(5,129)	21
6 Deferred Income Tax	(150)	21
7 Franchise Tax	(542)	21
8 Public Relations	(62,822)	20
9 Non-Allowable Auto Leases	(25,690)	35
10 Bldg Co. - Accounting Fees	(5,940)	19
11 Bldg Co. - Trust Fees	(500)	19
12 Jury Duty Income	(663)	10
13 Non-Allowable Professional Fees	(3,600)	19
14 Marketing Seminars	(290)	24
15 Non-Allowable Legal	(2,069)	19
16 Confined R & M	(2,910)	06
17 Marketing Salaries	(45,460)	43
18 Marketing Auto Expense	(7,743)	43
19 Non-Allowable Auto Exp.	(1,312)	25
20 Beauty Shop Expense	(993)	40
21 Non-reimbursable Salary	(70,802)	21
22 Marketing Salaries	(6,730)	43
23 Interest Paid to Owners and Related Parties	(185,215)	32
24 Settlements	(113,681)	19
25 Salary Collections	(17,169)	21
26		
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101 Total	(626,266)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

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				4,815								4,815	1
2	Food Purchase	(89)											(89)	2
3	Housekeeping				14,545								14,545	3
4	Laundry													4
5	Heat and Other Utilities				4,904								4,904	5
6	Maintenance	(2,910)			4,760								1,850	6
7	Other (specify):*													7
8	TOTAL General Services	(2,999)			29,024								26,025	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(7,001)											(7,001)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(7,001)											(7,001)	16
	C. General Administration													
17	Administrative			1,489		65,777	(3,241)						64,025	17
18	Directors Fees													18
19	Professional Services	(135,790)	5,940	91	(430,488)	2,393	927						(556,927)	19
20	Fees, Subscriptions & Promotions	(126,850)			3,193								(123,657)	20
21	Clerical & General Office Expenses	(495,100)	500	208	346,646	3,384	1,221						(143,141)	21
22	Employee Benefits & Payroll Taxes	17,860											17,860	22
23	Inservice Training & Education													23
24	Travel and Seminar	(299)			1,977		6						1,684	24
25	Other Admin. Staff Transportation	(1,587)											(1,587)	25
26	Insurance-Prop.Liab.Malpractice				1,177								1,177	26
27	Other (specify):*			172	95,941	3,802	4,031						103,946	27
28	TOTAL General Administration	(741,766)	6,440	1,960	18,446	75,356	2,944						(636,620)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(751,766)	6,440	1,960	47,470	75,356	2,944						(617,596)	29

STATE OF ILLINOIS

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06 Ending:

Summary B

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	324,949	207,762		15,316								548,027	30
31	Amortization of Pre-Op. & Org.				214								214	31
32	Interest	(209,068)	431,494		31,184								253,610	32
33	Real Estate Taxes		279,785		11,485								291,270	33
34	Rent-Facility & Grounds		(958,125)										(958,125)	34
35	Rent-Equipment & Vehicles	(25,680)			3,429								(22,251)	35
36	Other (specify):*		43,099										43,099	36
37	TOTAL Ownership	90,201	4,015		61,628								155,844	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(993)											(993)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(109,943)											(109,943)	43
44	TOTAL Special Cost Centers	(110,936)											(110,936)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(772,502)	10,455	1,960	109,098	75,356	2,944						(572,689)	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
See Attached		See Attached		See Attached		
				Halsted Assoc. Limited Partnership		Building Company

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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	34 Rent	\$ 958,125	Halsted Associates Limited Partnership	100.00%	\$	\$ (958,125)	1
2	V	32 Interest	1,624	Halsted Associates Limited Partnership	100.00%	433,118	431,494	2
3	V	36 Insurance		Halsted Associates Limited Partnership	100.00%	40,061	40,061	3
4	V	19 Accounting		Halsted Associates Limited Partnership	100.00%	5,940	5,940	4
5	V	21 Trust Fees		Halsted Associates Limited Partnership	100.00%	500	500	5
6	V	33 RE Taxes		Halsted Associates Limited Partnership	100.00%	279,785	279,785	6
7	V	30 Depreciation		Halsted Associates Limited Partnership	100.00%	207,762	207,762	7
8	V	36 Amortization of Loan Costs		Halsted Associates Limited Partnership	100.00%	3,038	3,038	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 959,749			\$ 970,204	\$ * 10,455	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr # 0020842 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item	4 Amount	Name of Related Organization						
15	V	17	J. RAJCHENBACH-COMP.	\$	JLR MANAGEMENT CORP.	100.00%	\$ 1,489	1,489	15	
16	V	19	PROFESSIONAL FEES				91	91	16	
17	V	21	OFFICE				208	208	17	
18	V	27	PAYROLL TAXES				172	172	18	
19	V								19	
20	V	17	C. RAJCHENBACH-COMP.						20	
21	V	27	PAYROLL TAXES						21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$			\$ 1,960	\$ *	1,960	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr # 0020842 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1		ITEX / AK CARE COMPANY	100.00%	\$ 4,815	4,815	15
16	V	3				14,545	14,545	16
17	V	5				4,904	4,904	17
18	V	6				4,760	4,760	18
19	V	19				7,611	7,611	19
20	V	20				3,193	3,193	20
21	V	21				29,464	29,464	21
22	V	24				1,977	1,977	22
23	V	26				1,177	1,177	23
24	V	27				1,741	1,741	24
25	V	30				15,316	15,316	25
26	V	31				214	214	26
27	V	32				31,184	31,184	27
28	V	33				11,485	11,485	28
29	V	35				3,429	3,429	29
30	V							30
31	V							31
32	V	21				317,182	317,182	32
33	V	27				94,200	94,200	33
34	V	19	438,099				(438,099)	34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 438,099			\$ 547,197	\$ * 109,098	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17	BERNIE HOLLANDER-SAL.	\$	SHAYMARK MANAGEMENT CORP.	100.00%	\$ 65,777	65,777	15
16	V	19	PROFESSIONAL FEES				2,393	2,393	16
17	V	21	OFFICE				3,384	3,384	17
18	V	27	PAYROLL TAXES				3,802	3,802	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$ 75,356	\$ * 75,356	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 18,971	\$ 18,971	15
16	V	19 PROFESSIONAL FEES				927	927	16
17	V	21 CLERICAL AND GENERAL				1,221	1,221	17
18	V	24 SEMINARS				6	6	18
19	V	27 GEN ADMIN.- EMP. BEN.				4,031	4,031	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V	17 MANAGEMENT FEES	22,212				(22,212)	24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 22,212			\$ 25,156	\$ * 2,944	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr # 0020842 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	Mark Hollander	Relative	Executive	0.00%	See Attadhed	20.00	33.33%	Salary	\$ 67,000	17-1	1
2	Bernard Hollander	President	Management	83.33%	See Attadhed	20.00	30.77%	Shaymark	65,777	17-7	2
3	Jack Rajenbach	Vice President	Management	10.00%	See Attadhed	1.00	1.54%	JLR Alloc	1,489	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 134,266		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 Halsted Terrace Nursing Ctr

0020842

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

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

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

Name of Related Organization JLR MANAGEMENT CORP.
 Street Address 6633 NORTH LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 679-9141
 Fax Number (847) 679-1820

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	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	55	10	\$ 81,900	\$ 81,900	1	\$ 1,489	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	55	10	5,000		1	91	2
3	21	OFFICE	AVG. HOURS WORKED	55	10	11,414	11,414	1	208	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED	55	10	9,486		1	172	4
5										5
6										6
7	17	C. RAJCHENBACH-COMP.	AVG. HOURS WORKED	40	1	60,037	60,037			7
8	27	PAYROLL TAXES	AVG. HOURS WORKED	40	1	4,770				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					\$ 172,607	\$ 153,351		\$ 1,960	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

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 ITEX / AK CARE COMPANY
 Street Address 6633 N. LINCOLN AVE.
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 679-9141
 Fax Number (847) 679-1820

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	DIETARY	AVAILABLE BED DAYS	464,645	5	\$ 20,433	\$ 109,500	\$ 4,815	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	464,645	5	61,719	109,500	14,545	2
3	5	UTILITIES	AVAILABLE BED DAYS	464,645	5	20,809	109,500	4,904	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	464,645	5	20,199	109,500	4,760	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	464,645	5	32,295	109,500	7,611	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	464,645	5	13,550	109,500	3,193	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	464,645	5	125,027	109,500	29,464	7
8	24	EDUCATION/SEMINARS	AVAILABLE BED DAYS	464,645	5	8,388	109,500	1,977	8
9	26	INSURANCE	AVAILABLE BED DAYS	464,645	5	4,996	109,500	1,177	9
10	27	EMPLOYEE BENEFITS	AVAILABLE BED DAYS	464,645	5	7,390	109,500	1,741	10
11	30	DEPRECIATION	AVAILABLE BED DAYS	464,645	5	64,993	109,500	15,316	11
12	31	AMORTIZATION	AVAILABLE BED DAYS	464,645	5	908	109,500	214	12
13	32	INTEREST	AVAILABLE BED DAYS	464,645	5	132,326	109,500	31,184	13
14	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	464,645	5	48,735	109,500	11,485	14
15	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	464,645	5	14,552	109,500	3,429	15
16									16
17									17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		6	957,084	957,084	317,182	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		6	284,246		94,200	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,817,650	\$ 957,084	\$ 547,197	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

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 SHAYMARK MANAGEMENT CORP.
 Street Address 6633 NORTH LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 679-9141
 Fax Number (847) 679-1820

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	17	BERNIE HOLLANDER-SAL.	AVG. HOURS WORKED	48	5	\$ 157,864	\$ 157,864	20	\$ 65,777	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	48	5	5,742		20	2,393	2
3	21	OFFICE	AVG. HOURS WORKED	48	5	8,121	8,121	20	3,384	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED	48	5	9,125		20	3,802	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					\$ 180,852	\$ 165,985		\$ 75,356	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

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

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

Name of Related Organization CAREPATH HEALTH NETWORK
 Street Address 6633 N LINCOLN AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (888) 707-6700
 Fax Number (847) 679-2150

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	17	ADMINISTRATIVE	CARE PATH FEES	302,112	9	\$ 258,032	\$ 22,212	\$ 18,971	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	302,112	9	12,615	22,212	927	2
3	21	CLERICAL AND GENERAL	CARE PATH FEES	302,112	9	16,607	22,212	1,221	3
4	24	SEMINARS	CARE PATH FEES	302,112	9	75	22,212	6	4
5	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	302,112	9	54,833	22,212	4,031	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					\$ 342,162	\$ 258,032	\$ 25,156	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842 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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Halsted Terrace Nursing Ctr

0020842

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	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	Cambridge		X	Mortgage	\$43,906.00	07/01/03	\$ 8,276,700	\$ 7,977,510	7/1/38	5.4000	\$ 433,118	1										
2	Hill Rom/TCF Leasing		X	Video Equipment				1,456			456	2										
3												3										
4												4										
5	See Supplemental Schedule											5										
	Working Capital																					
6	Bank Leumi		X	Line of Credit				2,165,000			240,199	6										
7	Due to Owners and Related PP	X		Working Capital				3,094,220			185,215	7										
8	See Supplemental Schedule										34,261	8										
9	TOTAL Facility Related				\$43,906.00		\$ 8,276,700	\$ 13,238,186			\$ 893,249	9										
	B. Non-Facility Related*																					
10	Interest Income		X								(23,853)	10										
11	Interest Income (Bldg Co)		X								(1,624)	11										
12	Owners Interest	X									(185,215)	12										
13	See Supplemental Schedule											13										
14	TOTAL Non-Facility Related						\$	\$			(210,692)	14										
15	TOTALS (line 9+line14)						\$ 8,276,700	\$ 13,238,186			\$ 682,557	15										

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 40,061 Line # 36

* 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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term									7										
Working Capital																				
8	A.I.Credit		X	Insurance Financing			\$	\$		\$ 2,558	8									
9	Home Depot		X							519	9									
10	Allocated from ITEX		X							31,184	10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital									34,261	14									
B. Non-Facility Related*																				
15							\$	\$		\$	15									
16											16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related										20									

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 Halsted Terrace Nursing Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0020842

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>25-16-316-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>26,472.31</u>	\$ <u>26,472.31</u>
2. <u>25-16-316-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>27,567.77</u>	\$ <u>27,567.77</u>
3. <u>25-16-332-012-0000</u>	<u>Long Term Care Property</u>	\$ <u>90,298.21</u>	\$ <u>90,298.21</u>
4. <u>25-16-332-013-0000</u>	<u>Long Term Care Property</u>	\$ <u>132,584.72</u>	\$ <u>132,584.72</u>
5. <u>10-35-312-022-0000</u>	<u>Home Office Allocation</u>	\$ <u>50,977.89</u>	\$ <u>11,485.04</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>327,900.90</u>	\$ <u>288,408.05</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Halsted Terrace Nursing Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0020842

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,068 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

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

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

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

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

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

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: 214 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>855,000</u>	1
2					2
3	TOTALS			\$ 855,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9	Various			1978	750		20			750	9
10	Various			1979	12,807		20			12,749	10
11	Various			1980	35,915		20			35,915	11
12	Various			1981	13,910		20			13,910	12
13	Various			1982	8,814		20			8,814	13
14	Various			1983	12,936		20			12,936	14
15	Various			1984	20,560		20			20,560	15
16	Various			1985	18,883		20			18,874	16
17	Various			1986	2,456		20			2,456	17
18	Various			1987	4,000		20	127	127	2,464	18
19	Various			1988	82,596		20	2,621	2,621	47,763	19
20	Various			1989	1,225		20	39	39	677	20
21	Various			1990	91,597		20	3,783	3,783	56,374	21
22	Various			1993	53,620		20	2,681	2,681	39,242	22
23	Various			1995	137,959		20	6,734	6,734	79,853	23
24	Various			1996	538,107		20	26,907	26,907	297,704	24
25	Various			1997	76,548		20	3,910	3,910	37,445	25
26	Various			1998	77,488		20	3,875	3,875	32,991	26
27	Various			1999	278,572		20	13,997	13,997	108,987	27
28	Various			2000	48,393		20	2,248	2,248	15,033	28
29	Various			2001	97,460		20	4,936	4,936	26,200	29
30	Various			2002	25,280		20	2,607	2,607	12,844	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		8,125,379	207,762		406,751	198,989	5,195,672	67
68		467,462	11,715		15,674	3,959	202,096	68
69			185,065			(185,065)		69
70		\$ 10,232,717	\$ 404,542		\$ 496,890	\$ 92,348	\$ 6,282,309	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 10,232,717	\$ 404,542		\$ 496,890	\$ 92,348	\$ 6,282,309	1
2	Wallcoverings	2003	5,601		20			5,601	2
3	Window Treatments	2003	451		20	23	23	90	3
4	Flooring	2003	14,743		20	1,474	1,474	5,897	4
5	Flooring	2003	2,488		20	249	249	995	5
6	Flooring	2003	14,743		20	1,474	1,474	5,897	6
7	Flooring	2003	2,488		20	249	249	995	7
8	Light Fixtures	2003	3,685		20	184	184	722	8
9	Window Treatments	2003	5,305		20	265	265	1,039	9
10	Carpeting	2003	3,146		20	157	157	616	10
11	Flooring	2003	21,810		20	2,181	2,181	8,542	11
12	Flooring	2003	4,550		20	455	455	1,782	12
13	Drapery And Rods	2003	5,882		20	294	294	1,127	13
14	Cleanout Covers	2003	1,700		20	170	170	638	14
15	Carpeting	2003	15,447		20	772	772	2,832	15
16	Insulation	2003	1,208		20	121	121	443	16
17	Insulation	2003	7,422		20	742	742	2,721	17
18	Roof Compressor	2003	14,394		20	720	720	2,579	18
19	Water Pump	2003	1,626		20	81	81	291	19
20	Compressor	2003	2,637		20	132	132	461	20
21	Carpeting	2003	2,663		20	133	133	466	21
22	Wallcovering	2003	21,003		20	1,050	1,050	3,588	22
23	Roof Repairs	2003	6,044		20	604	604	2,115	23
24	Flooring	2003	7,564		20	756	756	2,584	24
25	Flooring	2003	5,600		20	373	373	1,276	25
26	Flooring	2003	66,858		20	4,457	4,457	15,229	26
27	Light Fixtures	2003	780		20	39	39	133	27
28	Computer Cabeling	2003	1,669		20	334	334	1,140	28
29	Flooring	2003	6,113		20	611	611	1,987	29
30	Water Heater Repairs	2003	2,004		20	100	100	326	30
31	Light Fixtures	2003	1,300		20	65	65	211	31
32	Flooring	2003	553		20	55	55	180	32
33	Flooring	2003	8,559		20	856	856	2,782	33
34	TOTAL (lines 1 thru 33)		\$ 10,492,753	\$ 404,542		\$ 516,066	\$ 111,524	\$ 6,357,594	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 10,492,753	\$ 404,542		\$ 516,066	\$ 111,524	\$ 6,357,594	1
2	Flooring	2003	24,530		20	2,453	2,453	7,972	2
3	Light Fixtures	2003	520		20	26	26	82	3
4	Flooring	2003	7,564		20	756	756	2,332	4
5	Flooring	2003	5,600		20	560	560	1,727	5
6	Flooring	2003	66,858		20	6,686	6,686	20,614	6
7	Flooring	2003	8,559		20	856	856	2,639	7
8	Flooring	2003	553		20	55	55	170	8
9	Flooring	2003	6,113		20	611	611	1,885	9
10	Flooring	2003	7,780		20	778	778	2,399	10
11	Flooring	2003	41,155		20	4,116	4,116	12,689	11
12	Room Renovation	2003	10,670		20	1,067	1,067	3,290	12
13	Light Fixtures	2003	2,795		20	140	140	431	13
14	Dialysis Room Plumbing	2003	12,984		20	1,298	1,298	4,003	14
15	Hood Duct	2003	595		20	60	60	233	15
16	Nurse Call Unit	2003	515		20	103	103	403	16
17	Sprinkler System Drain	2003	516		20	52	52	194	17
18	Valves	2003	1,211		20	121	121	434	18
19	Gas Safety Valve	2003	542		20	54	54	190	19
20	Connector & Insulation	2003	500		20	50	50	179	20
21	Plate Assembly	2003	741		20	74	74	253	21
22	Air Conditioner Motor	2003	1,351		20	135	135	417	22
23	Wiring	2004	1,194		20	119	119	358	23
24	Electric Installation	2004	6,090		20	609	609	1,827	24
25	Cables And Wiring	2004	2,100		20	210	210	508	25
26	Air Conditioning	2004	3,806		20	381	381	856	26
27	Air Conditioners	2004	4,046		20	809	809	2,090	27
28	Pipes And Electrical	2004	4,950		20	990	990	2,310	28
29	Room Fixtures And Outlets	2004	1,165		20	233	233	699	29
30	Flooring	2004	9,400		20	1,880	1,880	5,640	30
31	Painting And Kitchen Installation	2004	2,425		20	485	485	1,455	31
32	Wall Covering	2004	7,763		20	1,553	1,553	4,399	32
33	Bathroom Sewer Line Repair	2004	4,800		20	480	480	1,300	33
34	TOTAL (lines 1 thru 33)		\$ 10,742,144	\$ 404,542		\$ 543,866	\$ 139,324	\$ 6,441,572	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,742,144	\$ 404,542		\$ 543,866	\$ 139,324	\$ 6,441,572	1
2	Paint	2004	990		20	99	99	297	2
3	Water Valve And Circulating Pump	2004	1,282		20	128	128	310	3
4	Hvac	2004	986		20	99	99	247	4
5	Roof Repair	2004	1,820		20	182	182	470	5
6	Roof Repair	2004	2,252		20	225	225	601	6
7	Wallpaper	2004	950		20	95	95	261	7
8	Heater Pump	2004	653		20	65	65	185	8
9	Sprinkler Heads	2004	938		20	94	94	281	9
10	Insulation	2004	2,198		20	220	220	476	10
11	Roof Repair	2004	817		20	82	82	170	11
12	Walk-In Cooler Repair	2004	945		20	95	95	197	12
13	Paint	2004	576		20	58	58	120	13
14	Plastered Walls	2005	7,100		20	4,733	4,733	7,100	14
15	Plastered Walls	2005	12,700		20	10,583	10,583	12,700	15
16	Sign	2005	5,615		20	561	561	842	16
17	Signs	2005	13,217		20	1,322	1,322	1,762	17
18	Wallpaper	2005	3,288		20	658	658	1,096	18
19	Wallpaper	2005	8,984		20	1,797	1,797	2,396	19
20	Window Treatments	2005	10,661		20	2,132	2,132	2,665	20
21	Wallcovering	2005	337		20	67	67	90	21
22	Blinds	2005	373		20	37	37	44	22
23	Floor Covering	2005	48,040		20	3,203	3,203	4,270	23
24	Doors	2005	3,245		20	649	649	919	24
25	Doors	2005	5,550		20	1,110	1,110	1,573	25
26	Exhaust Fan	2005	7,912		20	1,582	1,582	2,374	26
27	Closets	2005	6,300		20	630	630	788	27
28	Phone System	2005	7,130		20	713	713	1,367	28
29	Phone System	2005	4,170		20	417	417	591	29
30	Security System	2005	5,738		20	820	820	1,093	30
31	Boiler	2005	2,489		20	207	207	277	31
32	Walk- In Cooler	2005	3,585		20	512	512	811	32
33	Walk-In Cooler	2005	4,963		20	709	709	1,123	33
34	TOTAL (lines 1 thru 33)		\$ 10,917,948	\$ 404,542		\$ 577,750	\$ 173,208	\$ 6,489,068	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 10,917,948	\$ 404,542		\$ 577,750	\$ 173,208	\$ 6,489,068	1
2	Electrical Work	2005	6,800		20	680	680	850	2
3	Water Heater	2005	6,377		20	531	531	1,063	3
4	Roofing	2005	3,000		20	300	300	325	4
5	Flooring Adjustment	2005	(95,245)		20	(6,350)	(6,350)	(12,699)	5
6	Door	2005	1,544		20	13	13	219	6
7	Fixture Installation	2005	1,514		20	13	13	202	7
8	Roof Top Unit Repair	2005	3,479		20	29	29	406	8
9	Chiller Fan Repair	2005	2,359		20	20	20	295	9
10	Rooftop Units & Heat Exchanger	2005	2,910		20	146	146	146	10
11	Installing 58 Outlets	2006	15,000		20	750	750	750	11
12	Gerber Toilet And Tank	2006	1,700		20	340	340	340	12
13	New Rooftop Exhaust Fan	2006	2,124		20	248	248	248	13
14	Wallpaper Lounge And Resident Rooms	2006	4,033		20	672	672	672	14
15	Carpeting	2006	1,836		20	138	138	138	15
16	Pinch Pleated Draperies	2006	1,913		20	191	191	191	16
17	Elevator Shaft Smoke Detector And Recalls	2006	11,890		20	396	396	396	17
18	Sprinkler System Head Replacements	2006	11,766		20	392	392	392	18
19	Central Ac Unit Repair	2006	4,108		20	479	479	479	19
20	Chiller Repair	2006	5,237		20	524	524	524	20
21	2 Motorized Smoke Dampers	2006	1,400		20	140	140	140	21
22	40 Ton Chiller Replacement	2006	39,020		20	3,902	3,902	3,902	22
23	Emergency Work 2 Boilers Out	2006	6,233		20	1,143	1,143	1,143	23
24	Switches	2006	2,430		20	364	364	364	24
25	Perimeter Heating Pump Replacement	2006	3,635		20	545	545	545	25
26	Concrete Handicap Ramp	2006	1,800		20	90	90	90	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189	1
2								2
3								3
4								4
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28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189	1
2								2
3								3
4								4
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31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12I, Carried Forward	\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189		1
2									2
3									3
4									4
5									5
6									6
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189	1
2								2
3								3
4								4
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27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189	1
2								2
3								3
4								4
5								5
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27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12L, Carried Forward	\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189		1
2									2
3									3
4									4
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6									6
7									7
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12M, Carried Forward	\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189	1
2								2
3								3
4								4
5								5
6								6
7								7
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16								16
17								17
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19								19
20								20
21								21
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27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12P, Carried Forward	\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,964,811	\$ 404,542		\$ 583,446	\$ 178,904	\$ 6,490,189		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	300		1994	1976	\$ 7,334,294	\$ 188,059		\$ 366,715	\$ 178,656	\$ 4,736,735	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Halsted Associates		1994		791,085	19,703		40,036	20,333	458,937	9
10											10
11											11
12											12
13											13
14											14
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16											16
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30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 8,125,379	\$ 207,762		\$ 406,751	\$ 198,989	\$ 5,195,672	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocation from ITEX		1993	1993	\$ 378,017	\$ 9,693	35	\$ 10,800	\$ 1,107	\$ 146,706	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Allocation from ITEX			1993	47,565	280	20	2,379	2,099	32,598	9
10	Allocation from ITEX			1994	25,548	665	20	1,277	612	15,689	10
11	Allocation from ITEX			1995	4,354	11	20	218	207	2,438	11
12	Allocation from ITEX			1996	246	-	20	12	12	136	12
13	Allocation from ITEX			1997	7,345	188	20	367	179	3,489	13
14	Allocation from ITEX			1999	816	21	20	41	20	326	14
15	Allocation from ITEX			2005	3,571	857	20	580	(277)	714	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 467,462	\$ 11,715		\$ 15,674	\$ 3,959	\$ 202,096	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Halsted Terrace Nursing Ctr # 0020842 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	\$ 1,138,346	\$ 3,601	\$ 138,067	\$ 134,466	10	\$ 829,241	71
72	Current Year Purchases	98,302		11,142	11,142	10	11,142	72
73	Fully Depreciated Assets	1,671,376		437	437	10	1,671,376	73
74								74
75	TOTALS	\$ 2,908,024	\$ 3,601	\$ 149,646	\$ 146,045		\$ 2,511,759	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,727,835	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 408,143	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 733,092	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 324,949	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,001,948	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6	Storage				2,759			6
7	TOTAL				\$ 2,759			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 31,998 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2003 Ford Explorer	\$ _____	\$ 13,068	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ 13,068	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.

Facility Name & ID Number Halsted Terrace Nursing Ctr # 0020842 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

Facility Name & ID Number Halsted Terrace Nursing Ctr# 0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 61,198		\$			\$ 61,198	1
2	Licensed Speech and Language Development Therapist	39 - 02	hrs				1,309		1,309	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	90,519					90,519	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				159,560		159,560	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>					155	40,358		40,513	13
14	TOTAL			\$ 151,717		\$ 155	\$ 201,227		\$ 353,099	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 Halsted Terrace Nursing Ctr# 0020842Report 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	\$	\$ 295,769	1
2	Cash-Patient Deposits	74,870	74,870	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,102,954	1,102,954	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	72,465	92,378	6
7	Other Prepaid Expenses	35,548	35,548	7
8	Accounts Receivable (owners or related parties)	423,624	423,624	8
9	Other(specify): <u>See Attached Schedule</u>	9,768	294,106	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,719,229	\$ 2,319,249	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		855,000	13
14	Buildings, at Historical Cost		7,998,898	14
15	Leasehold Improvements, at Historical Cost	1,738,477	1,782,847	15
16	Equipment, at Historical Cost	2,485,220	3,381,388	16
17	Accumulated Depreciation (book methods)	(2,698,037)	(6,265,658)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		106,330	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(10,633)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	613,241	613,241	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,138,901	\$ 8,461,413	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,858,130	\$ 10,780,662	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,361,482	\$ 1,361,482	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	72,780	72,780	28
29	Short-Term Notes Payable	5,259,209	5,259,209	29
30	Accrued Salaries Payable	551,673	551,673	30
31	Accrued Taxes Payable (excluding real estate taxes)	62,441	62,441	31
32	Accrued Real Estate Taxes(Sch.IX-B)		290,769	32
33	Accrued Interest Payable	16,752	52,651	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	397,335	435,588	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,721,672	\$ 8,086,593	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,467	1,467	39
40	Mortgage Payable		7,977,510	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,467	\$ 7,978,977	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,723,139	\$ 16,065,570	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,865,009)	\$ (5,284,908)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,858,130	\$ 10,780,662	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,056,491)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,056,491)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,808,518)	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)	\$ (1,808,518)	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)	\$ (3,865,009)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nursing Ctr# 0020842Report Period Beginning: 01/01/06Ending: 12/31/06**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	\$ 9,442,044	1
2	Discounts and Allowances for all Levels	(110,446)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,331,598	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	656,319	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 656,319	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	5,253	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	296,456	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	52,004	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 353,713	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	23,853	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 23,853	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	331,971	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 331,971	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,697,454	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,716,100	31
32	Health Care	5,250,140	32
33	General Administration	3,269,233	33
B. Capital Expense			
34	Ownership	1,642,214	34
C. Ancillary Expense			
35	Special Cost Centers	464,035	35
36	Provider Participation Fee	164,250	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,505,972	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,808,518)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,808,518)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not complete 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 Halsted Terrace Nursing Ctr

0020842

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	856	900	\$ 30,025	\$ 33.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,190	25,972	842,190	32.43	3
4	Licensed Practical Nurses	64,407	69,806	1,657,419	23.74	4
5	CNAs & Orderlies	132,450	143,240	1,458,046	10.18	5
6	CNA Trainees					6
7	Licensed Therapist	5,651	6,106	151,717	24.85	7
8	Rehab/Therapy Aides	12,989	14,596	186,910	12.81	8
9	Activity Director	2,432	2,688	49,865	18.55	9
10	Activity Assistants	1,522	16,723	173,755	10.39	10
11	Social Service Workers	19,694	21,620	313,134	14.48	11
12	Dietician					12
13	Food Service Supervisor	1,776	2,080	29,672	14.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,390	34,356	298,743	8.70	15
16	Dishwashers					16
17	Maintenance Workers	5,689	6,121	98,358	16.07	17
18	Housekeepers	33,196	36,633	340,371	9.29	18
19	Laundry	10,197	12,262	95,514	7.79	19
20	Administrator	1,016	1,080	56,702	52.50	20
21	Assistant Administrator	3,571	3,750	69,419	18.51	21
22	Other Administrative	11,538	11,942	115,630	9.68	22
23	Office Manager					23
24	Clerical	11,118	11,366	179,103	15.76	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	1,816	2,080	34,601	16.64	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	12,312	13,209	187,206	14.17	33
34	TOTAL (lines 1 - 33)	386,810	436,530	\$ 6,368,380 *	\$ 14.59	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	404	\$ 12,930	01-03	35
36	Medical Director	Monthly	52,960	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	Monthly	14,875	10-03	38
39	Pharmacist Consultant	Monthly	4,050	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant		2,859	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,448	11-03	44
45	Social Service Consultant	56	3,152	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	460	\$ 97,498		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses			50	
51	Licensed Practical Nurses	1,644	70,558	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,644	\$ 70,558		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
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 Halsted Terrace Nursing Ctr

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$9,240; IL Assoc. HC \$4,800
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 51,360 Line 10
- (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. \$ 164,250
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 26,335 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT