

Facility Name & ID Number LaSalle Healthcare Center

0045740 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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3	51	Intermediate (ICF)	51	18,615	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	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	8,382	844	5,145	14,371	8
9	SNF/PED					9
10	ICF	13,511	3,204		16,715	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,893	4,048	5,145	31,086	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.32%

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

0 (Do not include bed-hold days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 01/01/1992

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

YES Date 01/01/1992 NO

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

YES NO If YES, enter number of beds certified 50 and days of care provided 5,003

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

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

Facility Name & ID Number LaSalle Healthcare Center # 0045740 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	162,771	22,648	5,668	191,087		191,087		191,087		1
2	Food Purchase		144,994		144,994		144,994		144,994		2
3	Housekeeping	141,551	19,085		160,636		160,636		160,636		3
4	Laundry	41,316	4,359		45,675		45,675		45,675		4
5	Heat and Other Utilities			90,914	90,914		90,914		90,914		5
6	Maintenance	65,027	8,322	37,848	111,197		111,197	(17,480)	93,717		6
7	Other (specify):*										7
8	TOTAL General Services	410,665	199,408	134,430	744,503		744,503	(17,480)	727,023		8
	B. Health Care and Programs										
9	Medical Director			10,241	10,241		10,241		10,241		9
10	Nursing and Medical Records	1,535,444	101,262	2,078	1,638,784		1,638,784		1,638,784		10
10a	Therapy	183,262	726	3,082	187,070		187,070		187,070		10a
11	Activities	51,864	4,620	2,649	59,133		59,133		59,133		11
12	Social Services	35,574	95	3,983	39,652		39,652		39,652		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,806,144	106,703	22,033	1,934,880		1,934,880		1,934,880		16
	C. General Administration										
17	Administrative	65,666		199,290	264,956		264,956		264,956		17
18	Directors Fees										18
19	Professional Services			54,524	54,524		54,524		54,524		19
20	Dues, Fees, Subscriptions & Promotions			15,146	15,146		15,146		15,146		20
21	Clerical & General Office Expenses	178,301	22,625	15,028	215,954		215,954		215,954		21
22	Employee Benefits & Payroll Taxes			553,064	553,064		553,064		553,064		22
23	Inservice Training & Education										23
24	Travel and Seminar			19,306	19,306		19,306		19,306		24
25	Other Admin. Staff Transportation			3,227	3,227		3,227		3,227		25
26	Insurance-Prop.Liab.Malpractice			113,229	113,229		113,229	(78,339)	34,890		26
27	Other (specify):*										27
28	TOTAL General Administration	243,967	22,625	972,814	1,239,406		1,239,406	(78,339)	1,161,067		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,460,776	328,736	1,129,277	3,918,789		3,918,789	(95,819)	3,822,970		29

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

Facility Name & ID Number

LaSalle Healthcare Center

#0045740

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			41,184	41,184		41,184	37,150	78,334			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			31,440	31,440		31,440		31,440			33
34	Rent-Facility & Grounds			473,945	473,945		473,945		473,945			34
35	Rent-Equipment & Vehicles			18,371	18,371		18,371		18,371			35
36	Other (specify):*											36
37	TOTAL Ownership			564,940	564,940		564,940	37,150	602,090			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		123,659		123,659		123,659		123,659			39
40	Barber and Beauty Shops			2,012	2,012		2,012		2,012			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,306	55,306		55,306		55,306			42
43	Other (specify):* Nonallowable Cost			148,865	148,865		148,865	(148,865)				43
44	TOTAL Special Cost Centers		123,659	206,183	329,842		329,842	(148,865)	180,977			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,460,776	452,395	1,900,400	4,813,571		4,813,571	(207,534)	4,606,037			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,223)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	37,150	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(1,406)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(79,716)	43		24
25	Fund Raising, Advertising and Promotional	(9,960)	43		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 Pg 5A	(152,379)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (207,534)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (207,534)		37

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

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

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

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

LaSalle Healthcare Center

ID# 0045740

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow Lab expense	\$ (5,195)	43	1
2	Disallow X-Ray expense	(30,994)	43	2
3	Reclassify repairs from expense to fixed asset	(17,480)	6	3
4	Disallow excess cable tv expense	(2,948)	43	4
5	Disallow marketing expense	(17,423)	43	5
6	Property & Liability adjustment	(78,339)	26	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(152,379)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LaSalle Healthcare Center

0045740

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	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(17,480)	0	0	0	0	0	0	0	0	0	0	(17,480)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(17,480)	0	(17,480)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(78,339)	0	0	0	0	0	0	0	0	0	0	(78,339)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(78,339)	0	(78,339)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(95,819)	0	(95,819)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LaSalle Healthcare Center # 0045740 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	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	37,150	0	0	0	0	0	0	0	0	0	0	37,150	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	37,150	0	37,150	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(148,865)	0	0	0	0	0	0	0	0	0	0	(148,865)	43
44	TOTAL Special Cost Centers	(148,865)	0	(148,865)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(207,534)	0	(207,534)	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
Mariner Health Care	100%	Litchfield Healthcare Center	Litchfield	Mariner Health	Atlanta, GA	Management
		Montebello Healthcare Center	Hamilton	Care		
		Nature Trail Healthcare Center	Mt. Vernon			
		Odin Healthcare Center	Odin			
		Mariner Health of Westchester	Westchester			

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

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

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

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

Facility Name & ID Number LaSalle Healthcare Center # 0045740 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									\$		1	
2	N/A											2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13								TOTAL	\$			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 **LaSalle Healthcare Center**

0045740 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	N/A								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

LaSalle Healthcare Center

0045740

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																				
2																				
3	N/A																			
4																				
5																				
Working Capital																				
6																				
7																				
8																				
9	TOTAL Facility Related					\$	\$		\$											
B. Non-Facility Related*																				
10																				
11																				
12																				
13																				
14	TOTAL Non-Facility Related					\$	\$		\$											
15	TOTALS (line 9+line14)					\$	\$		\$											

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LaSalle Healthcare Center COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0045740

CONTACT PERSON REGARDING THIS REPORT Chris Henderson

TELEPHONE (832) 467-6307 FAX #: (832) 467-6349

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>17-09-451-000</u>	<u>PT E 1/2 SE-BEG891.02 NE COR, S4</u>	<u>\$ 25,542.78</u>	<u>\$ 25,542.78</u>
2. <u>17-09-449-000</u>	<u>PT SE4-9-33-1 BEG 1291.02' S NE</u>	<u>\$ 1,319.40</u>	<u>\$ 1,319.40</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ 26,862.18	\$ 26,862.18

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 LaSalle Healthcare Center

0045740

Report Period Beginning:

01/01/06

Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,694 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>N/A</u>			\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LaSalle Healthcare Center

0045740

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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Building Improvements		1984	24,032		20			24,032	9
10	Building Improvements		1985	50,750		20			50,750	10
11	Building Improvements		1986	327		20	4	4	327	11
12	Building Improvements		1987	5,631		20	283	283	5,451	12
13	Building Improvements		1988	4,260		20	213	213	3,911	13
14	Building Improvements		1989	8,947		20	447	447	7,772	14
15	Building Improvements		1990	19,986		20	1,000	1,000	16,008	15
16	Building Improvements		1991	158,584		20	8,126	8,126	124,145	16
17	Building Improvements		1992	28,134		20	1,406	1,406	20,607	17
18	Building Improvements		1993	95,566		20	4,778	4,778	65,524	18
19	Building Improvements		1994	25,902		20	1,295	1,295	16,088	19
20	Building Improvements		1992	7,158		20	359	359	5,966	20
21	Building Improvements		1993	23,691		20	1,185	1,185	15,646	21
22	Building Improvements		1995	14,934		20	747	747	7,756	22
23	Building Improvements									23
24										24
25	Parking Lot Repairs		1996	2,400		20	120	120	1,248	25
26	Door & Frames		1996	1,679		20	84	84	878	26
27	Therapy Additions		1997	5,709		8.5	591	591	5,419	27
28	Therapy Room		1997	7,232		8.5	350	350	7,232	28
29	A/C repair		1996	1,120		20	56	56	604	29
30	Fire Alarm Systems		1996	14,927		20	746	746	7,761	30
31	Plumbing Repair		1996	772		20	39	39	396	31
32										32
33	Security System		1998	806		20	40	40	338	33
34	Exterior Sign/Flagpole		1998	3,221		20	268	268	2,213	34
35	Water Heater		1998	5,634		20	232	232	1,962	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 LaSalle Healthcare Center

0045740

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			\$	\$		\$	\$	\$	37
38									38
39	1:90 Gal Water Heater	1999	4,700		10	470	470	3,603	39
40									40
41	7.5 Ton Carrier Roof Top Instl	2001	8,250		10	825	825	4,813	41
42	W/N/C RTU Condenser, Evapcoil	2001	4,842		15	323	323	1,830	42
43									43
44	Replace Commerical Water Heater	2002	6,401		10	640	640	3,191	44
45	6-Interior & 1-entrance Door	2002	15,415	771	20	771		3,341	45
46	Rprs Leak under Concrete Floor	2002	1,090	55	20	55		251	46
47	Repl Water Heater	2002	6,850	685	10	685		3,140	47
48									48
49									49
50	Rplc VCT Cove Base	2003	5,000	500	10	500		1,708	50
51	Rplc Trane Rooftop Unit	2003	4,595	459	10	460	1	1,801	51
52	Custom Made Book Cases/Serv Co	2003	6,523	435	15	435		1,559	52
53	Instl Charge- Nurse call System	2003	4,137	414	10	414		1,483	53
54	Nurse Call System Equipo	2003	6,407	461	10	461		1,690	54
55	Rplc VCT- Cove Base -Final Due	2003	5,412	541	10	541		1,849	55
56									56
57									57
58	AIA Document G702-Roof	2004	44,055	4,406	10	4,406		9,118	58
59	Roof Instl - App No 2 (Bal Due)	2004	100,283	10,098	10	10,028	(70)	20,613	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)		\$ 735,362	\$ 18,825		\$ 43,383	\$ 24,558	\$ 452,024	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 735,362	\$ 18,825		\$ 43,383	\$ 24,558	\$ 452,024	1
2	Roof Repairs	2005	12,950	1,295	10	1,295		1,943	2
3	7.5 Ton RTU	2005	8,990	899	10	899		1,349	3
4	Plumbing Repair	2005	2,745	137	20	137		206	4
5	Plumbing Repair	2005	2,582	129	20	129		194	5
6									6
7	(2) 7.5 Ton RTU	2006	17,480		10	874	874	874	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 780,109	\$ 21,285		\$ 46,717	\$ 25,432	\$ 456,590	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number LaSalle Healthcare Center

0045740

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	\$ 287,961	\$ 19,899	\$ 31,617	\$ 11,718	3-10	\$ 226,372	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	70,024					70,024	73
74	Home Office Allocation							74
75	TOTALS	\$ 357,985	\$ 19,899	\$ 31,617	\$ 11,718		\$ 296,396	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	N/A									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)	\$ 1,138,094	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,184	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 78,334	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 37,150	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 752,986	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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: Nationwide Health Properties

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	<u>1973</u>	<u>101</u>	<u>07/01/89</u>	\$ <u>472,295</u>	<u>10</u>	<u>40</u>	3
4							4
5							5
6	<u>Offsite Storage Facility</u>			<u>1,650</u>			6
7	TOTAL	101		\$ 473,945			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 N/A N/A

9. Option to Buy: YES NO Terms: N/A *

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: \$ 18,371 Description: See Sch 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	<u>N/A</u>				18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 07/01/1989

Ending 06/01/2006

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

Fiscal Year Ending Annual Rent

12. 12/31/2007 \$ 196,510

13. /2008 \$

14. /2009 \$

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

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

LaSalle Healthcare Center
0045740
12/31/2006

Schedule 14A

XII. RENTAL COSTS

B. Equipment-Excluding Transportation and Fixed Equipment.

16. Rental Amount for movable equipment:

Nursing Equipment	5,831
Medical Equipment	602
Copier	3,500
Postage Meter	898
Miscellaneous Office Equipment	2,524
Ancillary Services Equipment	<u>5,016</u>

Total Rental for Moveable Equipment 18,371

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>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <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>
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B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(1)	1781	hrs	\$ 67,735		\$	\$	1,781	\$ 67,735	1
2	Licensed Speech and Language Development Therapist	10A(1)	262	hrs	9,957				262	9,957	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(1,2,3)	2775	hrs	105,570	45	3,082	726	2,820	109,378	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39(2)		# of prescrpts				121,837		121,837	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): Oxygen	39(2)						1,822		1,822	13
14	TOTAL				\$ 183,262	45	\$ 3,082	\$ 124,385	4,863	\$ 310,729	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 LaSalle Healthcare Center

0045740

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,496,222	\$ 2,496,222	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (215,112)	806,417	806,417	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from FMSC Leasehold</u>	929	929	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,303,568	\$ 3,303,568	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	248,259	780,109	15
16	Equipment, at Historical Cost	146,522	357,985	16
17	Accumulated Depreciation (book methods)	(156,882)	(752,986)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 237,899	\$ 385,108	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,541,467	\$ 3,688,676	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 222,323	\$ 222,323	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	229,985	229,985	30
31	Accrued Taxes Payable (excluding real estate taxes)	41,831	41,831	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,695	6,695	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Payroll Liabilities</u>	247,198	247,198	36
37	<u>Due to/from Related Parties</u>	2,790,922	2,790,922	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,538,954	\$ 3,538,954	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Benefits Reverse - Workers Comp</u>	194,897	194,897	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 194,897	\$ 194,897	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,733,851	\$ 3,733,851	46
47	TOTAL EQUITY(page 18, line 24)	\$ (192,384)	\$ (45,175)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,541,467	\$ 3,688,676	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 774,019	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(139,479)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 634,540	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(826,924)	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)	\$ (826,924)	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)	\$ (192,384)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,636,103	1
2	Discounts and Allowances for all Levels	(2,386,495)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,249,608	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	481,582	6
7	Oxygen	27,512	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 509,094	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	2,366	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	1,223	15
16	Rental of Facility Space		16
17	Sale of Drugs	162,946	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,915	19
20	Radiology and X-Ray	15,047	20
21	Other Medical Services	10,953	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 198,450	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Equipment Rental Revenue	29,293	28
28a	Miscellaneous Revenue	202	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 29,495	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,986,647	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	744,503	31
32	Health Care	1,934,880	32
33	General Administration	1,239,406	33
	B. Capital Expense		
34	Ownership	564,940	34
	C. Ancillary Expense		
35	Special Cost Centers	274,536	35
36	Provider Participation Fee	55,306	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,813,571	40
41	Income before Income Taxes (line 30 minus line 40)**	(826,924)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (826,924)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
Entity files a consolidated tax return.

*** 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 LaSalle Healthcare Center

0045740

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	1,740	1,912	\$ 60,041	\$ 31.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,509	9,350	209,198	22.37	3
4	Licensed Practical Nurses	19,622	21,563	390,860	18.13	4
5	CNAs & Orderlies	57,287	62,953	701,871	11.15	5
6	CNA Trainees					6
7	Licensed Therapist	4,503	4,948	183,262	37.04	7
8	Rehab/Therapy Aides	2,757	3,030	39,210	12.94	8
9	Activity Director					9
10	Activity Assistants	5,519	6,065	51,864	8.55	10
11	Social Service Workers	2,787	3,063	35,574	11.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,115	17,709	162,771	9.19	15
16	Dishwashers					16
17	Maintenance Workers	5,668	6,229	65,027	10.44	17
18	Housekeepers	15,916	17,490	141,551	8.09	18
19	Laundry	5,292	5,815	41,316	7.11	19
20	Administrator	1,820	2,000	65,666	32.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,459	10,394	143,665	13.82	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	945	1,038	11,129	10.72	31
32	Other Health C: See Sch 20A	5,618	6,173	123,135	19.95	32
33	Other(specify) <u>Admiss. Director</u>	1,781	1,957	34,636	17.70	33
34	TOTAL (lines 1 - 33)	165,337	181,689	\$ 2,460,776 *	\$ 13.54	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	143	\$ 5,668	1(3)	35
36	Medical Director	Monthly	10,241	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	2,078	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	46	2,649	11(3)	44
45	Social Service Consultant	97	3,983	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	334	\$ 24,619		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

LaSalle Healthcare Center

Provider #: 0045740

1/1/2006 to 12/31/2006

Schedule 20A

	Hours Worked	Hours Paid	Total Wages	Ave. Hrly. Wage
XVIII. Staffing & Salary Costs				
Line 32 - Other Healthcare				
Unit Services Coordinator	2,795	3,071	67,564	22.00
MDS Coordinator	1,893	2,080	45,763	22.00
Central Supply	930	1,022	9,808	9.60
	<u>5,618</u>	<u>6,173</u>	<u>123,135</u>	<u>19.95</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Angela Mehlbrech	Administrator	0	\$ 65,666	Workers' Compensation Insurance	\$ 52,918	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	129,759	Advertising: Employee Recruitment	4,509	
				FICA Taxes	188,403	Health Care Worker Background Check (Indicate # of checks performed <u>401</u>)	4,809	
				Employee Health Insurance	180,979	Patient Background Checks		
				Employee Meals		Illinois Health Care Association	2,272	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous License & Fees	182	
				Employee Relations	927	Miscellaneous Dues & Subscriptions	1,384	
				Employee Uniforms	78			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 65,666	TOTAL (agree to Schedule V, line 22, col.8)		\$ 15,146		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Family Senior Care - Management Fees			\$ 199,290	N/A			Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 199,290	TOTAL		\$	In-State Travel	
C. Professional Services				TOTAL			Seminar Expense	
Vendor/Payee	Type	Amount					See Attached Detail	
IT Management	Computer Services	\$ 23,030					19,306	
Clear Path Networks	Computer Services	1,930						
Millenium Health Care	Computer Services	673					Entertainment Expense	
IT Management	Data Processing	16,965					()	
National Datacare Corp.	Data Processing	652					(agree to Sch. V, line 24, col. 8)	
Moore, Stephens & Lovelace	Accounting	1,500					\$ 19,306	
Ernst & Young	Accounting	877						
LTCI	Operations Services	961						
Insight Communications	Internet Services	2,388						
ADP	Payroll Processing	5,548						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 54,524					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
FY2003					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
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19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LaSalle Healthcare Center# 0045740

Report Period Beginning:

01/01/06

Ending:

12/31/06**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Health Care Assoc. - \$2,272
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,328 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 55,306
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (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? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees