



Facility Name & ID Number KANKAKEE TERRACE

# 0022897 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	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			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	49,474	730	796	51,000
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	49,474	730	796	51,000

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.70%

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

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

NONE

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 11/01/06

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 11/01/06 NO

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

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

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number **KANKAKEE TERRACE** # **0022897** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	237,996	15,130	5,940	259,066		259,066	0	259,066		1
2	Food Purchase		202,987		202,987	0	202,987	(239)	202,748		2
3	Housekeeping	204,677	22,317	0	226,994		226,994	0	226,994		3
4	Laundry	78,996	11,187	2,882	93,065	0	93,065	1,151	94,216		4
5	Heat and Other Utilities			115,964	115,964		115,964	339	116,303		5
6	Maintenance	100,156	17,000	28,374	145,530		145,530	7,247	152,777		6
7	Other (specify):*			4,824	4,824		4,824	83	4,907		7
8	<b>TOTAL General Services</b>	<b>621,825</b>	<b>268,621</b>	<b>157,984</b>	<b>1,048,430</b>	<b>0</b>	<b>1,048,430</b>	<b>8,581</b>	<b>1,057,011</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		2,500	2,500		2,500	0	2,500		9
10	Nursing and Medical Records	1,320,189	56,314	28,737	1,405,240		1,405,240	0	1,405,240		10
10a	Therapy	21,343		0	21,343		21,343	0	21,343		10a
11	Activities	82,265	7,030	1,179	90,474		90,474	0	90,474		11
12	Social Services	0		1,484	1,484		1,484	0	1,484		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*				0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,423,797</b>	<b>63,344</b>	<b>33,900</b>	<b>1,521,041</b>	<b>0</b>	<b>1,521,041</b>	<b>0</b>	<b>1,521,041</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	80,862		388,532	469,394		469,394	(364,202)	105,192		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			33,976	33,976		33,976	6,186	40,162		19
20	Dues, Fees, Subscriptions & Promotions			15,665	15,665		15,665	(150)	15,515		20
21	Clerical & General Office Expenses	80,300	13,230	110,010	203,540		203,540	(87,148)	116,392		21
22	Employee Benefits & Payroll Taxes			372,834	372,834	0	372,834	0	372,834		22
23	Inservice Training & Education			3,358	3,358		3,358	0	3,358		23
24	Travel and Seminar			0	0		0	7	7		24
25	Other Admin. Staff Transportation			27,007	27,007		27,007	627	27,634		25
26	Insurance-Prop.Liab.Malpractice			60,551	60,551		60,551	522	61,073		26
27	Other (specify):*			17,400	17,400		17,400	(7,521)	9,879		27
28	<b>TOTAL General Administration</b>	<b>161,162</b>	<b>13,230</b>	<b>1,029,333</b>	<b>1,203,725</b>	<b>0</b>	<b>1,203,725</b>	<b>(451,679)</b>	<b>752,046</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,206,784</b>	<b>345,195</b>	<b>1,221,217</b>	<b>3,773,196</b>	<b>0</b>	<b>3,773,196</b>	<b>(443,098)</b>	<b>3,330,098</b>		<b>29</b>

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	5,940
	REPAIRS & MAINTENANCE	0
		0
		5,940
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	2,882
		0
		2,882
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	36,738
	ELECTRICITY	35,611
	WATER	34,610
	CABLE TV - LOBBY	9,005
		0
		115,964
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	2,640
	PAINTING & DECORATING	1,696
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	14,795
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,446
	FIRE SERVICE	6,797
		0
		0
		0
		0
		28,374
7	<b>OTHER</b>	
	SCAVENGER	3,999
	SECURITY SERVICE	825
		0
		0
		4,824
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	2,500
		2,500

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	16,630
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	4,260
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	6,347
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	<b>DENTAL</b>	1,500
		0
		28,737
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,179
		0
		1,179
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	1,484
	SOCIAL WORKER XVIII B 45-2	0
		0
		1,484
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	388,532
	<b>DIRECTORS FEES</b>	
<b>18</b>	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	13,634
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	20,342
		0
		33,976
<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	395
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	8,291
	LICENSES & PERMITS XIX F	3,350
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,599
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	1,000
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,000
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	30
	PATIENT BACKGROUND CHECKS XIX F	0
		15,665
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,533
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	91,500
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	16,977
	MESSENGER SERVICE	0
		0
		110,010

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	166,456
	UNEMPLOYMENT COMPENSATION XIX D	19,857
	WORKERS COMPENSATION INSURANC XIX D	82,820
	HOSPITALIZATION INSURANCE XIX D	87,365
	EMPLOYEE BENEFITS - OTHER XIX D	500
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	15,836
	CHICAGO HEAD TAX XIX D	0
		0
		372,834
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	3,358
		3,358
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	27,007
		27,007
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	60,551
		60,551
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	17,400
		17,400

GRAND TOTAL COLUMN 3 OTHER

1,221,217

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

TOTAL FOOD PURCHASE	202,987	PATIENT MEALS	153000
LESS SALES TAX	(239)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	202,748	TOTAL MEALS/YEAR	153000
TOTAL PATIENT CENSUS	51,000	NET FOOD	202748
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	153000
	-----		
TOTAL PATIENT MEALS	153000	COST PER MEAL	1.33
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name &amp; ID Number

KANKAKEE TERRACE

#0022897

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			47,695	47,695		47,695	13,366	61,061			30
31	Amortization of Pre-Op. & Org.			14,366	14,366		14,366	0	14,366			31
32	Interest			179,299	179,299		179,299	(71,861)	107,438			32
33	Real Estate Taxes			46,050	46,050		46,050	1,432	47,482			33
34	Rent-Facility & Grounds			171,561	171,561		171,561	0	171,561			34
35	Rent-Equipment & Vehicles			53,756	53,756		53,756	3,400	57,156			35
36	Other (specify):* <b>IME RENT</b>			11,232	11,232		11,232	(11,232)	0			36
37	<b>TOTAL Ownership</b>			523,959	523,959	0	523,959	(64,895)	459,064			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			79,935	79,935		79,935	0	79,935			42
43	Other (specify):*				0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	0	79,935	79,935	0	79,935	0	79,935			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,206,784	345,195	1,825,111	4,377,090	0	4,377,090	(507,993)	3,869,097			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:

**01/01/2006**

Ending:

**12/31/2006**

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	11,954	30		9
10	Interest and Other Investment Income	(73,858)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(239)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,000)	20		17
18	Fines and Penalties	0	21		18
19	Entertainment	0	20		19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(2,408)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,400)	27		24
25	Fund Raising, Advertising and Promotional	0	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,599)	20		28
29	Other-Attach Schedule	(20,556)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (106,106)		\$ 0	30

<b>BHF USE ONLY</b>					
48	49	50	51	52	

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(401,887)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (401,887)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (507,993)		37

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

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

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

KANKAKEE TERRACE

ID# 0022897

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 3,510	6	1
2	MARKETING SALARY	(24,066)	21	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	<b>Total</b>	(20,556)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number KANKAKEE TERRACE# 0022897

Report Period Beginning:

01/01/2006

Ending:

12/31/2006**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(239)	0	0	0	0	0	0	0	0	0	0	(239)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	1,151	0	0	0	0	0	0	0	0	1,151	4
5	Heat and Other Utilities	0	0	0	339	0	0	0	0	0	0	0	339	5
6	Maintenance	3,510	1,587	1,532	618	0	0	0	0	0	0	0	7,247	6
7	Other (specify):*	0	0	49	34	0	0	0	0	0	0	0	83	7
8	<b>TOTAL General Services</b>	<b>3,271</b>	<b>1,587</b>	<b>2,732</b>	<b>991</b>	<b>0</b>	<b>8,581</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(371,396)	7,194	0	0	0	0	0	0	0	0	(364,202)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,408)	906	7,637	51	0	0	0	0	0	0	0	6,186	19
20	Fees, Subscriptions & Promotions	(3,599)	0	3,449	0	0	0	0	0	0	0	0	(150)	20
21	Clerical & General Office Expenses	(24,066)	9,194	(72,339)	63	0	0	0	0	0	0	0	(87,148)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	7	0	0	0	0	0	0	0	0	7	24
25	Other Admin. Staff Transportation	0	250	377	0	0	0	0	0	0	0	0	627	25
26	Insurance-Prop.Liab.Malpractice	0	145	234	143	0	0	0	0	0	0	0	522	26
27	Other (specify):*	(17,400)	4,420	5,459	0	0	0	0	0	0	0	0	(7,521)	27
28	<b>TOTAL General Administration</b>	<b>(47,473)</b>	<b>(356,481)</b>	<b>(47,982)</b>	<b>257</b>	<b>0</b>	<b>(451,679)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(44,202)</b>	<b>(354,894)</b>	<b>(45,250)</b>	<b>1,248</b>	<b>0</b>	<b>(443,098)</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number KANKAKEE TERRACE

# 0022897

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	11,954	189	230	993	0	0	0	0	0	0	0	13,366	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(73,858)	0	0	1,997	0	0	0	0	0	0	0	(71,861)	32
33	Real Estate Taxes	0	0	0	1,432	0	0	0	0	0	0	0	1,432	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	359	2,712	329	0	0	0	0	0	0	0	3,400	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>(61,904)</b>	<b>548</b>	<b>2,942</b>	<b>(6,481)</b>	<b>0</b>	<b>(64,895)</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>(106,106)</b>	<b>(354,346)</b>	<b>(42,308)</b>	<b>(5,233)</b>	<b>0</b>	<b>(507,993)</b>	<b>45</b>						

Facility Name & ID Number

KANKAKEE TERRACE

# 0022897

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	\$ 381,532	EMI ENTERPRISES	100.00%	\$	\$ (381,532)	1
2	V							2
3	V	6 DRIVERS SALARY				1,587	1,587	3
4	V	17 OFFICERS SALARY				10,136	10,136	4
5	V	19 ACCOUNTING FEES				906	906	5
6	V	21 OFFICE EXPENSE				9,194	9,194	6
7	V	25 TRANSPORTATION				250	250	7
8	V	26 INSURANCE				145	145	8
9	V	27 EMPLOYEE BENEFITS				4,420	4,420	9
10	V	35 AUTO LEASE				359	359	10
11	V	30 DEPRECIATION				189	189	11
12	V							12
13	V							13
14	Total		\$ 381,532			\$ 27,186	\$ * (354,346)	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	\$ 91,500	EKS MANAGEMENT	100.00%	\$	\$ (91,500)
16	V						
17	V	4 HOUSEKEEPING SALARIES				1,151	1,151
18	V	6 PAINTERS SALARIES				1,532	1,532
19	V	7 SCAVENGER				49	49
20	V	17 CFO SALARY				7,194	7,194
21	V	19 PROFESSIONAL FEES				7,637	7,637
22	V	20 WANT ADDS/BACKGR CKS				3,449	3,449
23	V	21 OFFICE EXPENSE				19,161	19,161
24	V	24 IN STATE TRAVEL				7	7
25	V	25 TRANSPORTATION				377	377
26	V	26 INSURANCE				234	234
27	V	27 EMPLOYEE BENEFITS				5,459	5,459
28	V	30 DERPECIATION (SL)				230	230
29	V	35 EQUIPMENT RENT				2,712	2,712
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 91,500			\$ 49,192	\$ * (42,308)

\* 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	100.00%	\$	\$ (11,232)
16	V						
17	V						
18	V	5 UTILITIES				339	339
19	V	6 REPAIR & MAINTENANCE				618	618
20	V	7 ALARM SERVICE				34	34
21	V	19 PROFESSIONAL FEES				51	51
22	V	21 OFFICE EXPENSE				63	63
23	V	26 INSURANCE				143	143
24	V	30 DEPRECIATION				993	993
25	V	32 INTEREST				1,997	1,997
26	V	33 RE TAX				1,432	1,432
27	V	35 STORAGE FEES				329	329
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			\$ 5,999	\$ * (5,233)

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

Facility Name &amp; ID Number

KANKAKEE TERRACE

#

0022897

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES							SALARY	\$ 10,136	17-7	1
2	AVRUM WEINFELD	CEO						SALARY	7,194	17-7	2
3	PHILIP ESFORMES							MGMT FEE	7,000	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 24,330		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: **01/01/2006**

Ending: **2/31/2006**

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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	6	DRIVERS SALARY	PATIENT DAYS	778,042	14	\$ 28,965	\$ 42,629	\$ 1,587	1
2	17	OFFICERS SALARY	PATIENT DAYS	778,042	14	185,000	42,629	10,136	2
3	19	ACCOUNTING FEES	PATIENT DAYS	778,042	14	16,537	42,629	906	3
4	21	OFFICE EXPENSE	PATIENT DAYS	778,042	14	167,811	42,629	9,194	4
5	25	TRANSPORTATION	PATIENT DAYS	778,042	14	4,565	42,629	250	5
6	26	INSURANCE	PATIENT DAYS	778,042	14	2,648	42,629	145	6
7	27	EMPLOYEE BENEFITS	PATIENT DAYS	778,042	14	80,669	42,629	4,420	7
8	35	AUTO LEASE	PATIENT DAYS	778,042	14	6,544	42,629	359	8
9	30	DEPRECIATION	PATIENT DAYS	778,042	14	3,451	42,629	189	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 496,190	\$ 345,993	\$ 27,186	25

Facility Name & ID Number **KANKAKEE TERRACE**

# **0022897** Report Period Beginning: **01/01/2006**

Ending: **2/31/2006**

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	4	HOUSEKEEPING SALARIES	PATIENT DAYS	863,827	14	\$ 19,500	\$ 19,500	51,000	\$ 1,151	1
2	6	PAINTERS SALARIES	PATIENT DAYS	863,827	14	25,953	25,953	51,000	1,532	2
3	7	SCAVENGER	PATIENT DAYS	863,827	14	825		51,000	49	3
4	17	CFO SALARY	PATIENT DAYS	863,827	14	121,844	121,844	51,000	7,194	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	863,827	14	129,352		51,000	7,637	5
6	20	WANT ADDS/BACKGR CKS	PATIENT DAYS	863,827	14	58,423		51,000	3,449	6
7	21	OFFICE EXPENSE	PATIENT DAYS	863,827	14	324,544	218,865	51,000	19,161	7
8	24	IN STATE TRAVEL	PATIENT DAYS	863,827	14	112		51,000	7	8
9	25	TRANSPORTATION	PATIENT DAYS	863,827	14	6,388		51,000	377	9
10	26	INSURANCE	PATIENT DAYS	863,827	14	3,958		51,000	234	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	863,827	14	92,462		51,000	5,459	11
12	30	DERPECIATION (SL)	PATIENT DAYS	863,827	14	3,880		51,000	230	12
13	35	EQUIPMENT RENT	PATIENT DAYS	863,827	14	45,937		51,000	2,712	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 833,178	\$ 386,162		\$ 49,192	25

Facility Name & ID Number **KANKAKEE TERRACE**

# **0022897** Report Period Beginning: **01/01/2006**

Ending: **2/31/2006**

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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	344,402	15	\$ 10,404	\$ 11,232	\$ 339	1
2	6	REPAIR & MAINTENANCE	RENTAL INCOME	344,402	15	18,957	11,232	618	2
3	7	ALARM SERVICE	RENTAL INCOME	344,402	15	1,056	11,232	34	3
4	19	PROFESSIONAL FEES	RENTAL INCOME	344,402	15	1,575	11,232	51	4
5	21	OFFICE EXPENSE	RENTAL INCOME	344,402	15	1,942	11,232	63	5
6	26	INSURANCE	RENTAL INCOME	344,402	15	4,387	11,232	143	6
7	30	DEPRECIATION	RENTAL INCOME	344,402	15	30,446	11,232	993	7
8	32	INTEREST	RENTAL INCOME	344,402	15	61,229	11,232	1,997	8
9	33	RE TAX	RENTAL INCOME	344,402	15	43,904	11,232	1,432	9
10	35	STORAGE FEES	RENTAL INCOME	344,402	15	10,073	11,232	329	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 183,973	\$	\$ 5,999	25

Facility Name &amp; ID Number

KANKAKEE TERRACE

# 0022897

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1	LASALLE BANK		X	MORTGAGE	\$15,553.00	11/01/01	\$ 2,283,583	\$ 0			\$ 119,979	1						
2												2						
3												3						
4												4						
5												5						
	<b>Working Capital</b>																	
6	LASALLE BANK		X	WORKING CAPITAL				119,000			59,320	6						
7												7						
8	RELATED PARTY										1,997	8						
9	<b>TOTAL Facility Related</b>				\$15,553.00		\$ 2,283,583	\$ 119,000			\$ 181,296	9						
	<b>B. Non-Facility Related*</b>																	
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$ 0	\$ 0			\$ 0	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 2,283,583	\$ 119,000			\$ 181,296	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 2005 report.		\$	<b>46,200</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>46,306</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>106</b>	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>7,700</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>ADJ FOR OLD FACILITY</b> <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>38,244</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>46,050</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	<b>46,051</b>	8
	2002	<b>45,875</b>	9
	2003	<b>44,746</b>	10
	2004	<b>45,253</b>	11
	2005	<b>46,306</b>	12

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

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

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>17-09-20-107-040</u>	<u>NURSING HOME</u>	\$ <u>236.40</u>	\$ <u>236.40</u>
2. <u>17-09-20-107-041</u>	<u>NURSING HOME</u>	\$ <u>46,069.36</u>	\$ <u>46,069.36</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>46,305.76</u>	\$ <u>46,305.76</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

Facility Name & ID Number KANKAKEE TERRACE

# 0022897

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**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, CNA training facilities, etc.)  
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred: 2,500 2. Number of Years Over Which it is Being Amortized: 5  
 3. Current Period Amortization: 84 4. Dates Incurred: 11/01/06

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				\$	1
2					2
3	TOTALS			\$ 0	3

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

Report Period Beginning:

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

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	118	1976	1972	\$ 1,233,000	\$ 0	25	\$ 0	\$	\$ 1,233,000	4
5	28		1998	981,637	20,975	39	20,975		210,815	5
6										6
7										7
8	RELATED PARTY				954		954			8
	Improvement Type**									
9	BUILDING IMPROVEMENTS		1978	8,584	0	10	0		8,584	9
10	BUILDING IMPROVEMENTS		1981	8,060	0	15	0		8,060	10
11	BUILDING IMPROVEMENTS		1987	51,503	1,363	31.5	1,363		30,725	11
12	BUILDING IMPROVEMENTS		1988	7,400	196	10	0	(196)	7,400	12
13	BUILDING IMPROVEMENTS		1988	17,500	463	15	0	(463)	17,500	13
14	BUILDING IMPROVEMENTS		1990	27,632	731	20	731		22,152	14
15	BUILDING IMPROVEMENTS		1991	12,763	339	20	339		9,590	15
16	BUILDING IMPROVEMENTS		1992	36,068	954	31.5	954		16,271	16
17	BUILDING IMPROVEMENTS		1993	40,178	1,044	31.5	1,044		17,202	17
18	BUILDING IMPROVEMENTS		1994	18,233	372	39	372		5,814	18
19	CARPET		1996	8,028	172	39	172		2,103	19
20	SHADE STRUCTURE		1997	2,200	47	39	47		531	20
21	CONCRETE SLAB		1997	667	15	39	15		163	21
22	NURSE STATION		1998	4,950	106	39	106		1,155	22
23	ROOFTOP AC		1998	2,031	43	39	43		433	23
24	PARKING LOT		1999	18,460	1,026	15	1,026		9,027	24
25	ROOFTOP AC		1999	6,716	144	39	144		1,304	25
26	DOORS		1999	2,151	46	39	46		388	26
27	CARPET		1999	14,114	301	39	301		2,518	27
28	DRAPERIES & RODS/REPLACE SHINGLES		2000	7,865	266	20	266		2,428	28
29	LANDSCAPE RENOVATION		2000	6,700	372	15	372		2,830	29
30	VINYL/CERAMIC TILE		2000	1,941	59	27.5	59		470	30
31	CARPET & FLOOR TILE		2001	16,962	514	20	514		4,754	31
32	CONTROL VALVE REPL		2002	2,849	87	27.5	87		503	32
33	NEW FLOOR - LAUNDRY		2003	2,874	87	27.5	87		343	33
34	ROOF		2003	24,800	752	27.5	752		2,969	34
35	FURNACES		2003	23,436	710	27.5	710		2,805	35
36	GUTTERS		2003	6,231	189	27.5	189		747	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	2003	\$ 10,400	\$ 315	27.5	\$ 315	\$	\$ 1,244	37	
38	2004	5,458	166	27.5	166		456	38	
39	2004	2,625	80	27.5	80		219	39	
40	2004	2,882	87	27.5	87		240	40	
41	2005	1,958	59	27.5	59		91	41	
42	2005	9,700	294	27.5	294		455	42	
43	2005	7,575	421	15	421		926	43	
44	2005	3,250	98	27.5	98		152	44	
45	2005	1,742	53	27.5	53		83	45	
46	2006	6,428	89	27.5	89		89	46	
47	2006	3,429	48	27.5	48		48	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)		\$ 2,650,980	\$ 34,037		\$ 33,378	\$ (659)	\$ 1,626,587	70

\*\*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:

**01/01/2006**

Ending:

**12/31/2006**

**XI. OWNERSHIP COSTS (continued)**

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 268,843	\$ 9,872	\$ 25,803	\$ 15,931	10 YRS	\$ 181,834	71
72	Current Year Purchases	28,440	4,740	1,422	(3,318)	10 YRS	1,422	72
73	Fully Depreciated Assets	344,307			0		344,307	73
74	<b>RELATED PARTY</b>		458	458	0			74
75	<b>TOTALS</b>	\$ 641,590	\$ 15,070	\$ 27,683	\$ 12,613		\$ 527,563	75

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

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	<b>TOTALS</b>			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	80

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

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,292,570	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 49,107	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 61,061	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,954	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,154,150	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	<b>TOTALS</b>	\$	\$	\$	91

**G. Construction-in-Progress**

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: GRANITE KANKAKEE TERRACE LLC

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		146	11/01/06	\$ 171,561	66 MOS		3
4	Additions							4
5								5
6								6
7	TOTAL		146		\$ 171,561			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: \$ 8,041 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	SCHEDULE ATTACHED		\$	\$ 45,715	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 45,715	21

10. Effective dates of current rental agreement:

Beginning 11/01/06

Ending 04/01/12

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

Fiscal Year Ending Annual Rent

12. 11/01/2007 \$ 1,029,368

13. 11/01/2008 \$ 1,029,365

14. 11/01/2009 \$ 1,044,809

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

<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 CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	14

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

Facility Name & ID Number **KANKAKEE TERRACE**# **0022897**Report Period Beginning: **01/01/2006**Ending: **12/31/2006****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2006**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>17,400</u> )	669,073		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	98,650		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>RE TAX &amp; INS ESCROW</u>	9,111		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 776,834	\$ 0	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,500		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(84)		20
21	Restricted Funds	257,342		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>ADV RENT &amp; REPL RESV</u>	18,207		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 277,965	\$ 0	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,054,799	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 185,456	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	119,000		29
30	Accrued Salaries Payable	88,532		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,009		31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,700		32
33	Accrued Interest Payable	327		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)	\$ 410,024	\$ 0	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 0	\$ 0	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 410,024	\$ 0	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 644,775	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,054,799	\$ 0	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>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>ADJ NET INCOME OLD FACILITY</b>	<b>(556,757)</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>(556,757)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>631,532</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>MEMBERS EQUITY</b>	<b>570,000</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,201,532</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>644,775</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	\$ 4,948,913	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,948,913	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 0	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 0	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	73,858	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 73,858	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 0	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,022,771	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,048,430	31
32	Health Care	1,521,041	32
33	General Administration	1,203,725	33
	<b>B. Capital Expense</b>		
34	Ownership	523,959	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	0	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>	\$ 4,377,090	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	645,681	41
42	<b>Income Taxes</b>	(14,149)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 631,532	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:

01/01/2006

Ending:

12/31/2006

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,167	2,369	\$ 61,318	\$ 25.88	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,483	6,331	146,483	23.14	3
4	Licensed Practical Nurses	10,677	11,533	219,991	19.07	4
5	CNAs & Orderlies	54,767	59,693	673,438	11.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,406	1,607	21,343	13.28	8
9	Activity Director					9
10	Activity Assistants	7,756	8,750	82,265	9.40	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,603	21,726	237,996	10.95	15
16	Dishwashers					16
17	Maintenance Workers	10,011	10,507	100,156	9.53	17
18	Housekeepers	18,229	20,382	204,677	10.04	18
19	Laundry	4,651	5,421	78,996	14.57	19
20	Administrator	2,087	2,256	80,862	35.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,154	11,779	80,300	6.82	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					31
32	Other Health Care(specify)	17,929	19,724	218,959	11.10	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	165,920	182,078	\$ 2,206,784 *	\$ 12.12	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 5,940	1-3	35
36	Medical Director	O	2,500	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,347	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,179	11-3	44
45	Social Service Consultant	E	1,484	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 17,450		49

**C. CONTRACT NURSES**

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



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

1	2	3	4	5	6	7	8	9	10	11	12	13													
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
																	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	PAINT/DECORATING	2003	\$ 11,721	3	\$ 1,954	\$ 3,907	\$ 3,907	\$ 1,953																	
2	PAINT/DECORATING	2004	8,909	3		1,485	1,485	2,970	1,484																
3	PAINT/DECORATING	2006	1,696	3				283	565	565	283														
4																									
5																									
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20	<b>TOTALS</b>		\$ 22,326		\$ 1,954	\$ 5,392	\$ 5,392	\$ 5,206	\$ 2,049	\$ 565	\$ 283	\$													

Facility Name & ID Number **KANKAKEE TERRACE**# **0022897**Report Period Beginning: **01/01/2006**Ending: **12/31/2006****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. ICLTC \$ 3,176
- (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. \$ 546 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
KANKAKEE TERRACE #0022897 11/01/06
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department 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, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees