

		FOR BHF USE				

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

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023945

Facility Name: HEATHER HEALTH CARE CENTER

Address: 15600 SOUTH HONORE STREET HARVEY 60426
 Number City Zip Code

County: COOK

Telephone Number: (708)-333-9550 Fax # (708)-333-9554

HFS ID Number: 36-2949011

Date of Initial License for Current Owners: 06/01/81

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: STEVEN M. KROLL **Telephone Number:** (773)-286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>STEVEN M. KROLL</u>	
	(Title) <u>CHIEF FINANCIAL OFFICER</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____	Fax # () _____
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001	

Phone # (217) 782-1630

Facility Name & ID Number HEATHER HEALTH CARE CENTER

0023945 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	172	Skilled (SNF)	172	62,780	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	172	TOTALS	172	62,780	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	12,129	91	3,735	15,955	8
9	SNF/PED					9
10	ICF	20,531	736	11	21,278	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,660	827	3,746	37,233	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.31%

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

N/A (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)

N/A

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 4/1/78

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 89 and days of care provided 2,320

Medicare Intermediary ADMINASTAR FEDERAL, INC

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 HEATHER HEALTH CARE CENTER # 0023945 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	234,058	26,720	9,600	270,378	751	271,129	(6,334)	264,795			1
2	Food Purchase		236,520		236,520	(22,017)	214,503	(29,703)	184,800			2
3	Housekeeping	153,019	25,514		178,533	674	179,207		179,207			3
4	Laundry	56,137	20,237		76,374	177	76,551		76,551			4
5	Heat and Other Utilities			144,269	144,269		144,269	(15,228)	129,041			5
6	Maintenance	53,214	79	89,797	143,090	91	143,181	39,062	182,243			6
7	Other (specify):* Related Party Salary							32,410	32,410			7
8	TOTAL General Services	496,428	309,070	243,666	1,049,164	(20,324)	1,028,840	20,207	1,049,047			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	1,345,280	81,136	5,657	1,432,073	(3,409)	1,428,664	(808)	1,427,856			10
10a	Therapy											10a
11	Activities	136,698	13,887	3,081	153,666	20	153,686		153,686			11
12	Social Services	69,640			69,640		69,640		69,640			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Related Party Salary							24,568	24,568			15
16	TOTAL Health Care and Programs	1,551,618	95,023	29,738	1,676,379	(3,389)	1,672,990	23,760	1,696,750			16
	C. General Administration											
17	Administrative	94,278			94,278		94,278		94,278			17
18	Directors Fees											18
19	Professional Services			535,648	535,648		535,648	(483,081)	52,567			19
20	Dues, Fees, Subscriptions & Promotions			51,383	51,383		51,383	(31,580)	19,803			20
21	Clerical & General Office Expenses	119,648	15,464	29,626	164,738	322	165,060	10,055	175,115			21
22	Employee Benefits & Payroll Taxes			343,896	343,896	14,546	358,442	(4,178)	354,264			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,046	4,046		4,046	1,269	5,315			24
25	Other Admin. Staff Transportation							6,893	6,893			25
26	Insurance-Prop.Liab.Malpractice			183,841	183,841		183,841	5,133	188,974			26
27	Other (specify):* Related Party Salary			63,009	63,009		63,009	223,129	286,138			27
28	TOTAL General Administration	213,926	15,464	1,211,449	1,440,839	14,868	1,455,707	(272,360)	1,183,347			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,261,972	419,557	1,484,853	4,166,382	(8,845)	4,157,537	(228,393)	3,929,144			29

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

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

STATE OF ILLINOIS

Page 4

Facility Name & ID Number HEATHER HEALTH CARE CENTER #0023945 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			61,692	61,692		61,692	77,023	138,715			30
31	Amortization of Pre-Op. & Org.							2,156	2,156			31
32	Interest			95,584	95,584		95,584	108,695	204,279			32
33	Real Estate Taxes							630,113	630,113			33
34	Rent-Facility & Grounds			622,497	622,497		622,497	(622,497)				34
35	Rent-Equipment & Vehicles			6,642	6,642		6,642	24,800	31,442			35
36	Other (specify):* MIP & Amortiz.							8,287	8,287			36
37	TOTAL Ownership			786,415	786,415		786,415	228,577	1,014,992			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		141,459	156,587	298,046	8,845	306,891	(107,747)	199,144			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			94,718	94,718		94,718		94,718			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		141,459	251,305	392,764	8,845	401,609	(107,747)	293,862			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,261,972	561,016	2,522,573	5,345,561		5,345,561	(107,563)	5,237,998			45

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

HEATHER HEALTH CARE CENTER

12/31/06

Reclassifications - Pg 3 and 4k, column 5

Page 4A

From line	To line	Amount	Description
22		(7,471.00)	Uniforms
	1	751.00	Uniforms
	3	674.00	Uniforms
	4	177.00	Uniforms
	6	91.00	Uniforms
	10	5,436.00	Uniforms
	11	20.00	Uniforms
	21	322.00	Uniforms
2		(22,017.00)	Employee Meal
	22	22,017.00	Employee Meal
19		(1,616.00)	Pathway
	10	1,616.00	Pathway
10		(8,845.00)	Oxygen
	39	8,845.00	Oxygen
		<u>0</u>	Net Should be 0

Facility Name & ID Number HEATHER HEALTH CARE CENTER

0023945

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	(318)	2		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	68,971	30		9
10	Interest and Other Investment Income	(3)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(79)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(4,437)	21		17
18	Fines and Penalties	(21,363)	32		18
19	Entertainment	(1,161)	20		19
20	Contributions	(1,835)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(19,054)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(63,009)	27		24
25	Fund Raising, Advertising and Promotional	(27,134)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (69,422)		\$	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)	(113,440)	Various	34
35	Other- Attach Schedule See Pg 5A	75,299	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (38,141)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (107,563)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

HEATHER HEALTH CARE CENTER

ID# 0023945

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	Late fees on utilities	(6,056)	5	2
3	Late fee on telephone	(77)	21	3
4				4
5				5
6				6
7				7
8	Intercompany interest	(74,195)	32	8
9				9
10	Miscell Income (AR imports)	(463)	2	10
11				11
12	Marketing Manager & Aides	(27,484)	21	12
13	Back out % of Employee Benefits	(4,178)	22	13
14	Back out 30.65% (for 2006) of PAC fees	(2,927)	20	14
15	Vendor Settlements	11,143	21	15
16	Vendor Settlements	(11,143)	5	16
17				17
18	tax penalty-LLC	(29,690)	32	18
19	Fines and Penalties Heather LLC	(16,983)	32	19
20	R+M < 2,500 Capitalized on Books	12,600	6	20
21	R+M< 2,500 Capitalized on Books	7,200	6	21
22	R+M< 2,500 Capitalized on Books	4,948	6	22
23	R+M< 2,500 Capitalized on Books	7,883	6	23
24	R+M<2,500 Capitalized on Books	1,110	6	24
25	Deprec on '06 Maj Rep & Leas Improv	916	30	25
26	Refund relating to 2003	69,340	33	26
27				27
28	Elimin. Interest related to '05 build. Purchase	(17,576)	32	28
29	Mortgage Interest	139,826	32	29
30	Mortgage Insurance	8,287	36	30
31	Adj Defer. Maint. To Actual	62	6	31
32	Add back credit posted for prior years cost	2,756	19	32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	75,299		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HEATHER HEALTH CARE CENTER

0023945

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	(6,334)	0	0	0	0	0	0	0	(6,334)	1
2	Food Purchase	(860)	0	0	(28,843)	0	0	0	0	0	0	0	(29,703)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(17,199)	0	1,971	0	0	0	0	0	0	0	0	(15,228)	5
6	Maintenance	33,803	0	5,455	0	0	0	(196)	0	0	0	0	39,062	6
7	Other (specify):*	0	0	28,092	4,318	0	0	0	0	0	0	0	32,410	7
8	TOTAL General Services	15,744	0	35,518	(30,859)	0	0	(196)	0	0	0	0	20,207	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	398	(1,206)	0	0	0	0	0	0	(808)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	24,568	0	0	0	0	0	0	0	0	24,568	15
16	TOTAL Health Care and Programs	0	0	24,568	398	(1,206)	0	0	0	0	0	0	23,760	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(16,298)	0	(466,783)	0	0	0	0	0	0	0	0	(483,081)	19
20	Fees, Subscriptions & Promotions	(33,057)	0	1,477	0	0	0	0	0	0	0	0	(31,580)	20
21	Clerical & General Office Expenses	(20,855)	0	21,842	5,322	3,746	0	0	0	0	0	0	10,055	21
22	Employee Benefits & Payroll Taxes	(4,178)	0	0	0	0	0	0	0	0	0	0	(4,178)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,269	0	0	0	0	0	0	0	0	1,269	24
25	Other Admin. Staff Transportation	0	0	6,893	0	0	0	0	0	0	0	0	6,893	25
26	Insurance-Prop.Liab.Malpractice	0	4,972	161	0	0	0	0	0	0	0	0	5,133	26
27	Other (specify):*	(63,009)	0	275,525	6,876	3,737	0	0	0	0	0	0	223,129	27
28	TOTAL General Administration	(137,397)	4,972	(159,616)	12,198	7,483	0	0	0	0	0	0	(272,360)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(121,653)	4,972	(99,530)	(18,263)	6,277	0	(196)	0	0	0	0	(228,393)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HEATHER HEALTH CARE CENTER

0023945

Report Period Beginning:

01/01/06 Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
30	Depreciation	69,887	0	5,278	0	1,858	0	0	0	0	0	0	77,023	30
31	Amortization of Pre-Op. & Org.	0	260	1,896	0	0	0	0	0	0	0	0	2,156	31
32	Interest	(19,984)	64,331	63,454	0	503	391	0	0	0	0	0	108,695	32
33	Real Estate Taxes	69,340	556,200	4,385	0	188	0	0	0	0	0	0	630,113	33
34	Rent-Facility & Grounds	0	(622,497)	0	0	0	0	0	0	0	0	0	(622,497)	34
35	Rent-Equipment & Vehicles	0	0	24,800	0	0	0	0	0	0	0	0	24,800	35
36	Other (specify):*	8,287	0	0	0	0	0	0	0	0	0	0	8,287	36
37	TOTAL Ownership	127,530	(1,706)	99,813	0	2,549	391	0	0	0	0	0	228,577	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(37,037)	(17,282)	(53,428)	0	0	0	0	0	(107,747)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	(37,037)	(17,282)	(53,428)	0	0	0	0	0	(107,747)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,877	3,266	283	(55,300)	(8,456)	(53,037)	(196)	0	0	0	0	(107,563)	45

Facility Name & ID Number HEATHER HEALTH CARE CENTER

0023945

Report Period Beginning:

01/01/06

Ending:

12/31/06

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
The Alden Group Limited	100	See Pg 6K		See Pg 6K		

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 Rental Income	\$ 622,497	Heather Health Care Center II, LLC		\$	\$ (622,497)	1
2	V	32 Fines & Penalties		Heather Health Care Center II, LLC		16,983	16,983	2
3	V	33 Real Estate Tax		Heather Health Care Center II, LLC		556,200	556,200	3
4	V	26 General Insurance Exp		Heather Health Care Center II, LLC		4,972	4,972	4
5	V	32 Interest - Other		Heather Health Care Center II, LLC		17,658	17,658	5
6	V	31 Amortization		Heather Health Care Center II, LLC		260	260	6
7	V	32 Tax Penalty		Heather Health Care Center II, LLC		29,690	29,690	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 622,497			\$ 625,763	\$ * 3,266	14

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

Facility Name & ID Number **HEATHER HEALTH CARE CENTER**# **0023945**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	19 Professional Fees	\$ 483,600	Alden Management Services, Inc.		\$ 16,817	\$ (466,783)	15
16	V	21 Gen'l & Admin				21,842	21,842	16
17	V	5 Utilities				1,971	1,971	17
18	V	6 Rep & Maint				5,455	5,455	18
19	V	24 Travel & Seminar				1,269	1,269	19
20	V	25 Other Admin Travel				6,893	6,893	20
21	V	26 Forum Allocated Insurance				161	161	21
22	V	20 Dues, Subscriptions				1,477	1,477	22
23	V	30 Depreciation				5,278	5,278	23
24	V	31 Amortization				1,896	1,896	24
25	V	33 Real Estate Taxes				4,385	4,385	25
26	V	35 Rent-Equip. & Vehic				24,800	24,800	26
27	V	32 Interest				63,454	63,454	27
28	V	7 Gen'l Serv Salary				28,092	28,092	28
29	V	15 Health Care Salary				24,568	24,568	29
30	V	27 G & A Salaries				275,525	275,525	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		\$ 483,600			\$ 483,883	\$ * 283	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		\$	Prism Health Care Services, Inc.		\$		15
16	V	1 Diet. Cons.	9,600			3,266	(6,334)	16
17	V	2 Tube Feed	42,020			13,177	(28,843)	17
18	V	10 Equip Rent	3,060			3,458	398	18
19	V	39 Supplies	49,171			12,134	(37,037)	19
20	V	7 Diet: Salary				4,318	4,318	20
21	V	27 G & A Salary				6,876	6,876	21
22	V	21 G & A Salary				5,322	5,322	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		\$ 103,851			\$ 48,551	\$ * (55,300)	39

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

Facility Name & ID Number HEATHER HEALTH CARE CENTER # 0023945 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	39	Drugs	\$ 47,111	Forum Extended Care Services II, Inc.	\$ 66,146	\$ 19,035	15
16	V	39	I.V.	39,270		4,065	(35,205)	16
17	V	39	Wound Care	5,097		3,985	(1,112)	17
18	V	10	House Stock	5,564		5,016	(548)	18
19	V	10	Pharmacy Consultant	5,562		4,904	(658)	19
20	V	27	Employee Vaccination	2,005		1,568	(437)	20
21	V	27	G & A Salaries			4,174	4,174	21
22	V	21	G & A Expenses			3,746	3,746	22
23	V	32	Interest			503	503	23
24	V	33	Real Estate Tax			188	188	24
25	V	30	Depreciation			1,858	1,858	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		\$ 104,609			\$ 96,153	\$ * (8,456)	39

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

Facility Name & ID Number **HEATHER HEALTH CARE CENTER**

0023945

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	39	Therapy	\$ 152,199	Community Physical Therapy & Associates, Ltd.		\$ 98,771	\$ (53,428)	15
16	V	32	Interest				391	391	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			\$ 152,199			\$ 99,162	\$ * (53,037)	39

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

Facility Name & ID Number **HEATHER HEALTH CARE CENTER**

0023945

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	6	Repairs + Mainten	\$ 12,851	Alden Bennett Construction Company, Inc.		\$ 12,655	\$ (196)	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			\$ 12,851			\$ 12,655	\$ * (196)	39

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

STATE OF ILLINOIS

Facility Name & ID Number ALDEN NURSING CENTER - HEATHER # 002-3945

Report Period Beginning 01/01/06

Ending: 12/31/06

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Waterford	Aurora
ANC Lincoln Park	Chicago
ANC Northmoor	Chicago
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomingtondale
ANC Village for Children & Young Adults	Bloomingtondale
ANC Orland Park	Orland Park
ANC Princeton	Chicago
Alden of Old Town East	Bloomingtondale
Alden of Old Town West	Bloomingtondale
Alden Trails	Bloomingtondale
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Clinton, WI
ANC Poplar Creek	Hoffman Estates
ANC Governer's Park of Barrington	Barrington
ANC Gardens of Rockford	Rockford
ANC Springs	Bloomingtondale

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Pyramid Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living

Facility Name & ID Number HEATHER HEALTH CARE CENTER # 0023945 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	Floyd Schlossberg a.	President	Chief Executive	100.00	134,856	1.332	3.33	salary	\$ 4,644	27-7	1
2	Lauren Magnusson b.	Nurse coordinator	Nursing Admin.	0.00	79,043	1.332	3.33	salary	2,722	15-7	2
3	Terry Magnusson c.	Maint. Supervisor	Construct/maint	0.00	51,279	1.332	3.33	salary	1,766	7-7	3
4											4
5											5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of The Alden Group Ltd.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is the nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of floyd Schlossberg. Terry is in maintenance and construction.										9
10											10
11											11
12											12
13								TOTAL	\$ 9,132		13

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

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

Facility Name & ID Number HEATHER HEALTH CARE CENTER

0023945

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 Alden Management Services, Inc.
 Street Address 4200 W Peterson Ave
 City / State / Zip Code Chicago, IL 60646
 Phone Number (773) 286-3883
 Fax Number (773) 286-3743

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	See Page 8A (also on Page 6A)				\$	\$		\$	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

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	AFCO		X							\$ 82	1									
2											2									
3	Proforma allocation of mortg. Interest										3									
4	due to sale/leaseback		x	mortgage	\$17,353.57	6/1/80	2,430,000	1,657,336	12/31/2019	8.2500	139,826	4								
5	Therapeutic interest		X	Working Capital							26	5								
Working Capital																				
6	Related Party-FECH	X		Working Capital							503	6								
7	Related Party-AMS			Working Capital							63,454	7								
8	Related Party-CPT	X		Working Capital							391	8								
9	TOTAL Facility Related				\$17,353.57		\$ 2,430,000	\$ 1,657,336			\$ 204,282	9								
B. Non-Facility Related*																				
10												10								
11	Interest Income on Corp		X								(3)	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			(3)	14								
15	TOTALS (line 9+line14)						\$ 2,430,000	\$ 1,657,336			\$ 204,279	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 8,287 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.)

** 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 HEATHER HEALTH CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0023945

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE (773)286-3883 FAX #: (773)286-3743

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>29-18-410-063-0000</u>	<u>nursing home</u>	\$ <u>453,678.00</u>	\$ <u>453,678.00</u>
2. <u>29-18-410-054-0000</u>	<u>nursing home</u>	\$ <u>922.00</u>	\$ <u>922.00</u>
3. <u>See Attached</u>	<u>Related Party-AMS</u>	\$ <u>131,720.00</u>	\$ <u>4,385.00</u>
4. <u>See Attached</u>	<u>Related Party-Forum</u>	\$ <u>14,554.00</u>	\$ <u>188.00</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>600,874.00</u>	\$ <u>459,173.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number HEATHER HEALTH CARE CENTER

0023945 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,971 B. General Construction Type: Exterior Brick/Concrete Frame Steel Number of Stories 1, partial 2

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient Care	62,115	2005	\$ 187,500	1
2					2
3	TOTALS	62,115		\$ 187,500	3

Facility Name & ID Number HEATHER HEALTH CARE CENTER

0023945

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	49		1978	1975	\$ 496,626	\$	27	\$ 4,329	\$ 4,329	\$ 496,626	4
5	123		1980	1980	1,789,311		30	59,644	59,644	1,622,130	5
6	addition		1979	1979	38,500		30	1,283	1,283	34,223	6
7											7
8	related party- forum			1978	14,839		25			14,839	8
	Improvement Type**										
9		LAND IMPROVEMENT/ROFFING/HVAC		1980	168,496		10-27	3,279	3,279	165,028	9
10		PAVING/PAINTING/DRAINAGE TILE		1981	13,153		10-30	436	436	13,212	10
11		ROOFING		1983	3,100		12			3,100	11
12		DOOR WINDOW/BEARING ASSEMBLE/WATER PUMP		1984	15,805		5			15,805	12
13		ROOFING/HEAT EXCHANGE/MOTOR/BASEBOARD		1985	17,603		8-10			17,603	13
14		ROOF REPAIR/SEAL PARKING LOT/HEAT EXCHANGE		1986	40,170		2-10			40,170	14
15		COMPRESSOR REPR/INSTLL FLOW/SWTCH/REWIRE ALARM		1988	15,385		5 & 10			15,385	15
16		REPL HEAT EXCHANGE/ROOFTOP EXHST/RE-BRICK WALL		1991	22,663	486	5-25	486		20,049	16
17		HOT WATER TANK/SEWER REPAIR		1992	15,092	533	5 & 15	533		14,932	17
18		SEWAGE EJECTOR/VALVE/MOTOR		1993	12,871		5&10			12,871	18
19		ROOF REPAIR/BOILER/PUMP REPAAIR/ALARM REPAIR		1994	32,136		3			32,136	19
20		ALARM REPAIR/LOCK SET & KEYS/FLOOR REPAIR		1995	43,408	1,651	3-20	1,651		42,444	20
21		TILE INSTALLED & REPAIR CORRIDOR		1996	1,558	26	10	26		1,558	21
22		REMOVED & REPLACED NEW MOTOR		1996	3,292	55	10	55		3,292	22
23		REMOVED & INSTALLED NEW MOTOR		1996	1,714	29	10	29		1,714	23
24		ELECTRICAL REPAIR		1996	3,127	156	20	156		1,667	24
25		WINDOW REPAIR		1996	6,466	323	20	323		3,421	25
26		VALVE REPAIR		1996	1,523	102	15	102		1,076	26
27		BOILER LEAKING		1996	6,876	458	15	458		4,698	27
28		WINDOW REPAIR		1996	2,713	136	20	136		1,369	28
29		WINDOW REPAIR		1993	7,441		5			7,441	29
30		WINDOW REPAIR		1994	13,715		5			13,715	30
31		FLOOR TILE & BASE		1995	788	39	20	39		416	31
32		INSTALL ASPHALT		1996	16,215	1,622	10	1,622		15,270	32
33		INSTALL DOOR FRAME		1997	2,517	251	10	251		2,180	33
34		INSTALL VENT PIPE FOR DRYER		1997	6,180		5			6,180	34
35		INSTALL TILE		1997	1,706		5			1,706	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

Facility Name & ID Number HEATHER HEALTH CARE CENTER

0023945

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	
37	REPLACE BOILER ROOM- TOP A/C	1997	\$ 6,000	\$	5	\$	\$	\$ 6,000	37
38	INSTALL GAS PIPE	1997	4,220		5			4,220	38
39	INSTALL NEW VALVE AND RECOPPER	1998	1,864		5			1,864	39
40	PIPING	1998	7,104		25			7,104	40
41	ROOF REPAIR	1998	2,920	292	10	292		2,579	41
42	REPAIR & CHECK VOLTAGE OUTPUT	1998	1,780		5			1,780	42
43	REPLACED VALVE - HOT WATER	1998	3,270		5			3,270	43
44	REMODELED & DECORATED ROOMS	1998	28,760	1,917	15	1,917		16,616	44
45	WHIRLPOOL TURBINE	1998	1,599		5			1,599	45
46	REPLACE EXHAUST FAN	1998	1,950	130	15	130		1,127	46
47	FIX FLOOR TILE	1998	3,626	363	10	363		3,174	47
48	INSTALL DOOR MONITORING SYSTEM	1998	1,587	159	10	159		1,336	48
49	INSTALL SECURITRON ANNUNCIATOR	1998	1,764	176	10	176		1,484	49
50	REPLACE BOILER ON STEAMER	1998	4,283	428	10	428		3,675	50
51	INSTALL RESET CONTROL ON BOILER	1998	3,900	195	20	195		1,641	51
52	WRAP CHILLER PIPES	1998	2,682	134	20	134		1,095	52
53	REPLACE PUMP MOTOR	1998	4,425	295	15	295		2,409	53
54	PAINT	1998	7,845	392	5	392		2,529	54
55	CLIMATE SERICE (CLEANED BOILER, VALVE)	1999	1,374	69	20	69		550	55
56	CLIMATE SERVICE (REPLACE MISING VALVE	1999	3,317	221	15	221		1,769	56
57	CLIMATE SERVICE (INSTALLL HOT WATER HEATER)	1999	7,391	493	15	493		3,901	57
58	CLIMATE SERVICE (INSTALL ROOF TOP REPLACEMENT)	1999	9,935	994	10	994		7,866	58
59	CLIMATE SERVICE (REPAIR HEATING UNIT)	1999	1,643	110	15	110		469	59
60	ENVIRON VISION ENVIRONMENT	1999	2,919	292	10	292		2,311	60
61	CHICAGO COOLING CORP (SHUTDOWN BOILER & AC	1999	2,117	212	10	212		1,606	61
62	ABC CARPENTRY	1999	2,031	203	10	203		1,540	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,935,295	\$ 12,942		\$ 81,913	\$ 68,971	\$ 2,709,770	70

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

Facility Name & ID Number HEATHER HEALTH CARE CENTER

0023945

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		\$ 2,935,295	\$ 12,942		\$ 81,913	\$ 68,971	\$ 2,709,770	1
2	ABC WINDOW SCREENS	1999	3,916	392	10	392		2,971	2
3	ABC INSULATION	1999	3,203	214	10	214		642	3
4	CLIMATE SERVICE, INC. (INSTALL CONDENSER)	1999	4,565	304	15	304		2,282	4
5	WIGDAHL ELECTRIC (RECEPTACLES INSTALLED)	1999	5,457	273	20	273		2,047	5
6	CLIMATE SERVICE, INC. (REPLACE MOTOR ON FAN)	1999	2,772	277	10	277		2,079	6
7	CLIMATED SERVICE, INC. - REPLACE FAN MOTOR	1999	1,693	169	10	169		1,269	7
8	ADVANCED PARTS -GARBAGE DISPOSAL	1999	6,515		5			6,515	8
9	THE FLOOR SOURCE -INSTALL CARPET	1999	2,469		5			2,469	9
10	FOX VALLEY FIRE & SAFETY-DOOR ALARM SYSTEM	1999	2,540	169	15	169		1,213	10
11	CLIMATE SERVICE, INC.-BOILER	1999	8,437	422	20	422		2,988	11
12	ABC - GENERAL	1999	4,099	410	10	410		2,904	12
13									13
14	ABC ROOF	1999	2,501	250	10	250		1,771	14
15	ABC HARDWARE	1999	1,793	179	10	179		1,269	15
16	CLIMATE SERVICE, INC. REPAIR BURNER	1999	1,615	162	10	162		1,145	16
17	FOX VALLEY FIRE & SAFETY -SMOKE DETECTORS	1999	7,500	750	10	750		5,250	17
18	DELETE ABOVE ITEM	2000	(7,500)	(750)	10	(750)		(5,250)	18
19	ABC-BUILDING CONSTRUCTION/VARIOUS	2000	3,244	324	10	324		1,783	19
20	FOX VALLEY -SMOKE DETECTORS	2000	7,500	750	10	750		5,250	20
21	FOX VALLEY-DOOR ALARMS	2000	1,931	193	10	193		1,352	21
22	LONG ELEVATOR-ATTACHMENTS	2000	1,751	88	20	88		614	22
23	CLIMATE SERVICES-BOILER ROOM	2000	4,422	221	20	221		1,529	23
24	CI-SERVICE DRAPES/RODS	2000	9,460		5			9,460	24
25	ADJUST 1999 TOTAL TO CORRECT AMOUNTS	2000	10	1	10	1		7	25
26	ABC-BUILDING MAINT CONSTRUCT-VARIOUS	2000	19,015	1,901	10	1,901		12,359	26
27	NEW HORIZONS-TELEPHONEE SYSTEM	2000	1,670	167	10	167		1,099	27
28	ABC-SEAL & STRIPE PARK. LOT	2000	4,154	415	10	415		2,561	28
29	CSI CORKER SERVICE	2001	4,773	239	20	239		1,313	29
30	ABC-TIME & MATERIAL BILLING (JULY 2001)	2001	6,028	603	10	603		3,215	30
31	ABC-TIME & MATERIAL BILLING (OCT 2001)	2001	7,272	727	10	727		3,696	31
32	CAPPS PLUMBING	2001	12,236	1,223	10	1,223		6,418	32
33	GT MECHANICAL - WATER HEATER	2001	4,559	304	15	304		1,596	33
34	TOTAL (lines 1 thru 33)		\$ 3,074,895	\$ 23,319		\$ 92,290	\$ 68,971	\$ 2,793,586	34

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

Facility Name & ID Number HEATHER HEALTH CARE CENTER

0023945

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		\$ 3,074,895	\$ 23,319		\$ 92,290	\$ 68,971	\$ 2,793,586	1
2	Refile Basement Corridor 1	2002	3,650	365	10	365		1,703	2
3	Refile Basement Corridor 2	2002	3,650	365	10	365		1,642	3
4	Replace 4 Windows	2002	782	78	10	78		352	4
5	Replace 10 Windows	2002	2,204	220	10	220		1,101	5
6	Repiping 15' 2" galv pipe	2002	1,165	47	25	47		218	6
7	Replace RPZ Valve main Boiler Room	2002	545	36	15	36		175	7
8	Replace RPZ Valves 1 small Boiler Room	2002	1,865	124	15	124		600	8
9	Replace 3 oudside valves	2002	1,165	78	15	78		344	9
10	ABC - Replace doors	2002	4,103	410	10	410		1,675	10
11	Security Services - Keypad entry system	2002	1,575	105	15	105		429	11
12	Security Services - Door Alarm System	2002	2,035	136	15	136		555	12
13	CAPPS Replace Drain Line	2002	2,965	148	20	148		716	13
14	GT Mechanical - replace chiller condensor motor	2002	2,876	192	15	192		847	14
15	GT Mechanical - Replace Bearing assem. Big Boiler	2002	1,357	90	15	90		444	15
16	GT Mechanical - Hot water circ pump lg. Boiler room	2002	698	47	15	47		234	16
17	CSI - Replace valves, steamer & timer on ovens	2002	1,761	117	15	117		586	17
18	Healthcare Products - Repair wheelchairs	2002	2,282	350	3	350		2,282	18
19	CAPPS - Repair Sprinkler System	2002	1,165	78	15	78		344	19
20	GT Mechanical - Repair Heater	2002	1,658	111	15	111		471	20
21	A&B Custom Cabel install 21 cable outlets	2003	1,731	173	10	173		663	21
22	ABC - New floor in PT Room	2003	3,896	390	10	390		1,462	22
23	A&B Custom Cabel install 27 cable outlets	2003	2,318	232	10	232		831	23
24	A&B Custom Cabel install 97 cable outlets	2003	6,969	697	10	697		2,497	24
25	Security Service - Door alarm service	2003	2,284	152	15	152		532	25
26	Capps - Repair 1st floor drains	2003	1,553	155	10	155		608	26
27	GT Mech- Repair water pump	2003	1,674	335	5	335		1,340	27
28	CSI - Repair Dishwasher	2003	1,953	391	5	391		1,400	28
29	Capps - Repair Sewer	2003	3,755	250	15	250		896	29
30	New Horizons Comm - Repair Phone system	2003	1,908	382	5	382		1,368	30
31	Capps - New Laundry Tub 1of2	2003	1,800	180	10	180		630	31
32	Capps - New Laundry Tub 2of2	2003	2,214	221	10	221		774	32
33	New Horizons Comm - Repair Phone system	2003	2,897	579	5	579		2,027	33
34	TOTAL (lines 1 thru 33)		\$ 3,147,348	\$ 30,553		\$ 99,524	\$ 68,971	\$ 2,823,332	34

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

Facility Name & ID Number HEATHER HEALTH CARE CENTER

0023945

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		\$ 3,147,348	\$ 30,553		\$ 99,524	\$ 68,971	\$ 2,823,332	1
2	ABC - Repair Roof	2003	10,191	1,019	10	1,019		3,482	2
3	CSI - Repair Drain	2003	1,768	354	5	354		1,268	3
4	CAPPS - CLEAR BASIN & CLEAN DRAIN	2004	975	195	5	195		455	4
5	CAPPS - POWER RODDED MAIN SEWER	2004	1,720	344	5	344		803	5
6	CSI - WATER HEATER PARTS AND REPAIR	2004	1,760	352	5	352		836	6
7	ABC - REPAIR LEAKY ROOF	2004	3,203	641	5	641		1,496	7
8	TNS/TERMINX - PEST CONTROL DRVC OF 6 LOCATIONS	2004	2,028	406	5	406		1,150	8
9	ABC - HVAC WORK/INSULATION	2004	7,090	709	10	709		1,891	9
10	ABC - WATER HEATER	2004	8,891	889	10	889		2,519	10
11	Top Notch - Door & Frame w/Hardware	2005	3,595	180	10	180		360	11
12	ABC - Bathroom Repairs	2005	4,307	431	10	431		862	12
13	CAPPS - Install new Basin, backflow valave in manhole	2005	4,200	770	5	770		1,540	13
14	CAPPS - Replaced Pipe, Power Rodded	2005	2,400	440	5	440		880	14
15	ABC - Bathroom Repairs	2005	10,661	1,066	10	1,066		1,954	15
16	GT Mechanical - Repair Boiler	2005	4,334	433	10	433		758	16
17	CAPPS - New RPZ	2005	1,965	196	10	196		343	17
18	GT Mechanical - Bell and Gosset Bearing Assembly/GE Motor	2005	2,398	239	10	239		379	18
19	Cybor Fire Protection - Sprinkler System Pipe Work	2005	2,985	597	5	597		896	19
20	Oak Fire - Alarm Repair (new pit, connect Ansul to Fire Alarm, Ins	2005	4,980	498	10	498		747	20
21	ABC - Bathroom Repairs	2005	14,900	1,490	10	1,490		1,987	21
22	Long Elevator - Repairs to electric eye	2005	1,509	75	20	75		94	22
23	ABC - New Outdoor Sign Install	2005	1,637	136	12	136		147	23
24	ABC - New Mental Institution Unit	2006	32,303		20				24
25	GT MECH - new thermostats-repair	2006	3,355	56	5	56		56	25
26	Top Notch- Replace Sink Heater	2006	2,975	273	10	273		273	26
27	Roof Repairs	2006	3,060	102	10	102		102	27
28	GT MECH - Repair thermostat and replaced blower	2006	5,077		10				28
29	AMS-Generator Install remote Annunicator	2006	3,192	195	15	195		195	29
30	AC Compressor and Repair	2006	10,386	231	15	231		231	30
31	ABC - Fire ID plate and sprinkler system repairs	2006	10,563	59	15	59		59	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,315,755	\$ 42,927		\$ 111,898	\$ 68,971	\$ 2,849,095	34

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

Facility Name & ID Number **HEATHER HEALTH CARE CENTER**# **0023945**

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		\$ 3,315,755	\$ 42,927		\$ 111,898	\$ 68,971	\$ 2,849,095	1
2									2
3	Related Party-Forum Prof Center Building:								3
4	Leasehold Improvement-Remodeling	1980	11,260		15			11,260	4
5	Leasehold Improvement-Remodeling	1980	17,639		20			17,639	5
6	Leasehold Improvement-Tenant Improvement	1987	912		13			912	6
7	Leasehold Improvement-AMS Remodel	1988	14,634		10			14,634	7
8	Leasehold Improvement-Roof	1994	3,269	204	16	204		2,453	8
9	Leasehold Improvement-Build.Improv.	1996	1,153	72	16	72		789	9
10	Leasehold Improvement-Asphalting	2000	89		3			89	10
11	Leasehold Improvement-DAI	2001	157	16	10	16		81	11
12	Leasehold Improvement-Bathrooms	2002	681	77	7	77		324	12
13	Leasehold Improvement-Suite Renovation	2003	1,672	167	10	167		669	13
14	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	2004	2,071	360	7	360		835	14
15	Leasehold Improvement-Add-on Improvement, fixture base	1980	73		23			73	15
16	Leasehold Improvement-Add-on Improvement, lighting base	2001	126	6	5	6		126	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	6,060		7			6,060	27
28	Leasehold Improvement-Remodeling	2002	4,961	709	7	709		2,746	28
29	Leasehold Improvement-Remodeling	2003	5,189	741	7	741		2,856	29
30	FYL... This line goes to TM Only ----->								30
31									31
32									32
33	Forum Extended Care, LLC-building/building improv	1999	12,434	293	30	293		2,350	33
34	TOTAL (lines 1 thru 33)		\$ 3,398,135	\$ 45,572		\$ 114,543	\$ 68,971	\$ 2,912,991	34

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

Facility Name & ID Number HEATHER HEALTH CARE CENTER # 0023945 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	\$ 264,873	\$ 21,114	\$ 21,114	\$	Various	\$ 145,497	71
72	Current Year Purchases	25,871	179	179		Various	179	72
73	Fully Depreciated Assets	280,099	2,766	2,766		Various	280,099	73
74								74
75	TOTALS	\$ 570,843	\$ 24,059	\$ 24,059	\$		\$ 425,775	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	AMS-Bus/Travel Van	Chev/Lumina/00/Various	98-04	\$ 4,634	\$ 113	\$ 113	\$	3	\$ 4,747	76
77										77
78										78
79										79
80	TOTALS			\$ 4,634	\$ 113	\$ 113	\$		\$ 4,747	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)		\$ 4,161,112	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 69,744	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 138,715	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 68,971	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 3,343,513	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: related party - cost is backed out

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:		172		\$			3
4	Additions							4
5								5
6								6
7	TOTAL		172		\$			7

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 6,181 Description: Copy Machine Lease

(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	<u>related party - AMS</u>		\$ <u>#####</u>	\$ <u>24,800</u>	17
18	<u>transport-non-patients</u>		<u>38.42</u>	<u>461</u>	18
19					19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>25,261</u>	21

10. Effective dates of current rental agreement:

Beginning 07/01/05
Ending 06/30/15

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

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

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

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

Facility Name & ID Number HEATHER HEALTH CARE CENTER # 0023945 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><u>Skilled Nurses On-Site</u></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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 56,790	\$		\$ 56,790	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			12,468			12,468	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			81,941			81,941	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16A	# of prescrpts				66,146		66,146	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	See Pg 16A				(53,428)	35,227		(18,201)	13
14	TOTAL			\$		\$ 97,771	\$ 101,373		\$ 199,144	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.

XIV. Special Services (Direct Cost)

Page 16
Col 5: PT,OT, & ST
Col 6: Supplies

Service Description	Col. 1: Ref. No.	To Pg 16: Col. No.	
1. OT	39-3	To Col 5	\$56,790.15
2. ST	39-3	To Col 5	12,467.98
3.			
4. PT	39-3	To Col 5	81,940.70
5.			
6.			
7.			
8.			
Pharmacy Supplies per GL			47,110.75
Manual Input from Related Party- Forum Drugs			19,035.00
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	66,145.75
10.			
11.			
12. Exceptional Care-Salaries:	See pg 16A	To Col. 3	0.00
12. Exceptional Care-Supplies:	See pg 16A	To Col. 6	0.00
Total Exceptional Care (Line 12, Col 8)			0.00
13. Other:	See Pg 16A		
13. Col 5: Manual Input: Related Party - CPT		To Col 5	(53,428.00)
Other			99,736.06
Manual Input: Related Party - Prism			(37,037.00)
Manual Input: Related Party FECII - I.V.			(35,205.00)
Oxygen, from reclass worksheet			8,845.00
Wound Care			(1,112.00)
13. Col 6: Supplies Total		To Col 6	35,227.06
13. Total Line 13, Column 8			(18,200.94)
14. Total			199,143.64

Facility Name & ID Number HEATHER HEALTH CARE CENTER# 0023945Report 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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>59,000</u>)	732,640	732,640	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		4,229	6
7	Other Prepaid Expenses	3,142	3,142	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd parties</u>	112,697	112,697	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 848,479	\$ 852,708	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		197,659	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	896,089	896,089	15
16	Equipment, at Historical Cost	484,662	484,662	16
17	Accumulated Depreciation (book methods)	(933,979)	(934,369)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Financing Fees</u>		1,300	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 446,772	\$ 645,341	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,295,251	\$ 1,498,049	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 568,960	\$ 568,960	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	225,084	225,084	28
29	Short-Term Notes Payable		26,009	29
30	Accrued Salaries Payable	260,815	260,815	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,029	15,029	31
32	Accrued Real Estate Taxes(Sch.IX-B)		324,219	32
33	Accrued Interest Payable		477	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>accrued insurance and accrued expense</u>	90,123	95,589	36
37	<u>Due from Related Parties</u>	1,137,365		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,297,376	\$ 1,516,182	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		125,199	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Affiliates</u>	8,626,639	10,150,295	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 8,626,639	\$ 10,275,494	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,924,015	\$ 11,791,676	46
47	TOTAL EQUITY (page 18, line 24)	\$ (9,628,764)	\$ (10,293,627)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,295,251	\$ 1,498,049	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (8,664,640)	1
2	Restatements (describe):		2
3	external audit adjustments made after 2004 cost report		3
4	was submitted. These have no effect on prior years report.		4
5	Retained Earnings Current Heather LLC		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (8,664,640)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(964,124)	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) Paid in Capital		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (964,124)	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)	\$ (9,628,764)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number HEATHER HEALTH CARE CENTER# 0023945Report 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	\$ 4,315,204	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,315,204	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	14,586	6
7	Oxygen	2,277	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 16,863	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	(60)	13
14	Non-Patient Meals	318	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	395	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	727	19
20	Radiology and X-Ray		20
21	Other Medical Services	32,962	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 34,342	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Adj to 05 expense & 06 Misc Income Adj</u>	15,025	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,025	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,381,437	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,049,164	31
32	Health Care	1,676,379	32
33	General Administration	1,440,839	33
B. Capital Expense			
34	Ownership	786,415	34
C. Ancillary Expense			
35	Special Cost Centers	298,046	35
36	Provider Participation Fee	94,718	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,345,561	40
41	Income before Income Taxes (line 30 minus line 40)**	(964,124)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (964,124)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Yet Done 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.

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

Facility Name & ID Number **HEATHER HEALTH CARE CENTER**

0023945

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	1,824	2,056	\$ 77,166	\$ 37.53	1
2	Assistant Director of Nursing	304	304	10,929	35.95	2
3	Registered Nurses	4,155	4,341	125,417	28.89	3
4	Licensed Practical Nurses	24,129	25,819	611,594	23.69	4
5	CNAs & Orderlies	40,645	44,828	473,294	10.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,936	2,080	32,149	15.46	9
10	Activity Assistants	2,788	3,070	26,479	8.63	10
11	Social Service Workers	3,784	4,072	69,640	17.10	11
12	Dietician					12
13	Food Service Supervisor	3,378	3,908	60,157	15.39	13
14	Head Cook	4,781	5,411	60,969	11.27	14
15	Cook Helpers/Assistants	10,962	12,184	112,930	9.27	15
16	Dishwashers					16
17	Maintenance Workers	2,004	2,075	53,214	25.65	17
18	Housekeepers	15,463	16,368	153,020	9.35	18
19	Laundry	5,287	5,847	56,137	9.60	19
20	Administrator	2,144	2,240	94,278	42.09	20
21	Assistant Administrator					21
22	Other Administrative	3,441	3,705	69,631	18.79	22
23	Office Manager	1,968	2,080	32,770	15.75	23
24	Clerical	2,344	2,399	17,248	7.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,728	1,853	46,881	25.30	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	3,523	3,627	78,069	21.52	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	136,588	148,267	\$ 2,261,972 *	\$ 15.26	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	Monthly	\$ 9,600	1-3	35
36	Medical Director	Monthly	21,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,152	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	39	2,298	11-3	44
45	Social Service Consultant	3	183	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	42	\$ 37,233		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			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

Facility Name & ID Number **HEATHER HEALTH CARE CENTER**

0023945

Report Period Beginning: **01/01/06**

Ending: **12/31/06**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Margaret Clancy	Administrator		\$ 5,883	Workers' Compensation Insurance	\$ 50,543	IDPH License Fee	\$ 3,240	
Marianne Spratt	Administrator		88,395	Unemployment Compensation Insurance	34,593	Advertising: Employee Recruitment		
				FICA Taxes	164,472	Health Care Worker Background Check		
				Employee Health Insurance	28,906	(Indicate # of checks performed <u>60</u>)	600	
				Employee Meals	22,017	Patient Background Checks <u>168</u>	1,680	
				Illinois Municipal Retirement Fund (IMRF)*				
				Union, Health, & Welfare	36,335	Surety Bond, Illinois Health Care Assoc/Ehea	12,806	
				Dental, Pension, Life	16,576	Related Party -AMS	1,477	
				Employee Relations, Misc Payroll Costs	1,193			
				Drug Tests, 401K Match, Vaccinations	3,807			
				Marketing Employee Benefits Deduction	(4,178)	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 94,278	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 19,803
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
\$				\$			\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$				\$			\$	
C. Professional Services								
Vendor/Payee	Type		Amount					
AMS	Management Fee		\$ 483,600				Out-of-State Travel	
Barry Greenberg/Ken Fisch/Klafter	Legal Fees: Non Collections		5,947				\$	
SMS	Billing Service		8,300					
Total Computer Systems	Billing Services		384				In-State Travel	
Ken Fisch	Legal Fees-Collections		17,142					
BDO Siedman/Reznick	Accounting Fees		12,178				Gas Exp	
Maybro Matter	Various consulting/prof services		1,435				1,028	
Medcom	Billing & Medicare		319				Related Party AMS	
Condon/Marsh USA	401K Plan/Consulting Services		171				1,269	
AMS	Management Fee		56				Seminar Expense	
Kelapp Property Appraisal	Real Estate Appraisal fee		4,500				Leadership Training	
Pathway	Clinical Consultants		1,616				1,485	
							Seminar/Conv	
							1,533	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			Entertainment Expense	
\$ 535,648				\$			()	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 5,315	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number **HEATHER HEALTH CARE CENTER**

Report Period Beginning: 01/01/06 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5-13 Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	Repair boiler	1991	\$ 5,878	5	\$	\$	\$	\$	\$	\$	\$	\$	\$
2	A/C compressor	1992	8,561	5-15	180	180	180	180	120				
3	Fan/Misc. HVAC	1993	32,328	3-10	90	1	0						
4	Painting/HVAC	1995	32,616	3-15	513	513	513	513	513	513	513	513	513
5	Painting/HVAC	1996	38,397	3-15	831	831	831	676	494	494	494	494	494
6	Repair boiler	1/97	2,242	3									
7	Repair Exhaust pipe	2/97	1,583	3									
8	Replace mixing val.	3/97	1,850	3									
9	Repair hot water tank	12/97	5,170	3									
10	Replace heat exchange	10/97	2,287	3									
11	Repair hot water pipes	3/99	3,038	3									
12	Sump pump repair	8/99	3,450	3									
13	Painting>1500	7/99	11,105	3									
14	ABC-construction/maint	6/00	1,907	3	265								
15	GT Mechan-water storage	6/00	3,088	3	430								
16	ABC - wall deco/paint	9/00	13,642	3	3,033								
17	Painting >1500	7/00	9,031	3	1,506								
18	GT Mechan-circ pump	2/01	1,604	3	535	44							
19	CSI Corker Ser.	8/01	3,568	3	1,189	695							
20	TOTALS		\$ 181,345		\$ 8,572	\$ 2,264	\$ 1,524	\$ 1,369	\$ 1,127	\$ 1,007	\$ 1,007	\$ 1,007	\$ 1,007

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Il. Health Care Assn. \$12,475
- (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 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,424 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. \$ 94,718
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. \$ 22,017 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not required
- (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.