

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

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>0022897</u></p> <p><b>Facility Name:</b> <u>KANKAKEE TERRACE</u></p> <p><b>Address:</b> <u>100 BELLAIRE</u> <u>BOURBONNAIS</u> <u>60491</u>  Number City Zip Code</p> <p><b>County:</b> <u>KANKAKEE</u></p> <p><b>Telephone Number:</b> <u>(847) 674-5795</u> <b>Fax #</b> <u>(847) 674-5794</u></p> <p><b>IDPA ID Number:</b> <u>36-2883311</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>10/01/76</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><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 checked="" 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 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 checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input checked="" 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 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>01/01/2003</u> to <u>12/31/2003</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"> <tr> <td rowspan="2" style="width: 15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MORRIS ESFORMES</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>GENERAL PARTNER</u></td> </tr> <tr> <td rowspan="3"><b>Paid Preparer</b></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>KRUPNICK BOKOR KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u></td> </tr> <tr> <td colspan="2" style="text-align: center;"> <b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>  201 S. Grand Avenue East  Springfield, IL 62763-0001 Phone # (217) 782-1630 </td> </tr> </table>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>MORRIS ESFORMES</u> (Date) _____		(Title) <u>GENERAL PARTNER</u>	<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>	(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u>	<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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Facility Name & ID Number KANKAKEE TERRACE

# 0022897 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

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	146	Intermediate (ICF)	146	53,290	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,290	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				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	48,599	647	558	49,804	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,599	647	558	49,804	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.46%

D. How many bed-hold days during this year were paid by Public Aid? 1,255 (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     /    /    

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      and days of care provided     

Medicare Intermediary     

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

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

Facility Name & ID Number **KANKAKEE TERRACE** # **0022897** Report Period Beginning: **01/01/2003** Ending: **12/31/2003**

**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	212,402	12,459	5,940	230,801		230,801		230,801		1
2	Food Purchase		181,148		181,148		181,148	(826)	180,322		2
3	Housekeeping	172,686	21,662		194,348		194,348		194,348		3
4	Laundry	65,223	13,716	635	79,574		79,574		79,574		4
5	Heat and Other Utilities			113,216	113,216		113,216	411	113,627		5
6	Maintenance	102,875	18,702	34,492	156,069		156,069	(5,704)	150,365		6
7	Other (specify):*			5,591	5,591		5,591	29	5,620		7
8	<b>TOTAL General Services</b>	553,186	247,687	159,874	960,747		960,747	(6,090)	954,657		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,195	4,195		4,195		4,195		9
10	Nursing and Medical Records	1,094,875	38,483	14,120	1,147,478		1,147,478		1,147,478		10
10a	Therapy	54,010		1,160	55,170		55,170		55,170		10a
11	Activities	64,127	5,230	1,148	70,505		70,505		70,505		11
12	Social Services			2,771	2,771		2,771		2,771		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,213,012	43,713	23,394	1,280,119		1,280,119		1,280,119		16
	<b>C. General Administration</b>										
17	Administrative	70,560		379,000	449,560		449,560	(348,787)	100,773		17
18	Directors Fees										18
19	Professional Services			37,004	37,004		37,004	6,661	43,665		19
20	Dues, Fees, Subscriptions & Promotions			10,219	10,219		10,219	(2,713)	7,506		20
21	Clerical & General Office Expenses	71,666	14,675	127,493	213,834		213,834	(104,243)	109,591		21
22	Employee Benefits & Payroll Taxes			283,721	283,721		283,721	(1,825)	281,896		22
23	Inservice Training & Education			2,726	2,726		2,726	28	2,754		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			38,093	38,093		38,093	522	38,615		25
26	Insurance-Prop.Liab.Malpractice			76,949	76,949		76,949	698	77,647		26
27	Other (specify):*							4,582	4,582		27
28	<b>TOTAL General Administration</b>	142,226	14,675	955,205	1,112,106		1,112,106	(445,077)	667,029		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,908,424	306,075	1,138,473	3,352,972		3,352,972	(451,167)	2,901,805		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	5,940
	REPAIRS & MAINTENANCE	0
		0
		5,940
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	635
		0
		635
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	39,342
	ELECTRICITY	37,196
	WATER	30,338
	CABLE TV - LOBBY	6,340
		0
		113,216
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	3,545
	PAINTING & DECORATING	11,721
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	10,115
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,824
	FIRE SERVICE	7,287
		0
		0
		0
		34,492
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	4,820
	SECURITY SERVICE	771
		0
		5,591
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	4,195
		0
		4,195

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	126
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	4,743
	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	5,951
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL	3,300
		0
		14,120
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	548
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	612
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
		1,160
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,148
		0
		1,148
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	2,771
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,771
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	379,000
<b>18</b>	<b>DIRECTORS FEES</b>	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	12,377
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	24,627
		0
		37,004
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	0
	EMPLOYEE WANT ADS XIX F	86
	CONTRIBUTIONS VI 20 XIX F	500
	DUES & SUBSCRIPTIONS XIX F	5,868
	LICENSES & PERMITS XIX F	1,115
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	987
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,663
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
		10,219
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	3,545
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	86,764
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	10,732
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	26,452
		127,493

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	145,995
	UNEMPLOYMENT COMPENSATION XIX D	27,651
	WORKERS COMPENSATION INSURANCE XIX D	37,511
	HOSPITALIZATION INSURANCE XIX D	69,374
	EMPLOYEE BENEFITS - OTHER XIX D	1,365
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	1,825
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		283,721
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	2,726
		2,726
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
		0
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	38,093
		38,093
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	76,949
		76,949
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0
		0

GRAND TOTAL COLUMN 3 OTHER

1,138,473

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			67,949	67,949		67,949	4,767	72,716		30
31	Amortization of Pre-Op. & Org.			696	696		696		696		31
32	Interest			141,275	141,275		141,275	(10,542)	130,733		32
33	Real Estate Taxes			45,675	45,675		45,675	2,122	47,797		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			52,894	52,894		52,894	3,900	56,794		35
36	Other (specify):* OFFICE RENT			11,232	11,232		11,232	(11,232)			36
37	<b>TOTAL Ownership</b>			319,721	319,721		319,721	(10,985)	308,736		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			79,935	79,935		79,935		79,935		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			79,935	79,935		79,935		79,935		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,908,424	306,075	1,538,129	3,752,628		3,752,628	(462,152)	3,290,476		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 **KANKAKEE TERRACE**

# **0022897**

Report Period Beginning: **01/01/2003**

Ending: **12/31/2003**

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,468	30		9
10	Interest and Other Investment Income	(12,248)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(826)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(2,163)	20		20
21	Owner or Key-Man Insurance	(1,825)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(987)	20		28
29	Other-Attach Schedule	(51,073)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (65,654)		\$	30

OHF 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)	(396,498)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (396,498)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (462,152)		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					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

KANKAKEE TERRACE

ID# 0022897

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (8,093)	6	1
2	STAFF DEVELOPMENT	(26,452)	21	2
3	MARKETING SALARY	(16,528)	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>	(51,073)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number KANKAKEE TERRACE# 0022897

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## 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	(826)	0	0	0	0	0	0	0	0	0	0	(826)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	411	0	0	0	0	0	0	0	411	5
6	Maintenance	(8,093)	0	1,732	657	0	0	0	0	0	0	0	(5,704)	6
7	Other (specify):*	0	0	29	0	0	0	0	0	0	0	0	29	7
8	<b>TOTAL General Services</b>	<b>(8,919)</b>	<b>0</b>	<b>1,761</b>	<b>1,068</b>	<b>0</b>	<b>(6,090)</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	Nurse Aide 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	(354,086)	5,299	0	0	0	0	0	0	0	0	(348,787)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	134	6,352	175	0	0	0	0	0	0	0	6,661	19
20	Fees, Subscriptions & Promotions	(3,150)	0	437	0	0	0	0	0	0	0	0	(2,713)	20
21	Clerical & General Office Expenses	(42,980)	5,553	(66,899)	83	0	0	0	0	0	0	0	(104,243)	21
22	Employee Benefits & Payroll Taxes	(1,825)	0	0	0	0	0	0	0	0	0	0	(1,825)	22
23	Inservice Training & Education	0	0	28	0	0	0	0	0	0	0	0	28	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	160	362	0	0	0	0	0	0	0	0	522	25
26	Insurance-Prop.Liab.Malpractice	0	124	491	83	0	0	0	0	0	0	0	698	26
27	Other (specify):*	0	1,770	2,812	0	0	0	0	0	0	0	0	4,582	27
28	<b>TOTAL General Administration</b>	<b>(47,955)</b>	<b>(346,345)</b>	<b>(51,118)</b>	<b>341</b>	<b>0</b>	<b>(445,077)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(56,874)</b>	<b>(346,345)</b>	<b>(49,357)</b>	<b>1,409</b>	<b>0</b>	<b>(451,167)</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number KANKAKEE TERRACE# 0022897

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	3,468	0	192	1,107	0	0	0	0	0	0	0	4,767	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,248)	0	0	1,706	0	0	0	0	0	0	0	(10,542)	32
33	Real Estate Taxes	0	0	0	2,122	0	0	0	0	0	0	0	2,122	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	773	3,023	104	0	0	0	0	0	0	0	3,900	35
36	Other (specify):*	0	0	0	(11,232)	0	0	0	0	0	0	0	(11,232)	36
37	<b>TOTAL Ownership</b>	<b>(8,780)</b>	<b>773</b>	<b>3,215</b>	<b>(6,193)</b>	<b>0</b>	<b>(10,985)</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>(65,654)</b>	<b>(345,572)</b>	<b>(46,142)</b>	<b>(4,784)</b>	<b>0</b>	<b>(462,152)</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: 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 MANAGEMENT FEES	\$ 364,500	EMI ENTERPRISES		\$	\$ (364,500)	1
2	V							2
3	V	17 OFFICERS SALARY				10,414	10,414	3
4	V	19 ACCOUNTING FEES				134	134	4
5	V	21 OFFICE EXPENSE				5,553	5,553	5
6	V	25 TRANSPORTATION				160	160	6
7	V	26 INSURANCE				124	124	7
8	V	27 EMPLOYEE BENEFITS				1,770	1,770	8
9	V	35 AUTO LEASE				773	773	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 364,500			\$ 18,928	\$ * (345,572)	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	\$ 84,764	EKS MANAGEMENT		\$	\$ (84,764)
16	V						
17	V						
18	V	6 PAINTING/DECORATING				1,732	1,732
19	V	7 SCAVENGER				29	29
20	V	17 CFO SALARY				5,299	5,299
21	V	19 PROFESSIONAL FEES				6,352	6,352
22	V	20 WANT ADDS/BACKGR CKS				437	437
23	V	21 OFFICE EXPENSE				17,865	17,865
24	V	23 SEMINARS				28	28
25	V	25 TRANSPORTATION				362	362
26	V	26 INSURANCE				491	491
27	V	27 EMPLOYEE BENEFITS				2,812	2,812
28	V	30 DEPRECIATION				192	192
29	V	35 EQUIPMENT RENT				3,023	3,023
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 84,764			\$ 38,622	\$ * (46,142)

\* 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	36 OFFICE RENT	\$ 11,232	IME REALTY		\$	\$ (11,232)
16	V						
17	V						
18	V	5 UTILITIES				411	411
19	V	6 REPAIR & MAINTENANCE				657	657
20	V	19 PROFESSIONAL FEES				175	175
21	V	21 OFFICE EXPENSE				83	83
22	V	26 INSURANCE				83	83
23	V	30 DEPRECIATION				1,107	1,107
24	V	32 INTEREST				1,706	1,706
25	V	33 RE TAX				2,122	2,122
26	V	35 STORAGE FEES				104	104
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 11,232			\$ 6,448	\$ * (4,784)

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

Facility Name &amp; ID Number

KANKAKEE TERRACE

#

0022897

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## 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	BERNARD COHEN	GENERAL PARTN	ADMINISTRATION					MGMT. FEE	\$ 14,500	17-3	1
2	MORRIS ESFORMES	GENERAL PARTN	ADMINISTRATION					SALARY	10,414	17-7	2
3	AVRUM WEINFELD	CFO						SALARY	5,299	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 30,213		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 **KANKAKEE TERRACE**

# **0022897** Report Period Beginning: **01/01/2003**

Ending: **2/31/2003**

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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	17	OFFICERS SALARY	PATIENT DAYS	884,739	14	\$ 185,000	\$ 49,804	\$ 10,414	1
2	19	ACCOUNTING FEES	PATIENT DAYS	884,739	14	2,381	49,804	134	2
3	21	OFFICE EXPENSE	PATIENT DAYS	884,739	14	98,637	49,804	5,553	3
4	25	TRANSPORTATION	PATIENT DAYS	884,739	14	2,845	49,804	160	4
5	26	INSURANCE	PATIENT DAYS	884,739	14	2,209	49,804	124	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	884,739	14	31,442	49,804	1,770	6
7	35	AUTO LEASE	PATIENT DAYS	884,739	14	13,730	49,804	773	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					\$ 336,244	\$ 261,255	\$ 18,928	25

Facility Name & ID Number **KANKAKEE TERRACE**

# **0022897** Report Period Beginning: **01/01/2003**

Ending: **2/31/2003**

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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	PAINTING/DECORATING	PATIENT DAYS	884,739	14	\$ 30,769	\$ 49,804	\$ 1,732	1
2	7	SCAVENGER	PATIENT DAYS	884,739	14	510	49,804	29	2
3	17	CFO SALARY	PATIENT DAYS	884,739	14	94,128	49,804	5,299	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	884,739	14	112,835	49,804	6,352	4
5	20	WANT ADDS/BACKGR CKS	PATIENT DAYS	884,739	14	7,759	49,804	437	5
6	21	OFFICE EXPENSE	PATIENT DAYS	884,739	14	317,364	49,804	17,865	6
7	23	SEMINARS	PATIENT DAYS	884,739	14	490	49,804	28	7
8	25	TRANSPORTATION	PATIENT DAYS	884,739	14	6,427	49,804	362	8
9	26	INSURANCE	PATIENT DAYS	884,739	14	8,715	49,804	491	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	884,739	14	49,951	49,804	2,812	10
11	30	DEPRECIATION	PATIENT DAYS	884,739	14	3,418	49,804	192	11
12	35	EQUIPMENT RENT	PATIENT DAYS	884,739	14	53,700	49,804	3,023	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					\$ 686,066	\$ 436,513	\$ 38,622	25

Facility Name & ID Number **KANKAKEE TERRACE**

# **0022897** Report Period Beginning: **01/01/2003**

Ending: **2/31/2003**

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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	303,433	14	\$ 11,111	\$ 11,232	\$ 411	1
2	6	REPAIR & MAINTENANCE	RENTAL INCOME	303,433	14	17,749	11,232	657	2
3	19	PROFESSIONAL FEES	RENTAL INCOME	303,433	14	4,725	11,232	175	3
4	21	OFFICE EXPENSE	RENTAL INCOME	303,433	14	2,247	11,232	83	4
5	26	INSURANCE	RENTAL INCOME	303,433	14	2,237	11,232	83	5
6	30	DEPRECIATION	RENTAL INCOME	303,433	14	29,895	11,232	1,107	6
7	32	INTEREST	RENTAL INCOME	303,433	14	46,095	11,232	1,706	7
8	33	RE TAX	RENTAL INCOME	303,433	14	57,331	11,232	2,122	8
9	35	STORAGE FEES	RENTAL INCOME	303,433	14	2,800	11,232	104	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					\$ 174,190	\$	\$ 6,448	25

Facility Name & ID Number

**KANKAKEE TERRACE**

# **0022897**

Report Period Beginning:

**01/01/2003**

Ending:

**12/31/2003**

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	LASALLE BANK		X	MORTGAGE	\$15,553.00	11/01/01	\$ 2,283,583	\$ 2,149,933		PRIME+	\$ 116,654	1								
2												2								
3												3								
4												4								
5	CIB BANK		X	WORKING CAPITAL							2,358	5								
<b>Working Capital</b>																				
6	CORUS BANK		X	NOTE PAYABLE			805,000			PRIME+	8,828	6								
7	LASALLE BANK		X	WORKING CAPITAL							5,926	7								
8	LASALLE BANK		X	NOTE PAYABLE				437,911			7,509	8								
9	TOTAL Facility Related				\$15,553.00		\$ 3,088,583	\$ 2,587,844			\$ 141,275	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 3,088,583	\$ 2,587,844			\$ 141,275	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ 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 2002 report.	\$	<b>46,500</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>45,875</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(625)</b>	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>46,300</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>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>45,675</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1998	<b>46,150</b>	8
	1999	<b>45,914</b>	9
	2000	<b>45,914</b>	10
	2001	<b>46,051</b>	11
	2002	<b>45,875</b>	12

<b>FOR OHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2002	\$	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 2002 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:** 2002 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 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME KANKAKEE TERRACE COUNTY KANKAKEE

FACILITY IDPH LICENSE NUMBER 0022897

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 2002 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 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>17-09-20-107-040</u>	<u>NURSING HOME</u>	\$ <u>238.66</u>	\$ <u>238.66</u>
2. <u>17-09-20-107-041</u>	<u>NURSING HOME</u>	\$ <u>45,636.38</u>	\$ <u>45,636.38</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>45,875.04</u>	\$ <u>45,875.04</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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number KANKAKEE TERRACE

# 0022897

Report Period Beginning:

01/01/2003 Ending:

12/31/2003

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 28,663 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>		<u>1976</u>	<u>\$ 100,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 100,000</b>	<b>3</b>

Facility Name & ID Number **KANKAKEE TERRACE**# **0022897**

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

**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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	118	1976	1972	\$ 1,233,000	\$	25	\$	\$	\$ 1,233,000	4
5										5
6	18		1998	981,637	25,170	39	25,170		139,500	6
7										7
8					1,083		1,083			8
	<b>Improvement Type**</b>									
9	BUILDING IMPROVEMENTS		1978	8,584		10			8,584	9
10	BUILDING IMPROVEMENTS		1981	8,060		15			8,060	10
11	BUILDING IMPROVEMENTS		1987	51,503	1,635	31.5	1,635		26,092	11
12	BUILDING IMPROVEMENTS		1988	7,400	235	10		(235)	7,400	12
13	BUILDING IMPROVEMENTS		1988	17,500	556	15	481	(75)	17,500	13
14	BUILDING IMPROVEMENTS		1990	27,632	877	20	1,382	505	18,657	14
15	BUILDING IMPROVEMENTS		1991	12,763	406	20	638	232	7,975	15
16	BUILDING IMPROVEMENTS		1992	36,068	1,145	31.5	1,145		13,027	16
17	BUILDING IMPROVEMENTS		1993	40,178	1,253	31.5	1,276	23	13,606	17
18	BUILDING IMPROVEMENTS		1994	18,233	467	39	467		4,508	18
19	CARPET		1996	8,028	206	39	206		1,519	19
20	SHADE STRUCTURE		1997	2,200	56	39	56		371	20
21	CONCRETE SLAB		1997	667	18	39	18		113	21
22	NURSE STATION		1998	4,950	127	39	127		795	22
23	ROOFTOP AC		1998	2,031	52	39	52		286	23
24	PARKING LOT		1999	18,460	1,231	15	1,231		5,539	24
25	ROOFTOP AC		1999	6,716	172	39	172		816	25
26	DOORS		1999	2,151	55	39	55		232	26
27	CARPET		1999	14,114	362	39	362		1,493	27
28	DRAPERIES & RODS/REPLACE SHINGLES		2000	7,865	1,124	20	393	(731)	1,376	28
29	LANDSCAPE RENOVATION		2000	6,700	447	15	447		1,564	29
30	VINYL/CERAMIC TILE		2000	1,941	71	27.5	71		269	30
31	CARPET & FLOOR TILE		2001	16,962	617	20	848	231	2,544	31
32	CONTROL VALVE REPL		2002	2,849	104	27.5	104		208	32
33	NEW FLOOR - LAUNDRY		2003	2,874	48	27.5	48		48	33
34	ROOF		2003	24,800	413	27.5	413		413	34
35	FURNACES		2003	23,436	391	27.5	391		391	35
36	GUTTERS		2003	6,231	104	27.5	104		104	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.

Facility Name & ID Number **KANKAKEE TERRACE**

# **0022897**

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

**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 <b>INSTALL FURNACES</b>	<b>2003</b>	\$ <b>10,400</b>	\$ <b>173</b>	<b>27.5</b>	\$ <b>173</b>	\$	\$ <b>173</b>	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 <b>TOTAL (lines 4 thru 69)</b>		\$ <b>2,605,933</b>	\$ <b>38,598</b>		\$ <b>38,548</b>	\$ <b>(50)</b>	\$ <b>1,516,163</b>	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	\$ 328,132	\$ 18,127	\$ 32,813	\$ 14,686	10 YRS	\$ 236,750	71
72	Current Year Purchases	22,784	12,307	1,139	(11,168)	10 YRS	1,139	72
73	Fully Depreciated Assets	232,659					232,659	73
74	RELATED PARTY		216	216				74
75	TOTALS	\$ 583,575	\$ 30,650	\$ 34,168	\$ 3,518		\$ 470,548	75

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

**E. Summary of Care-Related Assets**

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,289,508	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 69,248	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 72,716	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,468	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,986,711	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: N/A

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

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	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: \$ 15,634 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	<u>SEE SCHEDULE ATTACHED</u>		\$	\$ <u>37,260</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>37,260</u>	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. \_\_\_\_\_ /2004 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2005 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2006 \$ \_\_\_\_\_

\* 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 NURSE AIDE TRAINING PROGRAMS (See instructions.)**

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</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 AIDE _____</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	Nurse Aide Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

**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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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	<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 nurse aides, who help with the above activities should not be listed on this schedule.**

Facility Name &amp; ID Number KANKAKEE TERRACE

# 0022897

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 444,712	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 36,000 )	445,178		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	77,050		6
7	Other Prepaid Expenses	6,665		7
8	Accounts Receivable (owners or related parties)	268,822		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,242,427	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable	1,105,403		11
12	Long-Term Investments			12
13	Land	100,000		13
14	Buildings, at Historical Cost	1,233,000		14
15	Leasehold Improvements, at Historical Cost	1,372,933		15
16	Equipment, at Historical Cost	583,576		16
17	Accumulated Depreciation (book methods)	(2,042,985)		17
18	Deferred Charges	15,674		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,367,601	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,610,028	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 595,155	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,477		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,292		31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,300		32
33	Accrued Interest Payable	11,531		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)	\$ 743,755	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	437,911		39
40	Mortgage Payable	2,149,933		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)	\$ 2,587,844	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 3,331,599	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 278,429	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,610,028	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>139,474</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</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>139,474</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	716,768	<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	(577,813)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<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>138,955</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>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>278,429</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	\$ 4,471,274	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,471,274	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>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	12,248	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 12,248	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>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,483,522	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	960,747	31
32	Health Care	1,280,119	32
33	General Administration	1,112,106	33
	<b>B. Capital Expense</b>		
34	Ownership	319,721	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers		35
36	Provider Participation Fee	79,935	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,752,628	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	730,894	41
42	<b>Income Taxes</b>	(14,126)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 716,768	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 KANKAKEE TERRACE

# 0022897

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

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	2,080	2,235	\$ 55,969	\$ 25.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,874	5,354	113,922	21.28	3
4	Licensed Practical Nurses	10,961	12,047	209,875	17.42	4
5	Nurse Aides & Orderlies	47,662	51,524	528,613	10.26	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,996	4,605	54,010	11.73	8
9	Activity Director					9
10	Activity Assistants	7,391	7,841	64,127	8.18	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,787	21,492	212,402	9.88	15
16	Dishwashers					16
17	Maintenance Workers	9,311	9,633	102,875	10.68	17
18	Housekeepers	20,539	22,268	172,686	7.75	18
19	Laundry	5,170	5,695	65,223	11.45	19
20	Administrator	2,080	2,132	70,560	33.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,698	10,241	71,666	7.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	12,742	13,500	155,331	11.51	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	729	808	8,894	11.01	31
32	Other Health C: <u>QUALITY ASSUR</u>	2,080	2,080	22,271	10.71	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	159,100	171,455	\$ 1,908,424 *	\$ 11.13	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY FEE \$ 5,940	1-3	35
36	Medical Director	MONTHLY FEE 4,195	9-3	36
37	Medical Records Consultant	0	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	MONTHLY FEE 5,951	10-3	39
40	Physical Therapy Consultant	MONTHLY FEE 548	10a-3	40
41	Occupational Therapy Consultant	MONTHLY FEE 612	10a-3	41
42	Respiratory Therapy Consultant	0	10a-3	42
43	Speech Therapy Consultant	0	10a-3	43
44	Activity Consultant	MONTHLY FEE 1,148	11-3	44
45	Social Service Consultant	MONTHLY FEE 2,771	12-3	45
46	Other(specify) <u>DENTAL</u>	MONTHLY FEE 3,300	10-3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 24,465		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	Nurse Aides	8 126	10-3	52
53	TOTAL (lines 50 - 52)	8 \$ 126		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
RANDY LEBEAU	ADMIN		\$ 70,560	Workers' Compensation Insurance	\$ 37,511	IDPH License Fee	\$ 200		
			0	Unemployment Compensation Insurance	27,651	Advertising: Employee Recruitment	86		
				FICA Taxes	145,995	Health Care Worker Background Check	0		
				Employee Health Insurance	69,374	(Indicate # of checks performed _____)			
				Employee Meals	#REF!	MARKETING/ADV/PROMO	987		
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	2,163		
				EMPLOYEE BENEFITS - OTHER	1,365	LICENSES & PERMITS	915		
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	5,868		
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOCATION	437		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(2,163)		
				INSURANCE - EXECUTIVE LIFE	1,825	Less: Public Relations Expense	( 0 )		
				INSURANCE - EXECUTIVE LIFE VI 21	(1,825)	Non-allowable advertising	( 0 )		
						Yellow page advertising	(987)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 70,560				\$ #REF!			\$ 7,506		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
EMI ENTERPRISES			\$ 364,500				Out-of-State Travel	\$	
BERNARD COHEN			14,500						
							In-State Travel	0	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense		0
\$ 379,000				\$			Entertainment Expense		( )
C. Professional Services									
Vendor/Payee	Type		Amount						
ALPHA DATA	DATA PROCESSING		\$ 4,254				TOTAL (agree to Sch. V, line 24, col. 8)		
LTC SOLUTIONS	DATA PROCESSING		1,320				\$		
MAXXSOURCE	DATA PROCESSING		1,330						
NURSING CARE SYSTEMS	DATA PROCESSING		5,473						
KRUPNICK, BOKOR, KAGDA	ACCOUNTING		11,100						
LAWRENCESCHWARTZ	LEGAL		6,175						
STONE, MCGUIRE & BENJAMIN	LEGAL		2,947						
WINSTON & STRAWN	LEGAL		3,712						
PERSONNEL PLANNERS	UC CONSULTANT		693						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL					
\$ 37,004				\$					

\* Attach copy of IMRF notifications

\*\*See instructions.

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

(See instructions.)

1	Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 Amount of Expense Amortized Per Year								
					6 FY2000	7 FY2001	8 FY2002	9 FY2003	10 FY2004	11 FY2005	12 FY2006	13 FY2007	14 FY2008
					1	PAINING/DECORATING	2000	\$ 4,183	3YRS	\$ 697	\$ 1,394	\$ 1,394	\$ 698
2	PAINING/DECORATING	2001	2,927	3YRS		488	976	976	487				
3	PAINING/DECORATING	2003	11,721	3YRS				1,954	3,907	3,907	1,953		
4													
5													
6													
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18													
19													
20	TOTALS		\$ 18,831		\$ 697	\$ 1,882	\$ 2,370	\$ 3,628	\$ 4,394	\$ 3,907	\$ 1,953	\$	\$

Facility Name & ID Number **KANKAKEE TERRACE**# **0022897**Report Period Beginning: **01/01/2003**Ending: **12/31/2003****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE 6947
- (3) Did the nursing home make political contributions or payments to a political 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. \$ \_\_\_\_\_ 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 \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 79,935  
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 of Public Aid, 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. \$ #REF! Has any meal income been offset against related costs? \_\_\_\_\_ 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.** \$ \_\_\_\_\_
- (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