

		FOR OHF USE					

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**2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)**

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>I. IDPH Facility ID Number: <u>0043943</u></p> <p>Facility Name: <u>TERRACE NURSING HOME</u></p> <p>Address: <u>1615 SUNSET AVENUE</u> <u>WAUKEGAN</u> <u>60087</u> <small>Number City Zip Code</small></p> <p>County: <u>LAKE</u></p> <p>Telephone Number: <u>(847) 244-6700</u> Fax # <u>(847) 244-7925</u></p> <p>IDPA ID Number: <u>36-4228300</u></p> <p>Date of Initial License for Current Owners: <u>07/01/98</u></p> <p>Type of Ownership:</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 type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</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>In the event there are further questions about this report, please contact: 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 type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2005</u> to <u>12/31/2005</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%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MORRIS ESFORMES</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>MEMBER</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</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 & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(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>MORRIS ESFORMES</u> (Date) _____		(Title) <u>MEMBER</u>	Paid Preparer	(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 & 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 TERRACE NURSING HOME

0043943 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	65	Skilled (SNF)	65	23,725	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	115	41,975	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	328	331	5,490	6,149	8
9	SNF/PED					9
10	ICF	22,459	8,690	532	31,681	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,787	9,021	6,022	37,830	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.13%

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 07/01/98

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/01/98 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 22 and days of care provided 5,490

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number **TERRACE NURSING HOME** # **0043943** Report Period Beginning: **01/01/2005** Ending: **12/31/2005**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	179,465	11,418	7,175	198,058		198,058		198,058		1
2	Food Purchase		154,951		154,951		154,951	(1,060)	153,891		2
3	Housekeeping	162,355	13,162		175,517		175,517		175,517		3
4	Laundry	57,310	12,980	3,734	74,024		74,024	817	74,841		4
5	Heat and Other Utilities			115,016	115,016		115,016	249	115,265		5
6	Maintenance	74,242	23,778	45,030	143,050		143,050	(279)	142,771		6
7	Other (specify):*			11,377	11,377		11,377	51	11,428		7
8	TOTAL General Services	473,372	216,289	182,332	871,993		871,993	(222)	871,771		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,960,397	91,966	9,195	2,061,558		2,061,558		2,061,558		10
10a	Therapy	84,958		737	85,695		85,695		85,695		10a
11	Activities	80,592	8,232	440	89,264		89,264		89,264		11
12	Social Services			5,330	5,330		5,330		5,330		12
13	CNA Training										13
14	Program Transportation			533	533		533		533		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,125,947	100,198	34,235	2,260,380		2,260,380		2,260,380		16
	C. General Administration										
17	Administrative	73,500		196,000	269,500		269,500	(177,910)	91,590		17
18	Directors Fees										18
19	Professional Services			37,502	37,502		37,502	6,571	44,073		19
20	Dues, Fees, Subscriptions & Promotions			30,771	30,771		30,771	(21,341)	9,430		20
21	Clerical & General Office Expenses	96,171	17,703	67,119	180,993		180,993	(17,748)	163,245		21
22	Employee Benefits & Payroll Taxes			519,172	519,172		519,172		519,172		22
23	Inservice Training & Education							16	16		23
24	Travel and Seminar			1,253	1,253		1,253		1,253		24
25	Other Admin. Staff Transportation			17,871	17,871		17,871	321	18,192		25
26	Insurance-Prop.Liab.Malpractice			58,986	58,986		58,986	1,555	60,541		26
27	Other (specify):*			95,293	95,293		95,293	(91,102)	4,191		27
28	TOTAL General Administration	169,671	17,703	1,023,967	1,211,341		1,211,341	(299,638)	911,703		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,768,990	334,190	1,240,534	4,343,714		4,343,714	(299,860)	4,043,854		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
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	5,940
	REPAIRS & MAINTENANCE		1,235
			0
			7,175
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		3,734
			0
			3,734
5	HEAT & OTHER UTILITIES		
	GAS HEAT		52,751
	ELECTRICITY		41,300
	WATER		20,495
	CABLE TV - LOBBY		470
			0
			115,016
6	MAINTENANCE		
	GROUNDS MAINTENANCE		6,740
	PAINTING & DECORATING		2,227
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		24,971
	ELEVATOR MAINTENANCE & REPAIR		6,958
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		1,844
	FIRE SERVICE		2,290
			0
			0
			0
			45,030
7	OTHER		
	SCAVENGER		8,396
	SECURITY SERVICE		2,981
			11,377
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	18,000
			18,000

LINE		SCHED REF	TOTAL
10	NURSING		
	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	5,024
	PHARMACY CONSULTANT	XVIII B 39-2	4,171
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
			0
			0
			9,195
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	537
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	200
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			737
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	440
			0
			440
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	5,330
	SOCIAL WORKER	XVIII B 45-2	0
			0
			5,330
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	533
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	196,000
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	14,912
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	22,590
		0
		37,502
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	5,570
	EMPLOYEE WANT ADS XIX F	1,790
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	5,839
	LICENSES & PERMITS XIX F	966
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	14,761
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,585
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	260
		30,771
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	6,626
	OUTSIDE CLERICAL SERVICES	36,500
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	23,993
	MESSENGER SERVICE	0
		0
		67,119

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	208,558
	UNEMPLOYMENT COMPENSATION XIX D	25,126
	WORKERS COMPENSATION INSURANCE XIX D	61,795
	HOSPITALIZATION INSURANCE XIX D	196,841
	EMPLOYEE BENEFITS - OTHER XIX D	5,289
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	21,563
	CHICAGO HEAD TAX XIX D	0
		519,172
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,253
	TRAVEL XIX G	0
		0
		0
		1,253
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	17,871
		17,871
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	58,986
		58,986
27	OTHER	
	BAD DEBTS VI 24	95,293
		95,293

GRAND TOTAL COLUMN 3 OTHER

1,240,534

TERRACE NURSING HOME
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2005

TOTAL FOOD PURCHASE	154,951	PATIENT MEALS	113490
LESS SALES TAX	(1,060)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	153,891	TOTAL MEALS/YEAR	113490
TOTAL PATIENT CENSUS	37,830	NET FOOD	153891
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	113490

TOTAL PATIENT MEALS	113490	COST PER MEAL	1.36
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number **TERRACE NURSING HOME**

#0043943

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			68,586	68,586		68,586	46,075	114,661			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,022	51,022		51,022	160,376	211,398			32
33	Real Estate Taxes			74,232	74,232		74,232	1,227	75,459			33
34	Rent-Facility & Grounds			205,307	205,307		205,307	(205,307)				34
35	Rent-Equipment & Vehicles			44,011	44,011		44,011	3,074	47,085			35
36	Other (specify):* IME			8,970	8,970		8,970	(8,970)				36
37	TOTAL Ownership			452,128	452,128		452,128	(3,525)	448,603			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		135,859	379,391	515,250		515,250		515,250			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,963	62,963		62,963		62,963			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		135,859	442,354	578,213		578,213		578,213			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,768,990	470,049	2,135,016	5,374,055		5,374,055	(303,385)	5,070,670			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 **TERRACE NURSING HOME**

0043943

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	(8,637)	30		9
10	Interest and Other Investment Income	(307)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,060)	2		13
14	Non-Care Related Interest	(44,990)	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	(1,585)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(95,293)	27		24
25	Fund Raising, Advertising and Promotional	(5,570)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(14,761)	20		28
29	Other-Attach Schedule	(1,855)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (174,058)		\$	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)	(129,327)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (129,327)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (303,385)		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	TOTAL (C): (sum of lines 38-46)			\$	47

TERRACE NURSING HOME

ID# 0043943

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ (1,855)	6 1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(1,855)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TERRACE NURSING HOME# 0043943

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	(1,060)	0	0	0	0	0	0	0	0	0	0	(1,060)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	817	0	0	0	0	0	0	0	0	817	4
5	Heat and Other Utilities	0	0	0	249	0	0	0	0	0	0	0	249	5
6	Maintenance	(1,855)	0	1,082	494	0	0	0	0	0	0	0	(279)	6
7	Other (specify):*	0	0	24	27	0	0	0	0	0	0	0	51	7
8	TOTAL General Services	(2,915)	0	1,923	770	0	(222)	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(182,280)	4,370	0	0	0	0	0	0	0	0	(177,910)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	281	6,249	41	0	0	0	0	0	0	0	6,571	19
20	Fees, Subscriptions & Promotions	(21,916)	0	575	0	0	0	0	0	0	0	0	(21,341)	20
21	Clerical & General Office Expenses	0	4,082	(22,029)	199	0	0	0	0	0	0	0	(17,748)	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	16	0	0	0	0	0	0	0	0	16	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	46	275	0	0	0	0	0	0	0	0	321	25
26	Insurance-Prop.Liab.Malpractice	0	116	1,289	150	0	0	0	0	0	0	0	1,555	26
27	Other (specify):*	(95,293)	1,252	2,939	0	0	0	0	0	0	0	0	(91,102)	27
28	TOTAL General Administration	(117,209)	(176,503)	(6,316)	390	0	(299,638)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(120,124)	(176,503)	(4,393)	1,160	0	(299,860)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TERRACE NURSING HOME# 0043943

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	(8,637)	0	151	789	53,772	0	0	0	0	0	0	46,075	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(45,297)	0	0	1,308	204,365	0	0	0	0	0	0	160,376	32
33	Real Estate Taxes	0	0	0	1,227	0	0	0	0	0	0	0	1,227	33
34	Rent-Facility & Grounds	0	0	0	0	(205,307)	0	0	0	0	0	0	(205,307)	34
35	Rent-Equipment & Vehicles	0	234	2,664	176	0	0	0	0	0	0	0	3,074	35
36	Other (specify):*	0	0	0	(8,970)	0	0	0	0	0	0	0	(8,970)	36
37	TOTAL Ownership	(53,934)	234	2,815	(5,470)	52,830	0	0	0	0	0	0	(3,525)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(174,058)	(176,269)	(1,578)	(4,310)	52,830	0	0	0	0	0	0	(303,385)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MORRIS ESFORMES	50			EMI ENTERPRISES	LINCOLNWOOD	CONSULTING
PHILLIP ESFORMES	50			EKS MGMT.	LINCOLNWOOD	BOOKKEEPING
				EKS MGMT.	LINCOLNWOOD	HOME OFF. RENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		THE TERRACE INV		
				GRP	LINCOLNWOOD	REAL ESTATE

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 FEE	\$ 190,000	EMI ENTERPRISES		\$	(190,000)	1
2	V	17 OFFICERS SALARY				7,720	7,720	2
3	V	19 ACCOUNTING FEES				281	281	3
4	V	21 TOTAL OFFICE				4,082	4,082	4
5	V	25 TRANSPORTATION				46	46	5
6	V	26 INSURANCE				116	116	6
7	V	27 EMPLOYEE BENEFITS				1,252	1,252	7
8	V							8
9	V	35 AUTO LEASE				234	234	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 190,000			\$ 13,731	\$ * (176,269)	14

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

Facility Name & ID Number TERRACE NURSING HOME# 0043943Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	OUTSIDE CLERICAL	\$ 36,500	EKS MANAGEMENT, INC.		\$ (36,500)
16	V	4	HOUSEKEEPING SALARIES			811	811
17	V	4	CLEANING SUPPLIES			6	6
18	V	6	PAINTERS SALARIES			1,082	1,082
19	V	7	SCAVENGER			24	24
20	V	17	C F O SALARY			4,370	4,370
21	V	19	PROFESSIONAL FEES			6,249	6,249
22	V	20	WANT ADS / BCK GRND CKS			575	575
23	V	21	OFFICE			14,471	14,471
24	V	23	SEMINARS			16	16
25	V	25	TRANSPORTATION			275	275
26	V	26	INSURANCE			1,289	1,289
27	V	27	EMPLOYEE BENEFITS			2,939	2,939
28	V	30	DEPRECIATION (SL)			151	151
29	V	35	EQUIPMENT RENT			2,664	2,664
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 36,500			\$ 34,922	\$ * (1,578)

* 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	\$ 8,970	IME REALTY CORP		\$	\$(8,970)
16	V	5 UTILITIES				249	249
17	V	6 REPAIRS & MAINTENANCE				494	494
18	V	7 ALARM SERVICE				27	27
19	V	19 PROFESSIONAL FEES				41	41
20	V	21 OFFICE EXPENSE				199	199
21	V	26 INSURANCE				150	150
22	V	30 DEPRECIATION (SL)				789	789
23	V	32 INTEREST				1,308	1,308
24	V	33 REAL ESTATE TAX				1,227	1,227
25	V	35 STORAGE FEES				176	176
26	V						
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		\$ 8,970			\$ 4,660	\$ * (4,310)

* 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	34 RENT	\$ 205,307	THE TERRACE INVESTOR GROUP		\$	(205,307)	15
16	V	30 DEPRECIATION				53,772	53,772	16
17	V	32 INTEREST				204,365	204,365	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 205,307			\$ 258,137	\$ * 52,830	39

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

Facility Name & ID Number

TERRACE NURSING HOME

#

0043943

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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		ADMINISTRATION		SEE			SALARY	\$ 7,720	17-7	1
2					ATTACHED						2
3	AVRUM WEINFELD	CFO	CFO		SCHEDULE			SALARY	4,370	17-7	3
4											4
5											5
6	PHILIP ESFORMES		ADMIN					MAN FEE	6,000	17-3	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 18,090		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 **TERRACE NURSING HOME**

0043943

Report Period Beginning:

01/01/2005

Ending: **2/31/2005**

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) 674-5795
 Fax Number (847) 674-5794

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	17	OFFICERS SALARY	PATIENT DAYS	901,761	15	\$ 185,000	\$ 37,630	\$ 7,720	1
2	19	ACCOUNTING FEES	PATIENT DAYS	901,761	15	6,725	37,630	281	2
3	21	TOTAL OFFICE	PATIENT DAYS	901,761	15	97,823	37,630	4,082	3
4	25	TRANSPORTATION	PATIENT DAYS	901,761	15	1,114	37,630	46	4
5	26	INSURANCE	PATIENT DAYS	901,761	15	2,768	37,630	116	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	901,761	15	29,997	37,630	1,252	6
7									7
8	35	AUTO LEASE	PATIENT DAYS	901,761	15	5,617	37,630	234	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					\$ 329,044	\$ 264,576	\$ 13,731	25

Facility Name & ID Number TERRACE NURSING HOME

0043943

Report Period Beginning:

01/01/2005

Ending: 2/31/2005

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, INC.
 Street Address 6865 N. LINCOLN AVE.
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-5795
 Fax Number (847) 674-5794

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	901,761	15	\$ 19,441	\$ 19,441	37,630	\$ 811	1
2	4	CLEANING SUPPLIES	PATIENT DAYS	901,761	15	140	37,630	6		2
3	6	PAINTERS SALARIES	PATIENT DAYS	901,761	15	25,925	25,925	37,630	1,082	3
4	7	SCAVENGER	PATIENT DAYS	901,761	15	573	37,630	24		4
5	17	C F O SALARY	PATIENT DAYS	901,761	15	104,714	104,714	37,630	4,370	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	901,761	15	149,759	37,630	6,249		6
7	20	WANT ADS / BCK GRND CKS	PATIENT DAYS	901,761	15	13,787	37,630	575		7
8	21	OFFICE EXPENSE	PATIENT DAYS	901,761	15	346,792	248,929	37,630	14,471	8
9	23	SEMINARS	PATIENT DAYS	901,761	15	380	37,630	16		9
10	25	TRANSPORTATION	PATIENT DAYS	901,761	15	6,593	37,630	275		10
11	26	INSURANCE	PATIENT DAYS	901,761	15	30,900	37,630	1,289		11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	901,761	15	70,423	37,630	2,939		12
13	30	DEPRECIATION S/L	PATIENT DAYS	901,761	15	3,617	37,630	151		13
14	35	EQUIPMENT RENT	PATIENT DAYS	901,761	15	63,848	37,630	2,664		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 836,892	\$ 399,009		\$ 34,922	25

Facility Name & ID Number TERRACE NURSING HOME

0043943

Report Period Beginning:

01/01/2005

Ending: 2/31/2005

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 AVE.
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-5795
 Fax Number (847) 674-5794

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	INCOME	346,361	15	\$ 9,618	\$ 8,970	\$ 249	1
2	6	REPAIRS & MAINTENANCE	INCOME	346,361	15	19,083	8,970	494	2
3	7	ALARM SERVICE	INCOME	346,361	15	1,056	8,970	27	3
4	19	PROFESSIONAL FEES	INCOME	346,361	15	1,575	8,970	41	4
5	21	OFFICE EXPENSE	INCOME	346,361	15	7,666	8,970	199	5
6	26	INSURANCE	INCOME	346,361	15	5,806	8,970	150	6
7	30	DEPRECIATION (SL)	INCOME	346,361	15	30,446	8,970	789	7
8	32	INTEREST	INCOME	346,361	15	50,514	8,970	1,308	8
9	33	REAL ESTATE TAX	INCOME	346,361	15	47,364	8,970	1,227	9
10	35	STORAGE FEES	INCOME	346,361	15	6,785	8,970	176	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					\$ 179,913	\$	\$ 4,660	25

Facility Name & ID Number **TERRACE NURSING HOME**

0043943

Report Period Beginning:

01/01/2005

Ending: **2/31/2005**

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 THE TERRACE INVESTOR GROUP
 Street Address 6865 N. LINCOLN AVE.
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-5795
 Fax Number (847) 674-5794

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	30	DEPRECIATION	DIRECT	1	1	\$ 53,772	\$ 1	\$ 53,772	1
2	32	INTEREST	DIRECT	1	1	204,365	1	204,365	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 258,137	\$	\$ 258,137	25

Facility Name & ID Number

TERRACE NURSING HOME

0043943

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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			
A. Directly Facility Related																		
Long-Term																		
1	LASALLE BANK		X	MORTGAGE	\$26,007.00	7/15/03	\$ 3,919,674	\$ 3,656,252	7/15/28	0.0543	\$ 204,365	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	LASALLE BANK		X	WORKING CAPITAL	INTEREST	REVOLV		77,000	REVOLV	PRUIME +	6,032	6						
7												7						
8	RELATED PARTIES										1,308	8						
9	TOTAL Facility Related				\$26,007.00		\$ 3,919,674	\$ 3,733,252			\$ 211,705	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11	TERRACE INVESTMENT GROUP				\$8,898.00	12/15/01	1,143,964	913,457	12/15/16	0.0475	44,990	11						
12												12						
13												13						
14	TOTAL Non-Facility Related				\$8,898.00		\$ 1,143,964	\$ 913,457			\$ 44,990	14						
15	TOTALS (line 9+line14)						\$ 5,063,638	\$ 4,646,709			\$ 256,695	15						

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

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

** 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 2004 report.	\$	72,205	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.)	\$	73,219	2
3. Under or (over) accrual (line 2 minus line 1).	\$	1,014	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	73,218	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	74,232	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	52,622	8
	2001	62,144	9
	2002	70,177	10
	2003	72,205	11
	2004	73,219	12

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2004	\$	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 2004 TAX BILL.

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TERRACE NURSING HOME COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0043943

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 2004 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 2004.

(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>08-08-403-011</u>	<u>NURSING HOME</u>	\$ <u>73,219.00</u>	\$ <u>73,219.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>73,219.00</u>	\$ <u>73,219.00</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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number TERRACE NURSING HOME

0043943

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,000 B. General Construction Type: Exterior BRICK Frame MASONRY/STEEL 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).

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>		<u>1989</u>	\$ <u>82,052</u>	1
2					2
3	TOTALS			\$ 82,052	3

Facility Name & ID Number TERRACE NURSING HOME

0043943

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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	112	1989		\$ 2,088,222	\$ 53,772	31.5	\$ 53,772	\$	\$ 1,002,107	4
5										5
6										6
7	RELATED PARTY			26,461	758		758			7
8										8
	Improvement Type**									
9	DOOR BYPASS ALARM		1998	3,453	89	39	89		627	9
10	BOILER		2000	32,900	1,196	27.5	1,196		7,030	10
11	DOORS AND FRAMES		2000	3,366	123	27.5	123		689	11
12	FIRE DOOR		2000	5,039	183	27.5	183		1,030	12
13	FIRE DAMPERS		2000	12,123	441	27.5	441		2,407	13
14	NURSING STATION		2001	15,200	553	27.5	553		2,511	14
15	EJECTOR PUMPS		2001	5,898	215	27.5	215		976	15
16	OVER THE BED LIGHTS		2001	6,142	223	27.5	223		1,013	16
17	FURNISHINGS - FLOORING		2001	81,365	9,373	10	8,137	(1,236)	36,614	17
18	FURNISHINGS - CUBICLE CURTAINS & BLINDS		2001	43,874	5,055	10	4,387	(668)	19,742	18
19	TILING		2002	8,448	307	27.5	307		1,087	19
20	HOT WATER TANK		2002	8,916	324	27.5	324		1,148	20
21	REPLACE PARKING LOT		2003	16,980	1,132	15	1,132		2,830	21
22	REPLACE PATIO & REPAIR STAIRS		2003	15,450	1,030	15	1,030		2,575	22
23	FENCE		2003	3,600	240	15	240		600	23
24	EJECTOR PUMPS		2003	8,780	319	27.5	319		811	24
25	5 TON AIR COOLING SYSTEM		2003	25,353	922	27.5	922		2,343	25
26	PANIC ALARM		2003	1,222	44	27.5	44		112	26
27	200 AMP ELECTRICAL PANEL		2003	6,975	254	27.5	254		646	27
28	FLOORING		2004	5,544	202	27.5	202		311	28
29	SLIDING DOOR		2004	9,024	328	27.5	328		506	29
30	BOILER REPAIR		2004	1,308	47	27.5	47		73	30
31	EXPANSION TANKS FOR HOT WATER HEATING SYSTEM		2004	2,134	78	27.5	78		120	31
32	CARPETTING		2005	9,123	1,825	10	183	(1,642)	183	32
33	DOORS		2005	3,030	51	27.5	51		51	33
34	WATER HEATER		2005	1,885	31	27.5	31		31	34
35	FIREALARM SYSTEM		2005	67,823	1,130	27.5	1,130		1,130	35
36	BOILER		2005	4,602	77	27.5	77		77	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 DOOR ALARM	2005	\$ 1,791	\$ 30	27.5	\$ 30	\$	\$ 30	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,526,031	\$ 80,352		\$ 76,806	\$ (3,546)	\$ 1,089,410	70

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

Facility Name & ID Number **TERRACE NURSING HOME**

0043943

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	\$ 369,117	\$ 39,721	\$ 36,912	\$ (2,809)	10 YRS	\$ 173,815	71
72	Current Year Purchases	15,215	3,043	761	(2,282)	10 YRS	761	72
73	Fully Depreciated Assets	2,851				10 YRS	2,851	73
74	RELATED PARTIES		182	182				74
75	TOTALS	\$ 387,183	\$ 42,946	\$ 37,855	\$ (5,091)		\$ 177,427	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)	\$ 2,995,266	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 123,298	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 114,661	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,637)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,266,837	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: _____

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:	115		\$ 205,307			3
4	Additions						4
5							5
6							6
7	TOTAL	115		\$ 205,307			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: \$ 35,077 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	NURSING FACILITY	03 ECONOLINE WAGON	\$ 686.00	\$ 7,643	17
18	NURSING FACILITY	03 CHEVY ASTRO VAN	645.00	1,291	18
19					19
20					20
21	TOTAL		\$ #####	\$ 8,934	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. _____/2006 \$ _____

13. _____/2007 \$ _____

14. _____/2008 \$ _____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39.8	hrs	\$		\$ 183,049	\$		\$ 183,049	1
2	Licensed Speech and Language Development Therapist	39.8	hrs			6,012			6,012	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39.8	hrs			189,857			189,857	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.8	# of prescripts				119,483		119,483	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): radiology, lab, supplies	39.8				473	16,376		16,849	13
14	TOTAL			\$		\$ 379,391	\$ 135,859		\$ 515,250	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number TERRACE NURSING HOME

0043943

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 40,949	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (200,000))	743,415		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	87,140		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	293,664		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,165,168	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	276,986		15
16	Equipment, at Historical Cost	521,545		16
17	Accumulated Depreciation (book methods)	(499,113)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): OPTION DEPOSIT	230,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 529,418	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,694,586	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,197,021	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	77,000		29
30	Accrued Salaries Payable	92,478		30
31	Accrued Taxes Payable (excluding real estate taxes)	36,766		31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,218		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,476,483	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,476,483	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 218,103	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,694,586	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 175,023	1
2	Restatements (describe):		2
3	ILLINOIS REPLACEMENT TAX	(7,017)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 168,006	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	457,597	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(407,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 50,097	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 218,103	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,594,506	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,594,506	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	236,839	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 236,839	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	307	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 307	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,831,652	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	871,993	31
32	Health Care	2,260,380	32
33	General Administration	1,211,341	33
	B. Capital Expense		
34	Ownership	452,128	34
	C. Ancillary Expense		
35	Special Cost Centers	515,250	35
36	Provider Participation Fee	62,963	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,374,055	40
41	Income before Income Taxes (line 30 minus line 40)**	457,597	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 457,597	43

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

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

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

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

Facility Name & ID Number TERRACE NURSING HOME

0043943

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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	3,095	3,717	\$ 90,464	\$ 24.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	24,989	26,945	753,869	27.98	3
4	Licensed Practical Nurses	5,142	5,780	113,151	19.58	4
5	CNAs & Orderlies	80,668	86,678	884,625	10.21	5
6	CNA Trainees					6
7	Licensed Therapist	3,602	3,741	28,648	7.66	7
8	Rehab/Therapy Aides	4,412	4,839	56,310	11.64	8
9	Activity Director					9
10	Activity Assistants	7,480	8,149	80,592	9.89	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,776	21,978	179,465	8.17	15
16	Dishwashers					16
17	Maintenance Workers	5,593	5,894	74,242	12.60	17
18	Housekeepers	18,148	20,155	162,355	8.06	18
19	Laundry	6,510	7,171	57,310	7.99	19
20	Administrator	2,080	2,305	73,500	31.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,626	10,608	96,171	9.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,852	1,860	26,898	14.46	31
32	Other Health C: <u>MDS, Q.A.</u>	3,727	4,015	91,390	22.76	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	196,700	213,835	\$ 2,768,990 *	\$ 12.95	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	18,000	9-3	36
37	Medical Records Consultant	monthly fee	5,024	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly fee	4,171	10-3	39
40	Physical Therapy Consultant	monthly fee	537	10a-3	40
41	Occupational Therapy Consultant	monthly fee	200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	8	440	11-3	44
45	Social Service Consultant	98	5,330	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	106	\$ 39,642		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		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	
ROSE SHULTS	ADMIN		\$ 73,500	Workers' Compensation Insurance	\$ 61,795	IDPH License Fee	\$	
	ASST ADMIN		0	Unemployment Compensation Insurance	25,126	Advertising: Employee Recruitment	1,790	
				FICA Taxes	208,558	Health Care Worker Background Check	260	
				Employee Health Insurance	196,841	(Indicate # of checks performed)		
				Employee Meals	0	MARKETING/ADV/PROMO	20,331	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,585	
				EMPLOYEE BENEFITS - OTHER	5,289	LICENSES & PERMITS	966	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	5,839	
				PENSION/PROFIT SHARING PLANS	21,563	MGMT CO ALLOCATION	575	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(1,585)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(5,570)	
						Yellow page advertising	(14,761)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 73,500	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 519,172		\$ 9,430		
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			\$ 190,000				Out-of-State Travel	\$
PHILIP ESFORMES, INC			6,000					
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 196,000				Seminar Expense	1,253
C. Professional Services			TOTAL			Entertainment Expense		
Vendor/Payee	Type		Amount			Amount	(
ALPHA DATA	DATA PROCESSING		\$ 4,959				(
COMCAST	DATA PROCESSING		401				(
HEALTH DATA SYSTEMS	DATA PROCESSING		6,065				(
IVANS	DATA PROCESSING		787				(
LTC SOLUTIONS	DATA PROCESSING		1,320				(
MAXXSOURCE	DATA PROCESSING		1,380				(
KRUPNICK, BOKOR	ACCOUNTING		15,900				(
LASALLE BANK	LEGAL		574				(
RICHARD PEELO	MEDICARE CONSULTANT		4,500				(
PERSONNEL PLANNERS	UC CONSULTANT		1,420				(
PROCLAIM	W/C CONSULTANT		196				(
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 37,502	\$			TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 1,253	

* 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	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									
																	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	
1	PAINT/DECORATING	07/99	\$ 3,639	3 YRS	\$ 607	\$	\$	\$	\$	\$	\$	\$														
2	PAINT/DECORATING	07/01	5,815	3 YRS	1,938	1,938	970																			
3	PAINT/DECORATING	07/05	2,227	3 YRS				372	742	742	371															
4																										
5																										
6																										
7																										
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18																										
19																										
20	TOTALS		\$ 11,681		\$ 2,545	\$ 1,938	\$ 970	\$ 372	\$ 742	\$ 742	\$ 371	\$														

Facility Name & ID Number TERRACE NURSING HOME

0043943

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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 LONG TERM CARE \$5,108
- (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. \$ 680 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 during this cost report period. \$ 62,963
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? _____ 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