

		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: 0042044

Facility Name: Washington Heights Nursing Home

Address: 1010 West 95th Street Chicago 60643
 Number City Zip Code

County: Cook

Telephone Number: (773) 298-1177 **Fax #** (773) 298-1666

HFS ID Number: 364100431001

Date of Initial License for Current Owners: 10/24/96

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 type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" 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: Steve Lavenda **Telephone Number:** (847) 236 - 1111

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) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

MAIL TO: BUREAU OF HEALTH FINANCE
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044 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	<u>228</u>	Skilled (SNF)	<u>228</u>	<u>83,220</u>	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	<u>228</u>	TOTALS	<u>228</u>	<u>83,220</u>	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	<u>58,969</u>	<u>2,076</u>	<u>8,581</u>	<u>69,626</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>58,969</u>	<u>2,076</u>	<u>8,581</u>	<u>69,626</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.66%

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

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

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

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

None

F. Does the facility maintain a daily midnight census? Yes

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

YES NO

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

YES NO

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

Date started 10/24/1996

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

YES Date 10/24/1996 NO

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

YES NO If YES, enter number of beds certified 228 and days of care provided 8,559

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL 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 Washington Heights Nursing Home # 0042044 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	378,671	85,919	14,180	478,770		478,770	8,104	486,874			1
2	Food Purchase		300,404		300,404	(40,077)	260,327	(16,720)	243,607			2
3	Housekeeping	239,446	64,518		303,964		303,964	(4,979)	298,985			3
4	Laundry	49,244	47,265	200,899	297,408		297,408		297,408			4
5	Heat and Other Utilities			239,257	239,257		239,257	3,110	242,367			5
6	Maintenance	94,473	56	251,350	345,879		345,879	45,912	391,791			6
7	Other (specify):*							8,212	8,212			7
8	TOTAL General Services	761,834	498,162	705,686	1,965,682	(40,077)	1,925,605	43,638	1,969,243			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	3,570,583	122,494	4,099	3,697,176		3,697,176	18,116	3,715,292			10
10a	Therapy	143,919		1,632	145,551		145,551	3,198	148,749			10a
11	Activities	196,200	9,957	2,328	208,485		208,485		208,485			11
12	Social Services	158,421	2,382	2,619	163,422		163,422	15,653	179,075			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,255	6,255			15
16	TOTAL Health Care and Programs	4,069,123	134,833	22,678	4,226,634		4,226,634	43,222	4,269,856			16
	C. General Administration											
17	Administrative	97,673			97,673		97,673	57,023	154,696			17
18	Directors Fees											18
19	Professional Services			471,037	471,037	(3,500)	467,537	(401,127)	66,410			19
20	Dues, Fees, Subscriptions & Promotions			70,160	70,160		70,160	(13,999)	56,161			20
21	Clerical & General Office Expenses	116,359	27,229	576,445	720,033		720,033	(364,846)	355,187			21
22	Employee Benefits & Payroll Taxes			855,425	855,425	40,077	895,502	(2,511)	892,991			22
23	Inservice Training & Education			268	268		268		268			23
24	Travel and Seminar			3,070	3,070		3,070	4,610	7,680			24
25	Other Admin. Staff Transportation			3,512	3,512		3,512	(480)	3,032			25
26	Insurance-Prop.Liab.Malpractice			302,813	302,813		302,813	(154)	302,659			26
27	Other (specify):*							34,765	34,765			27
28	TOTAL General Administration	214,032	27,229	2,282,730	2,523,991	36,577	2,560,568	(686,719)	1,873,849			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,044,989	660,224	3,011,094	8,716,307	(3,500)	8,712,807	(599,859)	8,112,948			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home #0042044 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			84,043	84,043		84,043	360,693	444,736			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			56,238	56,238		56,238	368,658	424,896			32
33	Real Estate Taxes			328,000	328,000	3,500	331,500	2,563	334,063			33
34	Rent-Facility & Grounds			1,080,000	1,080,000		1,080,000	(1,075,093)	4,907			34
35	Rent-Equipment & Vehicles			6,155	6,155		6,155	1,505	7,660			35
36	Other (specify):*							35,452	35,452			36
37	TOTAL Ownership			1,554,436	1,554,436	3,500	1,557,936	(306,222)	1,251,714			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		537,905	423,515	961,420		961,420	(53,077)	908,343			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			124,848	124,848		124,848	(18)	124,830			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		537,905	548,363	1,086,268		1,086,268	(53,095)	1,033,173			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,044,989	1,198,129	5,113,893	11,357,011		11,357,011	(959,176)	10,397,835			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

Report Period Beginning: 01/01/06

Ending: 12/31/06

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	94,209	30		9
10	Interest and Other Investment Income	(292,325)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(88)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,875)	21		18
19	Entertainment				19
20	Contributions	(1,140)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(302,412)	21		24
25	Fund Raising, Advertising and Promotional	(16,851)	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	(366,219)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (888,701)		\$	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)	(70,474)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (70,474)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (959,176)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1	Other Income	21
2	Bury Duty	10
3	Patient Clothing	10
4	Theft Loss	21
5	Collection Expense	21
6	Non-Allowable Expense	21
7	Excess Provider Participation Fees	42
8	Non-Allowable Legal Fees	19
9	Annual Report	20
10	COPE Dues	20
11	Building Co. - Filing Fees	20
12	Non-Allowable Billing Service	19
13	Related Party Interest Expense	32
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100		100
101	Total	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington Heights Nursing Home

0042044

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			589				4,813	2,709		(7)		8,104	1
2	Food Purchase	(88)							(16,632)				(16,720)	2
3	Housekeeping										(4,979)		(4,979)	3
4	Laundry													4
5	Heat and Other Utilities			2,687			120		303				3,110	5
6	Maintenance			4,075	6,965	33,694	79		484		(155)	770	45,912	6
7	Other (specify):*				1,007	6,382		823					8,212	7
8	TOTAL General Services	(88)		7,351	7,972	40,076	199	5,636	(13,136)		(5,142)	770	43,638	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(105)						25,776			(7,555)		18,116	10
10a	Therapy							3,198					3,198	10a
11	Activities													11
12	Social Services				3,844			11,809					15,653	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				516			5,739					6,255	15
16	TOTAL Health Care and Programs	(105)			4,360			46,522			(7,555)		43,222	16
	C. General Administration													
17	Administrative			2,623	5,820			43,888	4,692				57,023	17
18	Directors Fees													18
19	Professional Services	(18,483)		(264,533)			(118,247)		136				(401,127)	19
20	Fees, Subscriptions & Promotions	(21,690)	250	7,220			49		212		(40)		(13,999)	20
21	Clerical & General Office Expenses	(564,142)		15,086	165,420		37	12,371	6,382				(364,846)	21
22	Employee Benefits & Payroll Taxes					(821)				(1,519)	(171)		(2,511)	22
23	Inservice Training & Education													23
24	Travel and Seminar			4,557			53						4,610	24
25	Other Admin. Staff Transportation			(793)					313				(480)	25
26	Insurance-Prop.Liab.Malpractice			(648)			27		467				(154)	26
27	Other (specify):*				25,539			7,663	1,563				34,765	27
28	TOTAL General Administration	(604,315)	250	(236,488)	196,779	(821)	(118,081)	63,922	13,765	(1,519)	(211)		(686,719)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(604,508)	250	(229,137)	209,111	39,255	(117,882)	116,080	629	(1,519)	(12,908)	770	(599,859)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Washington Heights Nursing Home # 0042044 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	94,209	242,970	12,966			357		105			10,086	360,693	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(378,384)	714,515	30,409			1,020		12			1,086	368,658	32
33	Real Estate Taxes			2,221			234		108				2,563	33
34	Rent-Facility & Grounds		(1,080,000)	4,907									(1,075,093)	34
35	Rent-Equipment & Vehicles			1,314					191				1,505	35
36	Other (specify):*		35,452										35,452	36
37	TOTAL Ownership	(284,175)	(87,063)	51,817			1,611		416			11,172	(306,222)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(23,670)		(7,507)	(21,900)	(53,077)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(18)											(18)	42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(18)							(23,670)		(7,507)	(21,900)	(53,095)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(888,701)	(86,813)	(177,320)	209,111	39,255	(116,271)	116,080	(22,625)	(1,519)	(20,414)	(9,958)	(959,176)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Washington Heights Property LLC		

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	34 Rent	\$ 1,080,000	Washington Heights Property LLC	100.00%	\$	\$ (1,080,000)	1
2	V	32 Interest	56,238	Washington Heights Property LLC	100.00%	770,753	714,515	2
3	V	20 Filing Fees		Washington Heights Property LLC	100.00%	250	250	3
4	V	30 Depreciation		Washington Heights Property LLC	100.00%	242,970	242,970	4
5	V	36 Amortization		Washington Heights Property LLC	100.00%	35,452	35,452	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		\$ 1,136,238			\$ 1,049,425	\$ * (86,813)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home# 0042044Report Period Beginning: 01/01/06Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary	\$	Care Centers, Inc.	100.00%	\$ 589	589	15	
16	V	05	Utilities		Care Centers, Inc.	100.00%	2,687	2,687	16	
17	V	06	Maintenance		Care Centers, Inc.	100.00%	4,075	4,075	17	
18	V								18	
19	V	17	Administration		Care Centers, Inc.	100.00%	2,623	2,623	19	
20	V	19	Professional Fees	284,433	Care Centers, Inc.	100.00%	19,900	(264,533)	20	
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	7,220	7,220	21	
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	15,086	15,086	22	
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	4,557	4,557	23	
24	V	26	Insurance		Care Centers, Inc.	100.00%	(648)	(648)	24	
25	V	30	Depreciation		Care Centers, Inc.	100.00%	12,966	12,966	25	
26	V	32	Interest		Care Centers, Inc.	100.00%	30,409	30,409	26	
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,221	2,221	27	
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	4,907	4,907	28	
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,314	1,314	29	
30	V	25	Bus Reimbursement	793	Care Centers, Inc.	100.00%		(793)	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			\$ 285,226			\$ 107,906	\$ * (177,320)	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 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	06	Maintenance Salary					Care Centers, Inc.	100.00%		6,965			6,965	15
16	V	07	Emp. Ben. - Gen. Serv.					Care Centers, Inc.	100.00%		1,007			1,007	16
17	V	10	Nursing Salary					Care Centers, Inc.	100.00%						17
18	V	10a	Rehab Salary					Care Centers, Inc.	100.00%						18
19	V	12	Social Service Salary					Care Centers, Inc.	100.00%		3,844			3,844	19
20	V	15	Emp. Ben. - Healthcare					Care Centers, Inc.	100.00%		516			516	20
21	V	17	Administration Salary					Care Centers, Inc.	100.00%		5,820			5,820	21
22	V	21	Office Salary					Care Centers, Inc.	100.00%		165,420			165,420	22
23	V	27	Emp. Ben. - Gen. Admin.					Care Centers, Inc.	100.00%		25,539			25,539	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					\$					\$ 209,111	\$ *	209,111		39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 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	06 Maintenance Salary	4,233	Care Centers, Inc.	100.00%	37,927	33,694	15
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	6,382	6,382	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V	17 Administration Salary		Care Centers, Inc.	100.00%			21
22	V	21 Office Salary		Care Centers, Inc.	100.00%			22
23	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%			23
24	V							24
25	V	22 Employee Benefits	821				(821)	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		\$ 5,054			\$ 44,309	\$ * 39,255	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19	Professional Fees	\$ 118,764	Care Centers Clinical, Inc.	100.00%	\$ 517	\$ (118,247)	15
16	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	49	49	16
17	V	21	Office and Clerical		Care Centers Clinical, Inc.	100.00%	37	37	17
18	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	53	53	18
19	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	357	357	19
20	V	32	Interest		Care Centers Clinical, Inc.	100.00%	1,020	1,020	20
21	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	120	120	21
22	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	79	79	22
23	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	27	27	23
24	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	234	234	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		\$ 118,764				\$ 2,493	\$ * (116,271)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01	Dietary Salary	\$	Care Centers Clinical, Inc.	100.00%	\$ 4,813	\$ 4,813	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	823	823	16
17	V	10	Nursing Salary		Care Centers Clinical, Inc.	100.00%	25,776	25,776	17
18	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	3,198	3,198	18
19	V	12	Social Service Salary		Care Centers Clinical, Inc.	100.00%	11,809	11,809	19
20	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	5,739	5,739	20
21	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	43,888	43,888	21
22	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	12,371	12,371	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	7,663	7,663	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		\$				\$ 116,080	\$ * 116,080	39

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

Facility Name & ID Number Washington Heights Nursing Home # 0042044 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	01 Dietary	\$	Care Centers Health Systems	100.00%	\$ 2,709	\$ 2,709	15
16	V	02 Food	19,709	Care Centers Health Systems	100.00%	3,077	(16,632)	16
17	V	05 Utilities		Care Centers Health Systems	100.00%	303	303	17
18	V	06 Maintenance		Care Centers Health Systems	100.00%	484	484	18
19	V	17 Administration		Care Centers Health Systems	100.00%	709	709	19
20	V	19 Professional Fees		Care Centers Health Systems	100.00%	136	136	20
21	V	20 Dues & Subscriptions		Care Centers Health Systems	100.00%	212	212	21
22	V	21 Office & Clerical		Care Centers Health Systems	100.00%	447	447	22
23	V	25 Auto Expenses		Care Centers Health Systems	100.00%	313	313	23
24	V	26 Insurance		Care Centers Health Systems	100.00%	467	467	24
25	V	30 Depreciation		Care Centers Health Systems	100.00%	105	105	25
26	V	32 Interest Expense		Care Centers Health Systems	100.00%	12	12	26
27	V	33 Real Estate Taxes		Care Centers Health Systems	100.00%	108	108	27
28	V	35 Rent - Equipment & Auto		Care Centers Health Systems	100.00%	191	191	28
29	V	39 Ancillary Enteral Supplies	52,845	Care Centers Health Systems	100.00%	29,175	(23,670)	29
30	V	17 Administrative-Salary		Care Centers Health Systems	100.00%	3,983	3,983	30
31	V	21 Office & Clerical-Salary		Care Centers Health Systems	100.00%	5,935	5,935	31
32	V	27 Emp. Ben. - Gen. Admin.		Care Centers Health Systems	100.00%	1,563	1,563	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 72,554			\$ 49,929	\$ * (22,625)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 75,020	\$ 75,020	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	76,539	CCS EMPLOYEE BENEFIT GROUP	100.00%		(76,539)	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			\$ 76,539			\$ 75,020	\$ * (1,519)	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	01 Dietary	\$ 91	Xcel Supply, LLC	100.00%	\$ 83	\$ (7)	15
16	V	03 Housekeeping	61,401	Xcel Supply, LLC	100.00%	56,422	(4,979)	16
17	V	04 Laundry		Xcel Supply, LLC	100.00%			17
18	V	06 Repairs & Maintenance	1,915	Xcel Supply, LLC	100.00%	1,760	(155)	18
19	V	10 Nursing	93,157	Xcel Supply, LLC	100.00%	85,603	(7,555)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees, Subscriptions & Promotions	488	Xcel Supply, LLC	100.00%	448	(40)	22
23	V	21 Clerical & General Office		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	2,111	Xcel Supply, LLC	100.00%	1,939	(171)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	92,563	Xcel Supply, LLC	100.00%	85,057	(7,507)	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		\$ 251,726			\$ 231,311	\$ * (20,414)	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	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 770	\$ 770	15
16	V	30	Depreciation		Vent Lease, LLC.	100.00%	10,086	10,086	16
17	V	32	Interest		Vent Lease, LLC.	100.00%	1,086	1,086	17
18	V	39	Vent/Ancillary Reimbursement	21,900	Vent Lease, LLC.	100.00%		(21,900)	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			\$ 21,900			\$ 11,942	\$ * (9,958)	39

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

Facility Name & ID Number Washington Heights Nursing Home # 0042044 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	Eric Rothner	Relative	Administrative	N/A	See Attached	1.46	3.16%	Alloc. Salary	\$ 2,387	17-7	1
2	Gale Rothner	Relative	Administrative	N/A	See Attached	1.53	4.37%	Alloc. Salary	3,410	17-7	2
3	Mark Steinberg	Relative	Administrative	N/A	See Attached	2.40	4.36%	Alloc. Salary	5,839	17-7	3
4	David Aronin	Owner	Administrative	0.89%	See Attached	1.72	3.06%	Alloc. Salary	3,277	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 14,913		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 Washington Heights Nursing Home

0042044

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	01	Dietary	Patient Days	1,592,658	31	\$ 13,468	\$ 69,626	\$ 589	1
2	05	Utilities	Patient Days	1,592,658	31	61,456	69,626	2,687	2
3	06	Maintenance	Patient Days	1,592,658	31	93,209	69,626	4,075	3
4									4
5	17	Administration	Patient Days	1,592,658	31	60,000	69,626	2,623	5
6	19	Professional Fees	Patient Days	1,592,658	31	455,203	69,626	19,900	6
7	20	Dues and Subscriptions	Patient Days	1,592,658	31	165,158	69,626	7,220	7
8	21	Office & Clerical	Patient Days	1,592,658	31	345,085	69,626	15,086	8
9	24	Travel and Seminar	Patient Days	1,592,658	31	104,250	69,626	4,557	9
10	26	Insurance	Patient Days	1,592,658	31	(14,814)	69,626	(648)	10
11	30	Depreciation	Patient Days	1,592,658	31	296,584	69,626	12,966	11
12	32	Interest	Patient Days	1,592,658	31	695,586	69,626	30,409	12
13	33	Real Estate Taxes	Patient Days	1,592,658	31	50,799	69,626	2,221	13
14	34	Rent - Building	Patient Days	1,592,658	31	112,256	69,626	4,907	14
15	35	Rent - Equipment & Auto	Patient Days	1,592,658	31	30,066	69,626	1,314	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,468,306	\$	\$ 107,906	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	06	Maintenance Salary	Patient Days	1,592,658	31	159,318	159,318	69,626	6,965	1
2	07	Emp. Ben. - Gen. Serv.	Patient Days	1,592,658	31	23,038		69,626	1,007	2
3	10	Nursing Salary	Patient Days	1,592,658	31			69,626		3
4	10a	Rehab Salary	Patient Days	1,592,658	31			69,626		4
5	12	Social Service Salary	Patient Days	1,592,658	31	87,938	87,938	69,626	3,844	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,592,658	31	11,794		69,626	516	6
7	17	Administration Salary	Patient Days	1,592,658	31	133,122	133,122	69,626	5,820	7
8	21	Office Salary	Patient Days	1,592,658	31	3,783,895	3,783,895	69,626	165,420	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,592,658	31	584,195		69,626	25,539	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					\$ 4,783,299	\$ 4,164,272		\$ 209,111	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	06	Maintenance Salary	Direct Allocation	26	366,540	366,540		37,927	1
2	07	Emp. Ben. - Gen. Serv.	Direct Allocation	26	60,795			6,382	2
3									3
4									4
5									5
6									6
7									7
8	21	Office Salary	Direct Allocation	23	418,249	418,249			8
9	27	Emp. Ben. - Gen. Admin.	Direct Allocation	23	70,744				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				\$ 916,329	\$ 784,790		\$ 44,309	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 Care Centers Clinical, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	19	Professional Fees	Patient Days	1,592,658	30	\$ 11,820	\$ 69,626	\$ 517	1
2	20	Dues and Subscriptions	Patient Days	1,592,658	30	1,118	69,626	49	2
3	21	Office and Clerical	Patient Days	1,592,658	30	847	69,626	37	3
4	24	Travel and Seminar	Patient Days	1,592,658	30	1,201	69,626	53	4
5	30	Depreciation	Patient Days	1,592,658	30	8,167	69,626	357	5
6	32	Interest	Patient Days	1,592,658	30	23,321	69,626	1,020	6
7	05	Utilities	Patient Days	1,592,658	30	2,749	69,626	120	7
8	06	Maintenance	Patient Days	1,592,658	30	1,817	69,626	79	8
9	26	Insurance	Patient Days	1,592,658	30	623	69,626	27	9
10	33	Real Estate Taxes	Patient Days	1,592,658	30	5,358	69,626	234	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					\$ 57,020	\$	\$ 2,493	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 Care Centers Clinical, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	01	Dietary Salary	Patient Days	1,592,658	30	110,093	110,093	69,626	4,813	1
2	07	Emp. Ben. - Gen. Serv.	Patient Days	1,592,658	30	18,826	18,826	69,626	823	2
3	10	Nursing Salary	Patient Days	1,592,658	30	589,608		69,626	25,776	3
4	10a	Rehab Salary	Patient Days	1,592,658	30	73,158	73,158	69,626	3,198	4
5	12	Social Service Salary	Patient Days	1,592,658	30	270,126	270,126	69,626	11,809	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,592,658	30	131,280		69,626	5,739	6
7	17	Administration Salary	Patient Days	1,592,658	30	1,003,912		69,626	43,888	7
8	21	Office Salary	Patient Days	1,592,658	30	282,969	282,969	69,626	12,371	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,592,658	30	175,293		69,626	7,663	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					\$ 2,655,265	\$ 755,172		\$ 116,080	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 Care Centers Health Systems
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	01	Dietary	Billable Income	2,455,454	33	91,698	72,554	2,709	1
2	02	Food	Billable Income	2,455,454	33	104,128	72,554	3,077	2
3	05	Utilities	Billable Income	2,455,454	33	10,245	72,554	303	3
4	06	Maintenance	Billable Income	2,455,454	33	16,367	72,554	484	4
5	17	Administration	Billable Income	2,455,454	33	24,000	72,554	709	5
6	19	Professional Fees	Billable Income	2,455,454	33	4,618	72,554	136	6
7	20	Dues & Subscriptions	Billable Income	2,455,454	33	7,167	72,554	212	7
8	21	Office & Clerical	Billable Income	2,455,454	33	15,126	72,554	447	8
9	25	Auto Expenses	Billable Income	2,455,454	33	10,605	72,554	313	9
10	26	Insurance	Billable Income	2,455,454	33	15,802	72,554	467	10
11	30	Depreciation	Billable Income	2,455,454	33	3,557	72,554	105	11
12	32	Interest Expense	Billable Income	2,455,454	33	392	72,554	12	12
13	33	Real Estate Taxes	Billable Income	2,455,454	33	3,660	72,554	108	13
14	35	Rent - Equipment & Auto	Billable Income	2,455,454	33	6,478	72,554	191	14
15	39	Ancillary Enteral Supplies	Billable Income	2,455,454	33	987,356	72,554	29,175	15
16	17	Administrative-Salary	Billable Income	2,455,454	33	134,802	72,554	3,983	16
17	21	Office & Clerical-Salary	Billable Income	2,455,454	33	200,852	200,852	5,935	17
18	27	Emp. Ben. - Gen. Admin.	Billable Income	2,455,454	33	52,885	52,885	1,563	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,689,738	\$ 253,738	\$ 49,929	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 2201 MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

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	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 75,020	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				\$	\$		\$ 75,020	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 Xcel Supply, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

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	01	Dietary						\$ 83	1
2	03	Housekeeping						56,422	2
3	04	Laundry							3
4	06	Repairs & Maintenance						1,760	4
5	10	Nursing						85,603	5
6	11	Activities							6
7	12	Social Service							7
8	20	Dues, Fees, Subscriptions & Prom						448	8
9	21	Clerical & General Office							9
10	22	Employee Benefits						1,939	10
11	24	Seminars & Education							11
12	39	Ancillary						85,057	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				\$	\$		\$ 231,311	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 Vent Lease, LLC
 Street Address 2201 W. Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

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	06	Repairs	Direct Billing	868,537	31	\$ 30,521	\$ 21,900	\$ 770	1
2	30	Depreciation	Direct Billing	868,537	31	400,000	21,900	10,086	2
3	32	Interest	Direct Billing	868,537	31	43,063	21,900	1,086	3
4	39	Vent/Ancillary Reimbursement							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					\$ 473,584	\$	\$ 11,942	25

SEE ACCOUNTANTS' COMPILATION REPORT

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	Business Partners LLC		X	Mortgage			\$	\$ 10,149,805		\$ 684,693	1									
2											2									
3											3									
4											4									
5	See Supplemental Schedule										5									
Working Capital																				
6	Diawa		X	Line Of Credit						\$ 56,238	6									
7											7									
8	See Supplemental Schedule										8									
9	TOTAL Facility Related						\$	\$ 10,149,805		\$ 740,931	9									
B. Non-Facility Related*																				
10	South Shore Partnership	X						1,272,847		86,059	10									
11	Interest Income		X							(292,325)	11									
12	Interest Income - Bldg. Co.									(56,238)	12									
13	See Supplemental Schedule									(53,532)	13									
14	TOTAL Non-Facility Related						\$	\$ 1,272,847		\$ (316,036)	14									
15	TOTALS (line 9+line14)						\$	\$ 11,422,652		\$ 424,895	15									

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

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

	1	2		3	4	5	6		7	8	9	10							
		Name of Lender	Related**				Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
			YES											NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital											14							
	B. Non-Facility Related*																		
15	Care Centers Allocation		X				\$	\$			\$	32,527							
16	Related Party Interest	X										(86,059)							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related											(53,532)							

* 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 Washington Heights Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042044

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>25-05-423-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,207.91</u>	\$ <u>1,207.91</u>
2. <u>25-05-423-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,333.12</u>	\$ <u>1,333.12</u>
3. <u>25-05-423-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,523.81</u>	\$ <u>1,523.81</u>
4. <u>25-05-423-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,476.84</u>	\$ <u>1,476.84</u>
5. <u>25-05-423-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>7,804.95</u>	\$ <u>7,804.95</u>
6. <u>25-05-423-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>40,015.21</u>	\$ <u>40,015.21</u>
7. <u>25-05-423-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>48,256.85</u>	\$ <u>48,256.85</u>
8. <u>25-05-423-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>124,666.30</u>	\$ <u>124,666.30</u>
9. <u>25-05-423-009-0000</u>	<u>Long Term Care Property</u>	\$ <u>98,424.28</u>	\$ <u>98,424.28</u>
10. <u>Home Office Allocation</u>	<u>See Attached</u>	\$ <u>53,052.60</u>	\$ <u>2,773.30</u>
	TOTALS	\$ <u>377,761.87</u>	\$ <u>327,482.57</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

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

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington Heights Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042044

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>2201 MAIN BUILDING</u>	<u>CARE CENETR, INC.</u>	\$ <u>45,054.56</u>	\$ <u>1,969.64</u>
2. <u>2201 MAIN BUILDING</u>	<u>CARE CENTER CLINICAL</u>	\$ <u>4,751.91</u>	\$ <u>207.74</u>
3. <u>2201 MAIN BUILDING</u>	<u>CARE CENTER HEALTH SYSTEMS</u>	\$ <u>3,246.13</u>	\$ <u>95.92</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>53,052.60</u>	\$ <u>2,273.30</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Washington Heights Nursing Home

0042044 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,255 B. General Construction Type: Exterior Brick Frame Masonry/Steel Number of Stories 3

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

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

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

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

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 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	<u>Facility</u>	<u>85,244</u>	<u>1994</u>	<u>\$ 251,898</u>	1
2	<u>Care Centers Allocation</u>			<u>16,017</u>	2
3	TOTALS	85,244		\$ 267,915	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various			1996	21,522		20	1,077	1,077	11,254	9
10	Various			1997	179,381		20	8,971	8,971	84,796	10
11	Various			1998	71,893		20	3,596	3,596	30,657	11
12	Various			1999	54,109		20	2,705	2,705	20,140	12
13	Various			2000	102,147		20	5,618	5,618	37,425	13
14	Various			2001	61,238		20	3,063	3,063	17,918	14
15	Various			2002	93,299		20	10,866	10,866	49,753	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

*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 Washington Heights Nursing Home

0042044

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		10,226,094	242,970		254,542	11,572	2,555,458	67
68		62,857	1,779		2,604	825	10,370	68
69			84,043			(84,043)		69
70		\$ 10,872,540	\$ 328,792		\$ 293,042	\$ (35,750)	\$ 2,817,771	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

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Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 10,872,540	\$ 328,792		\$ 293,042	\$ (35,750)	\$ 2,817,771	1
2	Ceiling Tile	2003	585		20	59	59	234	2
3	Elevator Repair	2003	2,529		20	253	253	885	3
4	Exit Doors	2003	1,180		20	59	59	207	4
5	Elevator Doors	2004	3,187		20	159	159	478	5
6	Repair Elevator Door	2004	3,187		20	159	159	451	6
7	New Telephone System	2004	2,929		20	586	586	1,660	7
8	Midwest Mechanical	2004	575		20	58	58	163	8
9	New Telephone System	2004	2,670		20	534	534	1,513	9
10	Roof Repair	2004	1,200		20	120	120	300	10
11	Radio Controlled Doors	2004	4,763		20	476	476	1,151	11
12	Widen Driveway	2004	1,875		20	188	188	438	12
13	Widen Driveway	2004	2,000		20	200	200	467	13
14	Elevator Recall System	2004	2,200		20	110	110	257	14
15	Widen Driveway	2004	1,875		20	188	188	438	15
16	Back Lot Pavement	2004	2,685		20	269	269	627	16
17	Locks On Doors	2004	7,574		20	1,515	1,515	3,535	17
18	Piping & Wiring	2004	1,656		20	166	166	373	18
19	Lab To Remove Debris	2004	2,623		20	262	262	568	19
20	Repair Epdm Roof	2004	700		20	70	70	152	20
21	Fire Alarm System	2004	1,200		20	240	240	520	21
22	Elevator Recall System	2004	1,200		20	60	60	130	22
23	Lighting Maintenance	2004	578		20	58	58	120	23
24	Repair Epdm Roof	2004	650		20	65	65	135	24
25	Plumbing Maintenance	2004	1,300		20	130	130	271	25
26	Smoke Damper	2004	1,448		20	207	207	431	26
27	Zone Valve Thermostat	2004	1,020		20	204	204	425	27
28	Exhaust Fan	2004	1,223		20	245	245	510	28
29	Window Treatment Rods	2004	1,613		20	161	161	336	29
30	Hot Water Heater - Repair	2004	1,579		20	132	132	274	30
31	Hvac	2004	2,811		20	281	281	843	31
32	Repairs To Shower Rooms	2004	825		20	83	83	193	32
33	Hvac	2004	1,548		20	155	155	426	33
34	TOTAL (lines 1 thru 33)		\$ 10,935,528	\$ 328,792		\$ 300,494	\$ (28,298)	\$ 2,836,282	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 10,935,528	\$ 328,792		\$ 300,494	\$ (28,298)	\$ 2,836,282	1
2	Pneumatic Thermostat And Installation	2004	1,117		20	112	112	279	2
3	Sprinkler Repairs	2004	556		20	28	28	79	3
4	Doors	2004	2,077		20	104	104	251	4
5	Generator Repair	2005	5,667		20	1,133	1,133	1,983	5
6	5 Oak Doors	2005	3,440		20	688	688	1,147	6
7	Plumbing For Catch Basin	2005	5,437		20	544	544	861	7
8	Hvac Repair	2005	1,519		20	76	76	108	8
9	Plumbing	2005	2,124		20	106	106	133	9
10	Midwest Mech Repairs To Laundry Exhaust	2006	7,125		20	653	653	653	10
11	Midwest Mech Repairs To Boiler	2006	2,962		20	272	272	272	11
12	Home Office Pr-Painting	2006	1,241		20	83	83	83	12
13	Home Office Pr-Painting	2006	14,602		20	852	852	852	13
14	Home Office Pr-Painting	2006	7,947		20	397	397	397	14
15	New Door	2006	2,741		20	137	137	137	15
16	Vinyl Sheets-Dividers-Corners	2006	3,531		20	118	118	118	16
17	Home Office Pr - Painting	2006	2,070		20	52	52	52	17
18	Vinyl Sheets - Dividers Corners	2006	3,743		20	94	94	94	18
19	Home Office Pr - Painting	2006	12,605		20	210	210	210	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)		\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

Report Period Beginning:

01/01/06

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991	34

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	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	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991		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
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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)	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991	34

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	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991		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
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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)	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991		34

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	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 12G, Carried Forward	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991		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
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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)	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991		34

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	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 12H, Carried Forward		\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12I, Carried Forward	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991		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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991		34

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	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 12J, Carried Forward	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

Report Period Beginning:

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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 12K, Carried Forward		\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991	34

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	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12M, Carried Forward	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991		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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991	34

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	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12O, Carried Forward	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991		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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991		34

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	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		\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 11,016,032	\$ 328,792		\$ 306,153	\$ (22,639)	\$ 2,843,991	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	228		1996	1996	\$ 10,226,094	\$ 242,970	39	\$ 254,542	\$ 11,572	\$ 2,555,458	4
5											5
6											6
7											7
8											8
Improvement Type**											
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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 10,226,094	\$ 242,970		\$ 254,542	\$ 11,572	\$ 2,555,458	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4		2201 Main LLC Allocation	2002	2002	\$ 19,123	\$ 490		\$ 490	\$	\$ 2,104	4
5		Care Centers Clinical Allocation	2002	2002	2,017	52		52		222	5
6		Care Centers Health System Allocation	2002	2002	931	24		24		102	6
7											7
8											8
Improvement Type**											
9		2201 Main LLC Allocation		2002	15,797	657	20	790	133	3,554	9
10		2201 Main LLC Allocation		2003	18,616	354	20	931	577	3,258	10
11		2201 Main LLC Allocation		2005	925	41	20	46	5	69	11
12											12
13		Care Centers Clinical Allocation		2002	1,666	69	20	83	14	375	13
14		Care Centers Clinical Allocation		2003	1,963	37	20	98	61	344	14
15		Care Centers Clinical Allocation		2005	98	4	20	5	1	7	15
16											16
17		Care Centers Health System Allocation		2002	769	32	20	38	6	173	17
18		Care Centers Health System Allocation		2003	907	17	20	45	28	159	18
19		Care Centers Health System Allocation		2005	45	2	20	2		3	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	62,857	\$	1,779	\$	2,604	\$	825	\$	10,370	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home # 0042044 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	\$ 415,571	\$ 21,159	\$ 134,192	\$ 113,033	10	\$ 306,854	71
72	Current Year Purchases	19,264	64	1,681	1,617	10	1,681	72
73	Fully Depreciated Assets	679,044				10	679,044	73
74								74
75	TOTALS	\$ 1,113,879	\$ 21,223	\$ 135,873	\$ 114,650		\$ 987,579	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	Care Centers, Inc.	Allocation	1900	\$ 31,437	\$ 382	\$ 2,580	\$ 2,198	5	\$ 123,117	76
77	Care Centers Clinical	Allocation	1900	1,912	129	129		5	129	77
78										78
79										79
80	TOTALS			\$ 33,349	\$ 511	\$ 2,709	\$ 2,198		\$ 123,246	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)	\$ 12,431,175	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 350,526	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 444,735	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 94,209	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,954,816	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Care Centers Allocation				4,907			5
6								6
7	TOTAL				\$ 4,907			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 7,661 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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 - 03	hrs	\$		\$ 224,518	\$		\$ 224,518	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			32,040			32,040	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			145,335			145,335	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescripts			439	332,914		333,353	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 Supplemental					21,183	204,991		226,174	13
14	TOTAL			\$		\$ 423,515	\$ 537,905		\$ 961,420	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 Washington Heights Nursing Home# 0042044Report 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	\$ 1,000	\$ 133,780	1
2	Cash-Patient Deposits	56,674	56,674	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,848,838	2,189,738	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	360,739	360,739	6
7	Other Prepaid Expenses	10,968	10,968	7
8	Accounts Receivable (owners or related parties)		15,170	8
9	Other(specify): <u>See Attached Schedule</u>	3,381,205	3,481,399	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,659,424	\$ 6,248,468	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		251,898	13
14	Buildings, at Historical Cost		8,473,923	14
15	Leasehold Improvements, at Historical Cost	599,195	1,034,259	15
16	Equipment, at Historical Cost	430,471	2,415,898	16
17	Accumulated Depreciation (book methods)	(679,630)	(5,185,797)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>		121,373	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 350,036	\$ 7,111,554	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,009,460	\$ 13,360,022	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,862,808	\$ 2,203,707	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	50,529	50,529	28
29	Short-Term Notes Payable	1,101,908		29
30	Accrued Salaries Payable	194,498	194,498	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,042	8,042	31
32	Accrued Real Estate Taxes(Sch.IX-B)	340,900	340,900	32
33	Accrued Interest Payable		56,374	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	2,110	132,416	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,560,795	\$ 2,986,466	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		11,422,652	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 11,422,652	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,560,795	\$ 14,409,118	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,448,665	\$ (1,049,096)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,009,460	\$ 13,360,022	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,319,859	1
2	Restatements (describe):		2
3	<u>Retained Earnings</u>	(1,048)	3
4	<u>Depreciation</u>	3,253	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,322,064	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(770,199)	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	(103,200)	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)	\$ (873,399)	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)	\$ 2,448,665	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

Report Period Beginning: 01/01/06

Ending: 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	\$ 10,051,402	1
2	Discounts and Allowances for all Levels	(2,254,951)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,796,451	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,921,485	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,921,485	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	312,835	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	106,704	19
20	Radiology and X-Ray	11,280	20
21	Other Medical Services	93,683	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 524,502	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	292,325	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 292,325	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	52,049	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 52,049	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,586,812	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,965,682	31
32	Health Care	4,226,634	32
33	General Administration	2,523,991	33
B. Capital Expense			
34	Ownership	1,554,436	34
C. Ancillary Expense			
35	Special Cost Centers	961,420	35
36	Provider Participation Fee	124,848	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,357,011	40
41	Income before Income Taxes (line 30 minus line 40)**	(770,199)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (770,199)	43

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

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

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

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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	1,849	2,073	\$ 80,156	\$ 38.67	1
2	Assistant Director of Nursing	3,918	7,014	222,625	31.74	2
3	Registered Nurses	20,495	22,274	586,108	26.31	3
4	Licensed Practical Nurses	55,226	58,769	1,360,784	23.15	4
5	CNAs & Orderlies	121,587	133,630	1,293,234	9.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,241	10,213	143,919	14.09	8
9	Activity Director	3,466	3,911	52,427	13.41	9
10	Activity Assistants	15,655	16,800	143,773	8.56	10
11	Social Service Workers	10,422	11,875	158,421	13.34	11
12	Dietician	923	947	14,227	15.02	12
13	Food Service Supervisor	1,885	2,199	37,456	17.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,669	7,568	82,621	10.92	15
16	Dishwashers	27,632	29,643	244,367	8.24	16
17	Maintenance Workers	6,253	6,906	94,473	13.68	17
18	Housekeepers	26,012	28,606	239,446	8.37	18
19	Laundry	4,838	5,598	49,244	8.80	19
20	Administrator	1,417	1,618	52,045	32.17	20
21	Assistant Administrator	1,736	2,056	45,628	22.19	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,319	9,386	116,359	12.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,838	2,106	27,676	13.14	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	329,381	363,192	\$ 5,044,989 *	\$ 13.89	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	320	\$ 14,180	01-03	35
36	Medical Director	96	12,000	09-03	36
37	Medical Records Consultant	13	995	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,954	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,328	11-03	44
45	Social Service Consultant	49	2,619	12-03	45
46	Other(specify) <u>Therapy Consult.</u>	40	1,632	10a-03	46
47	<u>Nurse Consultant</u>	3	150	10-03	47
48					48
49	TOTAL (lines 35 - 48)	569	\$ 36,858		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

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	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	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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8													
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11													
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13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council On Long Term Care \$11,025
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,599 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. \$ 124,830
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. \$ 40,077 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT