

Facility Name & ID Number Washington and Jane Smith Community

0015032 Report Period Beginning: 7/1/05 Ending: 6/30/06

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	103	35,174	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	185	Sheltered Care (SC)	82	57,637	5
6		ICF/DD 16 or Less			6
7	279	TOTALS	185	92,811	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	9,073	18,339	3,611	31,023	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	1,845	30,130		31,975	12
13	DD 16 OR LESS					13
14	TOTALS	10,918	48,469	3,611	62,998	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.88%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 5/25/1926

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 103 and days of care provided 2,509

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/06 Fiscal Year: 6/30/06

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

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 7/1/05 Ending: 6/30/06

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	588,469		315,879	904,348		904,348		904,348		1
2	Food Purchase		519,028		519,028		519,028	(2,623)	516,405		2
3	Housekeeping	257,566	57,161		314,727		314,727		314,727		3
4	Laundry	107,009	22,816	205	130,030		130,030		130,030		4
5	Heat and Other Utilities			415,110	415,110		415,110		415,110		5
6	Maintenance	313,458	9,693	175,015	498,166		498,166	(22,925)	475,241		6
7	Other (specify):*			25,700	25,700		25,700	(25,700)			7
8	TOTAL General Services	1,266,502	608,698	931,909	2,807,109		2,807,109	(51,248)	2,755,861		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,849,885	62,048	37,535	2,949,468	(1,240)	2,948,228	(646)	2,947,582		10
10a	Therapy			276,467	276,467		276,467		276,467		10a
11	Activities	327,305	11,341	25,542	364,188		364,188		364,188		11
12	Social Services			754	754		754		754		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*			1,304	1,304		1,304	(1,304)			15
16	TOTAL Health Care and Programs	3,177,190	73,389	365,602	3,616,181	(1,240)	3,614,941	(1,950)	3,612,991		16
	C. General Administration										
17	Administrative	110,775		1,150,927	1,261,702		1,261,702	(1,150,927)	110,775		17
18	Directors Fees										18
19	Professional Services			76,132	76,132		76,132	51,204	127,336		19
20	Dues, Fees, Subscriptions & Promotions			11,229	11,229		11,229	5,526	16,755		20
21	Clerical & General Office Expenses	158,743	52,872	61,278	272,893	(1,041)	271,852	623,133	894,985		21
22	Employee Benefits & Payroll Taxes			1,197,403	1,197,403	1,027	1,198,430	149,650	1,348,080		22
23	Inservice Training & Education										23
24	Travel and Seminar			19,529	19,529		19,529	10,257	29,786		24
25	Other Admin. Staff Transportation					316	316		316		25
26	Insurance-Prop.Liab.Malpractice			216,842	216,842		216,842	14,500	231,342		26
27	Other (specify):*			24,106	24,106		24,106	(24,106)			27
28	TOTAL General Administration	269,518	52,872	2,757,446	3,079,836	302	3,080,138	(320,763)	2,759,375		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,713,210	734,959	4,054,957	9,503,126	(938)	9,502,188	(373,961)	9,128,227		29

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

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

Facility Name & ID Number Washington and Jane Smith Community

#0015032

Report Period Beginning:

7/1/05

Ending:

6/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			543,587	543,587		543,587	(5,349)	538,238			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			423,626	423,626		423,626	(90,483)	333,143			32
33	Real Estate Taxes			7,531	7,531		7,531	(7,531)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Amort debt issuance			97,468	97,468		97,468	(75,700)	21,768			36
37	TOTAL Ownership			1,072,212	1,072,212		1,072,212	(179,063)	893,149			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		221,568		221,568	938	222,506		222,506			39
40	Barber and Beauty Shops			52,276	52,276		52,276	(43,898)	8,378			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,762	52,762		52,762		52,762			42
43	Other (specify):*	90,090	81	27,809	117,980		117,980	(117,980)				43
44	TOTAL Special Cost Centers	90,090	221,649	132,847	444,586	938	445,524	(161,878)	283,646			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,803,300	956,608	5,260,016	11,019,924		11,019,924	(714,902)	10,305,022			45

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

Part V - Cost Center Expenses - Supplemental Schedule for Other Adjustments

<u>Description</u>	<u>Amount</u>	<u>Line</u>
Depreciation expense for R&M capitalized	\$ 5,988	30
Add back payroll clearing credits - wrong account	<u>1,325</u>	21
	\$ 7,313	

Part V - Reclassifications

		From Line	To Line
Reclassify employee appreciation	\$ 924	10	22
Reclassify business use gas & parking	316	10	25
Reclassify administrator license reimbursement	103	21	22
Reclassify resident dental work	938	21	39

Facility Name & ID Number Washington and Jane Smith Community

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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	(2,623)	2		4
5	Telephone, TV & Radio in Resident Rooms	(25,700)	7		5
6	Rented Facility Space	(14,000)	6		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(6,479)	6		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(209,923)	36		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	150,984	36		24
25	Fund Raising, Advertising and Promotional	(91,093)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(290,528)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (489,362)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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)	(232,853)		34
35	Other- Attach Schedule Part V-SUPP	7,313		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (225,540)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (714,902)		37

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

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

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

Washington and Jane Smith Community

ID# 0015032

Report Period Beginning: 7/1/05

Ending: 6/30/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Guest room income	\$ (2,446)	6	1
2	Late fee charges	(156)	10	2
3	Unallowable lab services	(490)	10	3
4	Flowers	(1,304)	15	4
5	Unallowable legal expense	(31,415)	19	5
6	Appraisal	(2,000)	19	6
7	Marketing consultant	(253)	19	7
8	Investment expense	(4,119)	21	8
9	Non-supported admin expense	(659)	21	9
10	Entertainment	(2,078)	21	10
11	Telephone income	(903)	21	11
12	Miscellaneous resident charges	(300)	21	12
13	Public relations	(1,787)	21	13
14	Benefits - investment advisory fee	(508)	22	14
15	Donations	(865)	27	15
16	Investment advisory fee	(23,241)	27	16
17	Apt - Depreciation expense	(32,444)	30	17
18	Interest on gift annuities	(15,450)	32	18
19	Bond Interest - Apt	(75,033)	32	19
20	Property taxes	(7,531)	33	20
21	Misc. bond expense	(23,661)	36	21
22	State and Federal Income tax	6,900	36	22
23	Beauty shop income offset	(43,898)	40	23
24	Apt - Yard maintenance	(1,135)	43	24
25	Apt - Equipment repairs	(651)	43	25
26	Apt - Plumbing repairs	(125)	43	26
27	Apt - Building repairs	(1,381)	43	27
28	Apt - Heating repairs	(70)	43	28
29	Apt - Interest on security deposit	(111)	43	29
30	Apt - Refuse disposal	(1,173)	43	30
31	Apt - Utilities gas	(16,558)	43	31
32	Apt - Utilities electric	(1,950)	43	32
33	Apt - Utilities water	(1,777)	43	33
34	Apt - Expensed furniture & equipment	(411)	43	34
35	Podiatry	(1,545)	43	35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(290,528)		49

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
				WJS-Corporate	Blue Island	Not-for-profit
				WJS-Orland Park	Orland Park	Not-for-profit CCRC

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	17 Corporate admin fees	\$ 1,150,927	Washington & Jane Smith Home - Corporate (WJS-Corporate)		\$	(1,150,927)	1
2	V	19 Professional fees				84,872	84,872	2
3	V	20 Fees, dues, subscriptions				5,526	5,526	3
4	V	21 Clerical & office expense				631,654	631,654	4
5	V	22 Employee benefits				150,158	150,158	5
6	V	24 Travel & seminar				10,257	10,257	6
7	V	26 Insurance				14,500	14,500	7
8	V	30 Depreciation				21,107	21,107	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,150,927			\$ 918,074	\$ * (232,853)	14

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

Facility Name & ID Number Washington and Jane Smith Community # 0015032 Report Period Beginning: 7/1/05 Ending: 6/30/06

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	James J. Nemece	Board Member	Trustee of the	None	None	5	12.50	Investment	\$ 23,749	27.3	1
2			Board and Owner					Services			2
3			Of Heritage Capital								3
4											4
5	Allen K. Flagler	Board Member	Trustee of the	None	None	0	0.00	Insurance	21,088	26.3	5
6			Board and Owner					Premiums			6
7			of Orthon Group								7
8											8
9	Thomas E. Chomicz	Board Member	Trustee of the	None	None	Less than 1	0.00	Legal Svc	4,350	19.3	9
10			Board and Partner								10
11			at Quarles & Brady								11
12											12
13								TOTAL	\$ 49,187		13

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

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

Facility Name & ID Number Washington and Jane Smith Community

0015032

Report Period Beginning:

7/1/05

Ending: 6/30/06

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 Washington and Jane Smith Home
 Street Address 12015 S. Western Avenue, Suite 201
 City / State / Zip Code Blue Island, IL 60406
 Phone Number (773) 474-7350
 Fax Number (773) 474-7352

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	19	Professional fees	Direct Cost	2	\$ 145,074	\$ 0	11,019,924	\$ 84,872	1
2	20	Fees, dues, subscriptions	Direct Cost	2	9,445	0	11,019,924	5,526	2
3	21	Clerical & office expense	Direct Cost	2	1,079,706	918,991	11,019,924	631,654	3
4	22	Employee benefits	Direct Cost	2	256,669	0	11,019,924	150,158	4
5	24	Travel & seminar	Direct Cost	2	17,532	0	11,019,924	10,257	5
6	26	Insurance	Direct Cost	2	24,786	0	11,019,924	14,500	6
7	30	Depreciation	Direct Cost	2	36,079	0	11,019,924	21,107	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				\$ 1,569,291	\$ 918,991		\$ 918,074	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	IHFA Series 1991		x	Construction	Varies	1991	\$ 5,800,000	\$	7/2026	Variable	\$ 76,220	1								
2	IHFA Series 2005A		x	Bond Refin & Construction	Varies	12/2005	34,305,000	34,305,000	11/2035	0.0525	74,380	2								
3	IHFA Series 2005B-1		x	Construction	Varies	12/2005	5,000,000	5,000,000	11/2035	0.0500	10,841	3								
4	IHFA Series 2005B-2		x	Construction	Varies	12/2005	2,500,000	2,500,000	11/2010	0.0500	5,420	4								
5	IHFA Series 2005C		x	Construction	Varies	12/2005	20,000,000	20,000,000	11/2010	Variable	43,363	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 67,605,000	\$ 61,805,000			\$ 210,224	9								
B. Non-Facility Related*																				
10	Bond Interest - Apt										75,033	10								
11	Interest on Gift Annuities										8,325	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 83,358	14								
15	TOTALS (line 9+line14)						\$ 67,605,000	\$ 61,805,000			\$ 293,582	15								

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.

\$ _____ 1

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$ _____ 2

3. Under or (over) accrual (line 2 minus line 1).

\$ _____ 3

4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ _____ 4

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$ _____ 5

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$ _____ 6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ _____ 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	_____	8
	2002	_____	9
	2003	_____	10
	2004	_____	11
	2005	_____	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2005	\$ _____	13
14	PLUS APPEAL COST FROM LINE 5	\$ _____	14
15	LESS REFUND FROM LINE 6	\$ _____	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ _____	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

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 and Jane Smith Community COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0015032

CONTACT PERSON REGARDING THIS REPORT Douglas J. Grimes, CPA

TELEPHONE (574) 232-3992 FAX #: (574) 236-8692

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>N/A</u>	<u></u>	\$ <u></u>	\$ <u></u>
2. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u></u>	\$ <u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 185,200 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

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

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

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

112248 S. Oakley Avenue - Morrison Home

11365 S. Western Avenue - Apartments (costs adjusted out on page 5)

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Land</u>	<u>247,516</u>	<u>Pre 1994</u>	<u>\$ 649,404</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	247,516		\$ 649,404	3

Facility Name & ID Number Washington and Jane Smith Community

0015032

Report Period Beginning:

7/1/05

Ending:

6/30/06

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	77		1992	\$ 4,868,578	\$ 139,102	35	\$ 139,102	\$	\$ 1,947,430	4
5	108		2006	14,625,000	121,875	40	121,875		121,875	5
6										6
7										7
8										8
	Improvement Type**									
9										9
10	ADJUSTMENTS:									
11	FY 2006 Depr exp related to demolished bldg									
12	FY 2006 Depr exp related to demolished bldg improvements									
13	FY 2006 Depr exp related to demolish R&M improvements									
14	Various		2002	896					896	14
15	Johansen windows		2003	2,652	133	20	133		376	15
16	Johansen roof coating		2003	7,900	790	10	790		2,238	16
17	Tub & toilet floors - Johansen		2003	12,900	1,290	10	1,290		3,548	17
18	Painting Johansen		2003	15,977	3,195	5	3,195		8,787	18
19	Painting Johansen		2003	4,093	819	5	819		2,183	19
20	Painting Johansen		2004	2,340	468	5	468		1,131	20
21	Painting Johansen		2004	7,896	1,579	5	1,579		3,290	21
22	Vinyl flooring - bathrooms		2005	4,960	496	10	496		992	22
23	Mini-blinds Johansen		2005	3,000	600	5	600		1,050	23
24	Mini-blinds Johansen		2005	4,017	803	5	803		1,339	24
25	Electrical wiring		2005	3,334	167	20	167		278	25
26	Painting lobby & auditorium		2005	1,950	390	5	390		618	26
27	Vinyl flooring		2005	26,260	2,626	10	2,626		4,158	27
28	Sewer line		2005	9,290	465	20	465		697	28
29	Surveillance camera		2005	1,864	373	5	373		559	29
30	Painting Johansen		2005	7,475	1,495	5	1,495		1,744	30
31	Painting Johansen		2005	4,300	860	5	860		1,003	31
32	Painting common areas		2005	3,302	660	5	660		715	32
33	Wheelchair/armrest - R&M		2005	725		5	145	145	290	33
34	Kitchen equipment - R&M		2005	16,975		7	2,425	2,425	4,850	34
35										35
36										36

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

See Page 12A, Line 70 for total

**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		
37	Painting common areas	2006	\$ 1,936	\$ 258		\$ 258	\$ 258	37	
38	Painting common areas	2006	720	84		84	84	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	Allocated Home Office Depreciation					21,107		67	
68								68	
69								69	
70	TOTAL (lines 4 thru 69)		\$ 19,638,340	\$ 419,523		\$ 446,618	\$ 5,988	\$ 2,110,389	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 455,524	\$ 51,887	\$ 51,887	\$		\$ 173,078	71
72	Current Year Purchases	72,278	5,261	5,261			5,261	72
73	Fully Depreciated Assets	218,220	9,200	9,200			218,220	73
74	Curr Yr depr exp on disposals		18,047	18,047				74
75	TOTALS	\$ 746,022	\$ 84,395	\$ 84,395	\$		\$ 396,559	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	Nursing Facility	2000 Ford Goshen Bus	2000	\$ 45,104	\$ 3,007	\$ 3,007	\$	15	\$ 18,042	76
77	Nursing Facility	2002 Pick-up Truck	2002	21,905	2,190	2,190		10	8,762	77
78	Nursing Facility	2005 Chevy Impala	2005	17,756	1,776	1,776		10	2,219	78
79	Nursing Facility	Trailer	2005	4,326	252	252		10	252	79
80	TOTALS			\$ 89,091	\$ 7,225	\$ 7,225	\$		\$ 29,275	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)	\$ 21,122,857	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 511,143	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 538,238	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,988	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,536,223	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	Land - Apt	\$ 112,500	\$	\$	86
87	Building - Apt	487,975	12,199	115,894	87
88	Building Improvements - Apt	201,055	19,545	101,208	88
89	Furniture & Equip - Apt	32,916	700	30,422	89
90	Morrison Home/Oakley St.	440,692			90
91	TOTALS	\$ 1,275,138	\$ 32,444	\$ 247,524	91

G. Construction-in-Progress

	Description	Cost	
92	Redevelopment of property	\$ 4,382,923	92
93			93
94			94
95		\$ 4,382,923	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

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

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

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

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

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

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

16. Rental Amount for movable equipment: \$ N/A Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2007 \$ _____

13. /2008 \$ _____

14. /2009 \$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.03	hrs	\$	68,927	\$ 94,397	\$	68,927	\$ 94,397	1
2	Licensed Speech and Language Development Therapist	10a.03	hrs		2,037	7,072		2,037	7,072	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.03	hrs		93,372	174,998		93,372	174,998	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	164,336	\$ 276,467	\$	164,336	\$ 276,467	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.

Facility Name & ID Number Washington and Jane Smith Community

0015032

Report Period Beginning: 7/1/05

Ending:

6/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/06

(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	\$ 148,489	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 163,148)	486,610		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	132,225		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	57,336		8
9	Other(specify): See supplemental schedule	385,320		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,209,980	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	4,918,084		12
13	Land	1,202,596		13
14	Buildings, at Historical Cost	20,309,670		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	868,029		16
17	Accumulated Depreciation (book methods)	(2,777,711)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	46,650,208		21
22	Other Long-Term Assets (spec CIP	4,382,923		22
23	Other(specify): See supplemental schedule	2,998,526		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 78,552,325	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 79,762,305	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 844,177	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	364,363		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See supplemental schedule	2,577,266		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,785,806	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	61,805,000		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See supplemental schedule	699,080		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 62,504,080	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 66,289,886	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 13,472,419	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 79,762,305	\$	48

*(See instructions.)

Facility Name & ID Number: Washington and Jane Smith

0015032

Report Period Beginning: 07/01/05

Ending:

06/30/06

Supplemental Schedule of Other Assets and Liabilities As of 6/30/05

Other Current Assets:		Amount	Other current Liabilities:		Amount
		<u> </u>			<u> </u>
09A	Employee Advances Receivable	650	36A	Accrued compensation	284,287
09B	Accts Receivable - Miscellaneous	384,670	36B	Accrued pension	85,856
09C			36C	Resident credit balances	15,364
09D			36D	Advance from affiliate	-
09E			36E	Other	13,466
09F			36F	Gift Annuities payable	13,130
09G			36G	Refundable resident deposits	2,165,163
		<u>385,320</u>			<u>2,577,266</u>
		<u> </u>			<u> </u>
Other Non-Current Assets:		Amount	Other Long-term Liabilities		Amount
		<u> </u>			<u> </u>
23A	Cost of acquiring initial continuing care contracts	1,559,564	23A	Due to affiliate	339,469
23B	Derivative asset - interest rate swap	24,692	23B	Gift annuities payable, net of current installments	5,836
23C	Net debt issuance cost	1,333,240	23C	Unamortized bond premium	353,775
23D	Assets held in perpetual trust	81,030	23D		
23E			23E		
23F			23F		
23G			23G		
		<u>2,998,526</u>			<u>699,080</u>
		<u> </u>			<u> </u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,653,713	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,653,713	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	5,818,706	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 5,818,706	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)	\$ 13,472,419	24 *

* This must agree with page 17, line 47.

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	\$ 7,990,244	1
2	Discounts and Allowances for all Levels	(1,413,180)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,577,064	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	680,345	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 680,345	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	43,898	13
14	Non-Patient Meals	2,623	14
15	Telephone, Television and Radio	903	15
16	Rental of Facility Space	14,000	16
17	Sale of Drugs	111,893	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	509	19
20	Radiology and X-Ray		20
21	Other Medical Services	309,146	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 482,972	23
D. Non-Operating Revenue			
24	Contributions	9,774,366	24
25	Interest and Other Investment Income***	1,127,256	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,901,622	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See supplemental schedule</u>	(1,803,373)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (1,803,373)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,838,630	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	2,807,109	31
32	Health Care	3,616,181	32
33	General Administration	3,079,836	33
B. Capital Expense			
34	Ownership	1,072,212	34
C. Ancillary Expense			
35	Special Cost Centers	391,824	35
36	Provider Participation Fee	52,762	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,019,924	40
41	Income before Income Taxes (line 30 minus line 40)**	5,818,706	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 5,818,706	43

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

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

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

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

XVII. INCOME STATEMENT - Detail of Other Revenue, Line 28

<u>Description</u>	<u>Amount</u>
Apartment Rents	\$ 133,837
Resident Transport	6,479
Miscellaneous Resident Charges	300
Guest Room Income	2,446
Other Miscellaneous	21,472
Gain/(Loss) on disposal of fixed assets	(1,677,883)
Loss on early extinguishment of debt	(290,024)
	<u>\$ (1,803,373)</u>

Line 25 Interest and Other Investment Income

Income reported on this line includes changes to the market value of investments and restricted funds. These amounts have not been offset against interest expense reported on Schedule V, line 32.

Facility Name & ID Number Washington and Jane Smith Community

0015032

Report Period Beginning:

7/1/05

Ending:

6/30/06

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	1,875	1,950	\$ 68,683	\$ 35.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,874	23,336	384,243	16.47	3
4	Licensed Practical Nurses	29,841	32,019	504,855	15.77	4
5	CNAs & Orderlies	130,781	135,496	1,746,856	12.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,638	8,634	141,344	16.37	8
9	Activity Director	1,823	1,950	37,421	19.19	9
10	Activity Assistants	17,048	23,765	289,690	12.19	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	50,180	56,958	588,469	10.33	15
16	Dishwashers					16
17	Maintenance Workers	21,254	18,638	313,458	16.82	17
18	Housekeepers	15,903	26,071	257,566	9.88	18
19	Laundry	8,842	10,168	107,009	10.52	19
20	Administrator	1,815	1,987	110,775	55.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,732	11,635	158,743	13.64	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	289	291	4,098	14.08	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	6,180	7,297	90,090	12.35	33
34	TOTAL (lines 1 - 33)	325,075	360,195	\$ 4,803,300 *	\$ 13.34	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	\$ 24,000	9.3	36	
37	Medical Records Consultant	4,224	10.3	37	
38	Nurse Consultant			38	
39	Pharmacist Consultant	1,919	10.3	39	
40	Physical Therapy Consultant	1,163	10A.3	40	
41	Occupational Therapy Consultant			41	
42	Respiratory Therapy Consultant			42	
43	Speech Therapy Consultant			43	
44	Activity Consultant	48	2,497	11.3	44
45	Social Service Consultant	18	754	12.3	45
46	Other(specify)			46	
47				47	
48				48	
49	TOTAL (lines 35 - 48)	66	\$ 34,557	49	

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	78	\$ 4,238	10.3	50
51	Licensed Practical Nurses	116	4,158	10.3	51
52	Certified Nurse Assistants/Aides	24	407	10.3	52
53	TOTAL (lines 50 - 52)	218	\$ 8,803	53	

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	6	7	8	9	10	11	12	13
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

