

		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.

<p><b>I. IDPH Facility ID Number:</b> <u>0022871</u></p> <p><b>Facility Name:</b> <u>WEST CHICAGO TERRACE</u></p> <p><b>Address:</b> <u>928 JOLIET ROAD</u> <u>WEST CHICAGO</u> <u>60185</u>  Number City Zip Code</p> <p><b>County:</b> <u>DUPAGE</u></p> <p><b>Telephone Number:</b> <u>(847) 674-5795</u> <b>Fax #</b> <u>(847) 674-5974</u></p> <p><b>HFS ID Number:</b> <u>300383284-01</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>11/1/2006</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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	<b>IRS Exemption Code</b> _____	<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 _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2006</u> to <u>12/31/2006</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>AVRUM WEINFELD</u> (Title) <u>CEO</u></td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u> (Firm Name &amp; Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>AVRUM WEINFELD</u> (Title) <u>CEO</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number WEST CHICAGO TERRACE

# 0022871 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

**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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,800	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	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	
8	SNF				8
9	SNF/PED				9
10	ICF	40,272	2,062		42,334
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	40,272	2,062		42,334

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.65%**

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

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

NONE

**F. Does the facility maintain a daily midnight census?** YES

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

**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 11/1/06

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date 11/1/06 NO

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

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number **WEST CHICAGO TERRACE** # **0022871** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

**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
	<b>A. General Services</b>										
1	Dietary	146,934	10,914	11,907	169,755		169,755	0	169,755		1
2	Food Purchase		150,062		150,062	0	150,062	(190)	149,872		2
3	Housekeeping	122,783	14,184	0	136,967		136,967	0	136,967		3
4	Laundry	54,392	11,533	0	65,925	0	65,925	956	66,881		4
5	Heat and Other Utilities			114,519	114,519		114,519	283	114,802		5
6	Maintenance	65,250	48,305	18,612	132,167		132,167	5,057	137,224		6
7	Other (specify):*			11,725	11,725		11,725	68	11,793		7
8	<b>TOTAL General Services</b>	<b>389,359</b>	<b>234,998</b>	<b>156,763</b>	<b>781,120</b>	<b>0</b>	<b>781,120</b>	<b>6,174</b>	<b>787,294</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		18,000	18,000		18,000	0	18,000		9
10	Nursing and Medical Records	1,231,261	40,191	5,664	1,277,116		1,277,116	0	1,277,116		10
10a	Therapy	113,727	1,261	0	114,988		114,988	0	114,988		10a
11	Activities	91,423	6,221	4,834	102,478		102,478	0	102,478		11
12	Social Services	22,728		3,942	26,670		26,670	0	26,670		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,459,139</b>	<b>47,673</b>	<b>32,440</b>	<b>1,539,252</b>	<b>0</b>	<b>1,539,252</b>	<b>0</b>	<b>1,539,252</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	62,850		184,220	247,070		247,070	(166,355)	80,715		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			80,023	80,023		80,023	2,422	82,445		19
20	Dues, Fees, Subscriptions & Promotions			11,510	11,510		11,510	1,011	12,521		20
21	Clerical & General Office Expenses	76,275	20,938	121,126	218,339		218,339	(72,802)	145,537		21
22	Employee Benefits & Payroll Taxes			256,159	256,159	0	256,159	0	256,159		22
23	Inservice Training & Education			6,899	6,899		6,899	0	6,899		23
24	Travel and Seminar			0	0		0	5	5		24
25	Other Admin. Staff Transportation			9,669	9,669		9,669	521	10,190		25
26	Insurance-Prop.Liab.Malpractice			63,248	63,248		63,248	433	63,681		26
27	Other (specify):*			12,700	12,700		12,700	(4,510)	8,190		27
28	<b>TOTAL General Administration</b>	<b>139,125</b>	<b>20,938</b>	<b>745,554</b>	<b>905,617</b>	<b>0</b>	<b>905,617</b>	<b>(239,275)</b>	<b>666,342</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,987,623</b>	<b>303,609</b>	<b>934,757</b>	<b>3,225,989</b>	<b>0</b>	<b>3,225,989</b>	<b>(233,101)</b>	<b>2,992,888</b>		<b>29</b>

\*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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	11,880
	REPAIRS & MAINTENANCE	27
		0
		11,907
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	37,298
	ELECTRICITY	31,032
	WATER	46,189
	CABLE TV - LOBBY	0
		0
		114,519
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	6,520
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	6,800
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,439
	FIRE SERVICE	3,853
		0
		0
		0
		0
		18,612
7	<b>OTHER</b>	
	SCAVENGER	11,413
	SECURITY SERVICE	312
		0
		0
		11,725
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	18,000
		18,000

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	4,164
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	<b>DENTAL</b>	1,500
		0
		5,664
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	4,834
		0
		4,834
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	3,942
	SOCIAL WORKER XVIII B 45-2	0
		0
		3,942
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	184,220
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	12,859
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	67,164
		0
		80,023
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	350
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	5,381
	LICENSES & PERMITS XIX F	4,255
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	364
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	1,140
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	20
	PATIENT BACKGROUND CHECKS XIX F	0
		11,510
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	993
	EQUIPMENT REPAIR & MAINTENANCE	2,694
	OUTSIDE CLERICAL SERVICES	77,500
	PENALTIES / OVERDRAFT CHARGES VI 18	5,305
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	21,394
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	13,240
		121,126

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	149,680
	UNEMPLOYMENT COMPENSATION XIX D	27,313
	WORKERS COMPENSATION INSURANC XIX D	58,738
	HOSPITALIZATION INSURANCE XIX D	19,719
	EMPLOYEE BENEFITS - OTHER XIX D	709
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		256,159
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	6,899
		6,899
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	9,669
		9,669
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	63,248
		63,248
27	<b>OTHER</b>	
	BAD DEBTS VI 24	12,700
		12,700

GRAND TOTAL COLUMN 3 OTHER

934,757

WEST CHICAGO TERRACE  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2006

TOTAL FOOD PURCHASE	150,062	PATIENT MEALS	127002
LESS SALES TAX	(190)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	149,872	TOTAL MEALS/YEAR	127002
TOTAL PATIENT CENSUS	42,334	NET FOOD	149872
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	127002
	-----		
TOTAL PATIENT MEALS	127002	COST PER MEAL	1.18
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number **WEST CHICAGO TERRACE**

#0022871

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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	
	<b>D. Ownership</b>											
30	Depreciation			31,938	31,938		31,938	3,819	35,757			30
31	Amortization of Pre-Op. & Org.			23,967	23,967		23,967	0	23,967			31
32	Interest			72,042	72,042		72,042	(10,182)	61,860			32
33	Real Estate Taxes			86,244	86,244		86,244	1,193	87,437			33
34	Rent-Facility & Grounds			75,487	75,487		75,487	0	75,487			34
35	Rent-Equipment & Vehicles			32,722	32,722		32,722	2,821	35,543			35
36	Other (specify):* <b>IME RENT</b>			9,360	9,360		9,360	(9,360)	0			36
37	<b>TOTAL Ownership</b>			331,760	331,760	0	331,760	(11,709)	320,051			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			65,700	65,700		65,700	0	65,700			42
43	Other (specify):*				0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	0	65,700	65,700	0	65,700	0	65,700			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,987,623	303,609	1,332,217	3,623,449	0	3,623,449	(244,810)	3,378,639			45

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

Facility Name & ID Number **WEST CHICAGO TERRACE**

# **0022871**

Report Period Beginning:

**01/01/2006**

Ending:

**12/31/2006**

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
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	2,643	30		9
10	Interest and Other Investment Income	(11,846)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(190)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,140)	20		17
18	Fines and Penalties	(5,305)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(4,709)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,700)	27		24
25	Fund Raising, Advertising and Promotional	(350)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(364)	20		28
29	Other-Attach Schedule	(11,610)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (45,571)		\$ 0	30

<b>BHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(199,239)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (199,239)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (244,810)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

## WEST CHICAGO TERRACE

ID# 0022871

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1,958	6	1
2	STAFF DEVELOPMENT	(13,240)	21	2
3	MARKETING SALARY	(328)	21	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(11,610)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number WEST CHICAGO TERRACE

# 0022871

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(190)	0	0	0	0	0	0	0	0	0	0	(190)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	956	0	0	0	0	0	0	0	0	956	4
5	Heat and Other Utilities	0	0	0	283	0	0	0	0	0	0	0	283	5
6	Maintenance	1,958	1,312	1,272	515	0	0	0	0	0	0	0	5,057	6
7	Other (specify):*	0	0	39	29	0	0	0	0	0	0	0	68	7
8	<b>TOTAL General Services</b>	<b>1,768</b>	<b>1,312</b>	<b>2,267</b>	<b>827</b>	<b>0</b>	<b>6,174</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(172,327)	5,972	0	0	0	0	0	0	0	0	(166,355)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,709)	750	6,338	43	0	0	0	0	0	0	0	2,422	19
20	Fees, Subscriptions & Promotions	(1,854)	0	2,865	0	0	0	0	0	0	0	0	1,011	20
21	Clerical & General Office Expenses	(18,873)	7,614	(61,596)	53	0	0	0	0	0	0	0	(72,802)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	5	0	0	0	0	0	0	0	0	5	24
25	Other Admin. Staff Transportation	0	207	314	0	0	0	0	0	0	0	0	521	25
26	Insurance-Prop.Liab.Malpractice	0	121	193	119	0	0	0	0	0	0	0	433	26
27	Other (specify):*	(12,700)	3,660	4,530	0	0	0	0	0	0	0	0	(4,510)	27
28	<b>TOTAL General Administration</b>	<b>(38,136)</b>	<b>(159,975)</b>	<b>(41,379)</b>	<b>215</b>	<b>0</b>	<b>(239,275)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(36,368)</b>	<b>(158,663)</b>	<b>(39,112)</b>	<b>1,042</b>	<b>0</b>	<b>(233,101)</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number WEST CHICAGO TERRACE# 0022871

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

## 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	2,643	158	190	828	0	0	0	0	0	0	0	3,819	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,846)	0	0	1,664	0	0	0	0	0	0	0	(10,182)	32
33	Real Estate Taxes	0	0	0	1,193	0	0	0	0	0	0	0	1,193	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	296	2,251	274	0	0	0	0	0	0	0	2,821	35
36	Other (specify):*	0	0	0	(9,360)	0	0	0	0	0	0	0	(9,360)	36
37	<b>TOTAL Ownership</b>	<b>(9,203)</b>	<b>454</b>	<b>2,441</b>	<b>(5,401)</b>	<b>0</b>	<b>(11,709)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(45,571)</b>	<b>(158,209)</b>	<b>(36,671)</b>	<b>(4,359)</b>	<b>0</b>	<b>(244,810)</b>	<b>45</b>						

**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
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	17	MANAGEMENT FEES	\$ 180,720	EMI ENTERPRISES	100.00%	\$	\$ (180,720)	1
2	V								2
3	V	6	DRIVERS SALARY			1,312		1,312	3
4	V	17	OFFICERS SALARY			8,393		8,393	4
5	V	19	ACCOUNTING FEES			750		750	5
6	V	21	OFFICE EXPENSE			7,614		7,614	6
7	V	25	TRANSPORTATION			207		207	7
8	V	26	INSURANCE			121		121	8
9	V	27	EMPLOYEE BENEFITS			3,660		3,660	9
10	V	35	AUTO LEASE			296		296	10
11	V	30	DEPRECIATION			158		158	11
12	V								12
13	V								13
14	Total		\$ 180,720			\$ 22,511	\$ *	(158,209)	14

\* 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	21 BOOKKEEPING	\$ 77,500	EKS MANAGEMENT	100.00%	\$	\$ (77,500)
16	V						
17	V	4 HOUSEKEEPING SALARIES				956	956
18	V	6 PAINTERS SALARIES				1,272	1,272
19	V	7 SCAVENGER				39	39
20	V	17 CFO SALARY				5,972	5,972
21	V	19 PROFESSIONAL FEES				6,338	6,338
22	V	20 WANT ADS/BACKGR CKS				2,865	2,865
23	V	21 OFFICE EXPENSE				15,904	15,904
24	V	24 IN STATE TRAVEL				5	5
25	V	25 TRANSPORTATION				314	314
26	V	26 INSURANCE				193	193
27	V	27 EMPLOYEE BENEFITS				4,530	4,530
28	V	30 DEPRECIATION				190	190
29	V	35 EQUIPMENT RENT				2,251	2,251
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 77,500			\$ 40,829	\$ * (36,671)

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

Facility Name & ID Number WEST CHICAGO TERRACE# 0022871Report Period Beginning: 01/01/2006 Ending: 12/31/2006

## 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	36 OFFICE RENT	\$ 9,360	IME REALTY	100.00%	\$	\$ (9,360)
16	V						
17	V						
18	V	5 UTILITIES				283	283
19	V	6 REPAIR & MAINTENANCE				515	515
20	V	7 ALARM SERVICE				29	29
21	V	19 PROFESSIONAL FEES				43	43
22	V	21 OFFICE EXPENSE				53	53
23	V	26 INSURANCE				119	119
24	V	30 DEPRECIATION				828	828
25	V	32 INTEREST				1,664	1,664
26	V	33 RE TAX				1,193	1,193
27	V	35 STORAGE FEES				274	274
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 9,360			\$ 5,001	\$ * (4,359)

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

Facility Name &amp; ID Number

WEST CHICAGO TERRACE

#

0022871

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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	MORRIS ESFORMES							SALARY	\$ 8,393	17-7	1
2	AVRUM WEINFELD	CEO						SALARY	5,972	17-7	2
3	PHILIP ESFORMES							MGMT FEE	3,500	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 17,865		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 WEST CHICAGO TERRACE

# 0022871 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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 EMI ENTERPRISES, INC  
 Street Address 6865 N. LINCOLN AVE.  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number ( 847)674-1946  
 Fax Number ( 847)674-1962

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	6	DRIVERS SALARY	PATIENT DAYS	778,042	14	\$ 28,965	\$ 35,299	\$ 1,312	1
2	17	OFFICERS SALARY	PATIENT DAYS	778,042	14	185,000	35,299	8,393	2
3	19	ACCOUNTING FEES	PATIENT DAYS	778,042	14	16,537	35,299	750	3
4	21	OFFICE EXPENSE	PATIENT DAYS	778,042	14	167,811	35,299	7,614	4
5	25	TRANSPORTATION	PATIENT DAYS	778,042	14	4,565	35,299	207	5
6	26	INSURANCE	PATIENT DAYS	778,042	14	2,648	35,299	121	6
7	27	EMPLOYEE BENEFITS	PATIENT DAYS	778,042	14	80,669	35,299	3,660	7
8	35	AUTO LEASE	PATIENT DAYS	778,042	14	6,544	35,299	296	8
9	30	DEPRECIATION	PATIENT DAYS	778,042	14	3,451	35,299	158	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					\$ 496,190	\$ 345,993	\$ 22,511	25

Facility Name & ID Number WEST CHICAGO TERRACE

# 0022871 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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 EKS MANAGEMENT  
 Street Address 6865 N. LINCOLN AVE.  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number ( 847)674-1946  
 Fax Number ( 847)674-1962

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	4	HOUSEKEEPING SALARIES	PATIENT DAYS	863,827	14	\$ 19,500	\$ 42,334	\$ 956	1
2	6	PAINTERS SALARIES	PATIENT DAYS	863,827	14	25,953	42,334	1,272	2
3	7	SCAVENGER	PATIENT DAYS	863,827	14	825	42,334	39	3
4	17	CFO SALARY	PATIENT DAYS	863,827	14	121,844	42,334	5,972	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	863,827	14	129,352	42,334	6,338	5
6	20	WANT ADS/BACKGR CKS	PATIENT DAYS	863,827	14	58,423	42,334	2,865	6
7	21	OFFICE EXPENSE	PATIENT DAYS	863,827	14	324,544	42,334	15,904	7
8	24	IN STATE TRAVEL	PATIENT DAYS	863,827	14	112	42,334	5	8
9	25	TRANSPORTATION	PATIENT DAYS	863,827	14	6,388	42,334	314	9
10	26	INSURANCE	PATIENT DAYS	863,827	14	3,958	42,334	193	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	863,827	14	92,462	42,334	4,530	11
12	30	DEPRECIATION	PATIENT DAYS	863,827	14	3,880	42,334	190	12
13	35	EQUIPMENT RENT	PATIENT DAYS	863,827	14	45,937	42,334	2,251	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					\$ 833,178	\$ 496,665	\$ 40,829	25

Facility Name & ID Number WEST CHICAGO TERRACE

# 0022871 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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 IME REALTY CORP.  
 Street Address 6865 N. LINCOLN AVE.  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number ( 847)674-1946  
 Fax Number ( 847)674-1962

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	5	UTILITIES	RENTAL INCOME	344,402	15	\$ 10,404	\$ 9,360	\$ 283	1
2	6	REPAIR & MAINTENANCE	RENTAL INCOME	344,402	15	18,957	9,360	515	2
3	7	ALARM SERVICE	RENTAL INCOME	344,402	15	1,056	9,360	29	3
4	19	PROFESSIONAL FEES	RENTAL INCOME	344,402	15	1,575	9,360	43	4
5	21	OFFICE EXPENSE	RENTAL INCOME	344,402	15	1,942	9,360	53	5
6	26	INSURANCE	RENTAL INCOME	344,402	15	4,387	9,360	119	6
7	30	DEPRECIATION	RENTAL INCOME	344,402	15	30,446	9,360	828	7
8	32	INTEREST	RENTAL INCOME	344,402	15	61,229	9,360	1,664	8
9	33	RE TAX	RENTAL INCOME	344,402	15	43,904	9,360	1,193	9
10	35	STORAGE FEES	RENTAL INCOME	344,402	15	10,073	9,360	274	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					\$ 183,973	\$	\$ 5,001	25

Facility Name & ID Number

WEST CHICAGO TERRACE

# 0022871

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

**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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	<b>SOUTH TRUST</b>		<b>X</b>	<b>MORTGAGE</b>		<b>08/01/95</b>	<b>\$ 1,390,000</b>	<b>\$ 0</b>			<b>\$ 45,156</b>	<b>1</b>						
2												<b>2</b>						
3												<b>3</b>						
4												<b>4</b>						
5												<b>5</b>						
<b>Working Capital</b>																		
6	<b>LASALLE BANK</b>		<b>X</b>	<b>WORKING CAPITAL</b>				<b>119,000</b>			<b>26,886</b>	<b>6</b>						
7												<b>7</b>						
8	<b>RELATED PARTY</b>										<b>1,664</b>	<b>8</b>						
9	<b>TOTAL Facility Related</b>						<b>\$ 1,390,000</b>	<b>\$ 119,000</b>			<b>\$ 73,706</b>	<b>9</b>						
<b>B. Non-Facility Related*</b>																		
10												<b>10</b>						
11												<b>11</b>						
12												<b>12</b>						
13												<b>13</b>						
14	<b>TOTAL Non-Facility Related</b>						<b>\$ 0</b>	<b>\$ 0</b>			<b>\$ 0</b>	<b>14</b>						
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 1,390,000</b>	<b>\$ 119,000</b>			<b>\$ 73,706</b>	<b>15</b>						

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.)

\*\* 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.		\$	<b>81,700</b>	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.)		\$	<b>84,335</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>2,635</b>	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>13,600</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>ADJ FOR OLD FACILITY</b> <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>70,009</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>86,244</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	<b>63,216</b>	8
	2002	<b>74,580</b>	9
	2003	<b>76,575</b>	10
	2004	<b>80,129</b>	11
	2005	<b>84,335</b>	12

<b>FOR BHF USE ONLY</b>			
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

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED**

**ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.**

**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 WEST CHICAGO TERRACE COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0022871

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

**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>04-16-202-008</u>	<u>NURSING HOME</u>	\$ <u>84,335.10</u>	\$ <u>84,335.10</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>84,335.10</u>	\$ <u>84,335.10</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

Facility Name & ID Number WEST CHICAGO TERRACE

# 0022871

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 26,898 B. General Construction Type: Exterior BRICK Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_

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).

N/A

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				\$	1
2					2
3	TOTALS			\$ 0	3

Facility Name &amp; ID Number WEST CHICAGO TERRACE

# 0022871

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

**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	120		1976		\$ 1,233,000	\$	25	\$	\$	\$ 1,233,000	4
5											5
6											6
7											7
8	RELATED PARTY					796		796			8
	<b>Improvement Type**</b>										
9	BUILDING IMPROVEMENT		1983		34,112					34,112	9
10	BUILDING IMPROVEMENT		1987		17,555	464	20	464		10,562	10
11	BUILDING IMPROVEMENT		1988		51,503	1,363	31.5	1,363		30,725	11
12	BUILDING IMPROVEMENT		1990		4,140	109	31.5	109		2,101	12
13	BUILDING IMPROVEMENT		1992		23,333	617	31.5	617		10,453	13
14	BUILDING IMPROVEMENT		1993		22,204	508	31.5	508		8,193	14
15	BUILDING IMPROVEMENT		1994		74,985	1,602	39	1,602		24,267	15
16	TILE		1996		2,547	54	39	54		691	16
17	ROOFTOP COMPRESSOR		1998		1,653	35	39	35		348	17
18	FIRE BACKFLOW DEVICE		1998		7,245	155	39	155		1,465	18
19	DOORS		1999		2,734	59	39	59		535	19
20	SIGNS		1999		968	54	15	54		476	20
21	ELECTRICAL WORK		1999		8,138	174	39	174		1,559	21
22	CARPET, TILE, COVE BASE		2000		20,242	1,506	20	1,506		7,075	22
23	CUBICLE CURTAINS, DRAPERS		2000		12,817	954	20	954		4,479	23
24	ROOF		2000		9,850	298	27.5	298		2,252	24
25	ASBESTOS ABATEMENT		2000		4,193	127	27.5	127		995	25
26	PAVING		2001		4,855	270	15	270		1,404	26
27	VINYL TILE		2001		4,165	310	20	310		1,350	27
28	FLOORING/CARPET		2002		8,200	523	20	523		2,163	28
29	CONDENSING UNIT		2003		1,564	47	27.5	47		187	29
30	FLOORING/CARPET/TILES		2004		29,094	882	27.5	882		2,425	30
31	FURNACES		2004		23,436	710	27.5	710		1,952	31
32	CEILING TILES		2004		2,490	75	27.5	75		207	32
33	NEW NURSE CALL SYSTEM		2004		19,973	605	27.5	605		1,664	33
34	LAMP FIXTURE/HANDRAILS/CUBICLE CURTAINS/BUMPERS		2004		37,244	1,129	27.5	1,129		3,104	34
35	SMOKE DETECTORS		2004		4,612	140	27.5	140		385	35
36			2004		1,660	50	27.5	50		138	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 CERAMIC TILES DINING ROOM	2005	\$ 8,300	\$ 251	27.5	\$ 251	\$	\$ 389	37
38 DOORS	2005	3,250	98	27.5	98		152	38
39 BUILT-IN WARDROBES	2005	39,060	1,184	27.5	1,184		1,835	39
40 GENERATOR	2006	18,000	250	27.5	250		250	40
41 PAVING	2006	99,443	1,381	27.5	1,381		1,381	41
42 LOCKING SYSTEM	2006	4,389	61	27.5	61		61	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)		\$ 1,840,954	\$ 16,841		\$ 16,841	\$ 0	\$ 1,392,335	70

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

Facility Name & ID Number WEST CHICAGO TERRACE

# 0022871

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	\$ 192,163	\$ 15,764	\$ 18,497	\$ 2,733	10 YRS	\$ 97,290	71
72	Current Year Purchases	776	129	39	(90)	10 YRS	39	72
73	Fully Depreciated Assets	374,802			0		374,802	73
74	RELATED PARTY		380	380	0			74
75	TOTALS	\$ 567,741	\$ 16,273	\$ 18,916	\$ 2,643		\$ 472,131	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 2,408,695	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 33,114	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 35,757	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,643	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,864,466	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: **GRANITE WEST CHICAGO TERRACE LLC**

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:		120	11/01/06	\$ 75,487	66 MOS		3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 75,487			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: \$ **13,744** Description: **SEE SCHEDULE ATTACHED**

(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	SCHEDULE ATTACHED		\$	\$ 18,978	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 18,978	21

10. Effective dates of current rental agreement:

Beginning 11/01/06

Ending 04/01/12

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

Fiscal Year Ending Annual Rent

12. 11/01/2007 \$ 452,922

13. 11/01/2008 \$ 452,922

14. 11/01/2009 \$ 460,688

\* 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>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	<b>TOTALS</b>	\$ 0	\$ 0	\$ 0	\$ 0
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 0			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts							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	<b>TOTAL</b>			\$		\$	\$		\$	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 &amp; ID Number WEST CHICAGO TERRACE

# 0022871

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>12,700</u> )	475,280		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	91,648		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>RE TAX &amp; INS ESCROW</u>	15,324		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 582,252	\$ 0	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,500		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(84)		20
21	Restricted Funds	113,231		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>REPL RESV/ ADV RENT</u>	11,250		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 126,897	\$ 0	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 709,149	\$ 0	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 172,950	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	119,000		29
30	Accrued Salaries Payable	74,603		30
31	Accrued Taxes Payable (excluding real estate taxes)	28,643		31
32	Accrued Real Estate Taxes(Sch.IX-B)	13,600		32
33	Accrued Interest Payable	276		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 409,072	\$ 0	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 0	\$ 0	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 409,072	\$ 0	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 300,077	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 709,149	\$ 0	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>ADJ NET INCOME OLD FACILITY</b>	<b>41,823</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>41,823</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(41,746)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>MEMBERS EQUITY</b>	<b>300,000</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>258,254</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>300,077</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,575,226	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,575,226	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 0	8
	<b>C. Other Operating Revenue</b>		
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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 0	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	11,846	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 11,846	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 0	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,587,072	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	781,120	31
32	Health Care	1,539,252	32
33	General Administration	905,617	33
	<b>B. Capital Expense</b>		
34	Ownership	331,760	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	0	35
36	Provider Participation Fee	65,700	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,623,449	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(36,377)	41
42	<b>Income Taxes</b>	(5,369)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (41,746)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number **WEST CHICAGO TERRACE**

# 0022871

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

**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	1,647	1,668	\$ 45,967	\$ 27.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,548	7,310	205,358	28.09	3
4	Licensed Practical Nurses	8,351	9,017	187,488	20.79	4
5	CNAs & Orderlies	56,287	60,447	658,806	10.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,914	8,370	113,727	13.59	8
9	Activity Director					9
10	Activity Assistants	8,663	9,170	91,423	9.97	10
11	Social Service Workers	1,345	1,481	22,728	15.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,570	17,042	146,934	8.62	15
16	Dishwashers					16
17	Maintenance Workers	5,774	6,147	65,250	10.61	17
18	Housekeepers	14,534	15,736	122,783	7.80	18
19	Laundry	7,284	7,638	54,392	7.12	19
20	Administrator	2,080	2,080	62,850	30.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,074	8,588	76,275	8.88	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	5,574	5,826	80,341	13.79	31
32	Other Health C: MDS	2,321	2,377	53,301	22.42	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	151,966	162,897	\$ 1,987,623 *	\$ 12.20	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	M	\$ 11,880	1-3	35
36	Medical Director	O	18,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,164	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	4,834	11-3	44
45	Social Service Consultant	E	3,942	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 42,820		49

**C. CONTRACT NURSES**

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



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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13													
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
																	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	<b>PAINT/DECORATING</b>	<b>2003</b>	<b>\$ 4,134</b>	<b>3</b>	<b>\$ 689</b>	<b>\$ 1,378</b>	<b>\$ 1,378</b>	<b>\$ 689</b>																	
2	<b>PAINT/DECORATING</b>	<b>2004</b>	<b>3,807</b>	<b>3</b>		<b>635</b>	<b>1,269</b>	<b>1,269</b>	<b>634</b>																
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20	<b>TOTALS</b>		<b>\$ 7,941</b>		<b>\$ 689</b>	<b>\$ 2,013</b>	<b>\$ 2,647</b>	<b>\$ 1,958</b>	<b>\$ 634</b>																

Facility Name &amp; ID Number WEST CHICAGO TERRACE

# 0022871

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. ICLTC \$ 4,860
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (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 X NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
WEST CHICAGO TERRACE #0022871 11/01/06
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,700  
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. \$ 0 Has any meal income been offset against related costs? N/A 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? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ 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