

Facility Name & ID Number TERRACE NURING HOME

0043943 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	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	575	238	5,671	6,484	8
9	SNF/PED					9
10	ICF	26,225	6,561	2	32,788	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,800	6,799	5,673	39,272	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.56%

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 ADMINISTAR

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 **TERRACE NURING HOME** # **0043943** 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
	A. General Services										
1	Dietary	188,661	13,576	8,075	210,312		210,312	0	210,312		1
2	Food Purchase		162,883		162,883	(3,913)	158,970	(746)	158,224		2
3	Housekeeping	163,046	24,783	0	187,829		187,829	0	187,829		3
4	Laundry	59,765	16,334	5,558	81,657	0	81,657	887	82,544		4
5	Heat and Other Utilities			112,598	112,598		112,598	271	112,869		5
6	Maintenance	67,705	53,951	42,287	163,943		163,943	3,627	167,570		6
7	Other (specify):*			19,620	19,620		19,620	66	19,686		7
8	TOTAL General Services	479,177	271,527	188,138	938,842	(3,913)	934,929	4,105	939,034		8
	B. Health Care and Programs										
9	Medical Director	0		18,000	18,000		18,000	0	18,000		9
10	Nursing and Medical Records	2,069,033	95,741	9,460	2,174,234		2,174,234	0	2,174,234		10
10a	Therapy	85,081		3,933	89,014		89,014	0	89,014		10a
11	Activities	81,785	12,381	717	94,883		94,883	0	94,883		11
12	Social Services	0		5,648	5,648		5,648	0	5,648		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			8,347	8,347		8,347	0	8,347		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	2,235,899	108,122	46,105	2,390,126	0	2,390,126	0	2,390,126		16
	C. General Administration										
17	Administrative	73,500		96,015	169,515		169,515	(69,242)	100,273		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			48,316	48,316		48,316	6,613	54,929		19
20	Dues, Fees, Subscriptions & Promotions			28,901	28,901		28,901	(15,217)	13,684		20
21	Clerical & General Office Expenses	107,764	21,389	96,140	225,293		225,293	(44,467)	180,826		21
22	Employee Benefits & Payroll Taxes			548,904	548,904	3,913	552,817	0	552,817		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			1,984	1,984		1,984	5	1,989		24
25	Other Admin. Staff Transportation			14,686	14,686		14,686	481	15,167		25
26	Insurance-Prop.Liab.Malpractice			60,151	60,151		60,151	405	60,556		26
27	Other (specify):*			38,455	38,455		38,455	(30,879)	7,576		27
28	TOTAL General Administration	181,264	21,389	933,552	1,136,205	3,913	1,140,118	(152,301)	987,817		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,896,340	401,038	1,167,795	4,465,173	0	4,465,173	(148,196)	4,316,977		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	6,435
	REPAIRS & MAINTENANCE	1,640
		0
		8,075
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	5,558
		0
		5,558
5	HEAT & OTHER UTILITIES	
	GAS HEAT	51,677
	ELECTRICITY	39,680
	WATER	21,103
	CABLE TV - LOBBY	138
		0
		112,598
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,875
	PAINTING & DECORATING	1,488
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	24,185
	ELEVATOR MAINTENANCE & REPAIR	6,680
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,507
	FIRE SERVICE	3,552
		0
		0
		0
		0
		42,287
7	OTHER	
	SCAVENGER	14,648
	SECURITY SERVICE	4,972
		0
		0
		19,620
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	124
	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	5,424
	PHARMACY CONSULTANT XVIII B 39-2	3,912
	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
		9,460
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	1,952
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	1,981
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		3,933
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	717
		0
		717
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	5,648
	SOCIAL WORKER XVIII B 45-2	0
		0
		5,648
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	8,347
		8,347
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	96,015
		96,015
	DIRECTORS FEES	
18	DIRECTORS FEES	0
		0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	16,470
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	31,846
		0
		48,316
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	3,566
	EMPLOYEE WANT ADS XIX F	1,209
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	5,378
	LICENSES & PERMITS XIX F	4,261
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	11,051
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,256
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	180
	PATIENT BACKGROUND CHECKS XIX F	0
		28,901
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	4,262
	OUTSIDE CLERICAL SERVICES	46,000
	PENALTIES / OVERDRAFT CHARGES VI 18	20,288
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	25,590
	MESSENGER SERVICE	0
		0
		96,140

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	217,802
	UNEMPLOYMENT COMPENSATION XIX D	34,052
	WORKERS COMPENSATION INSURANC XIX D	79,672
	HOSPITALIZATION INSURANCE XIX D	194,882
	EMPLOYEE BENEFITS - OTHER XIX D	4,202
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	18,294
	CHICAGO HEAD TAX XIX D	0
		0
		548,904
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,984
	TRAVEL XIX G	0
		1,984
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	14,686
		14,686
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	60,151
		60,151
27	OTHER	
	BAD DEBTS VI 24	38,455
		38,455

GRAND TOTAL COLUMN 3 OTHER

1,167,795

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

TOTAL FOOD PURCHASE	162,883	PATIENT MEALS	117816
LESS SALES TAX	(746)	ADD EMPLOYEE MEALS	2920
	-----		-----
NET FOOD	162,137	TOTAL MEALS/YEAR	120736
TOTAL PATIENT CENSUS	39,272	NET FOOD	162137
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	120736

TOTAL PATIENT MEALS	117816	COST PER MEAL	1.34
		TIME EMPLOYEE MEALS	2920
ADD # EMPLOYEE MEALS/DAY	8		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	3913
	-----		=====
TOTAL EMPLOYEE MEALS	2920		

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

#0043943

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	
	D. Ownership											
30	Depreciation			335,749	335,749		335,749	(216,604)	119,145			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			54,193	54,193		54,193	130,923	185,116			32
33	Real Estate Taxes			75,540	75,540		75,540	1,143	76,683			33
34	Rent-Facility & Grounds			266,890	266,890		266,890	(145,082)	121,808			34
35	Rent-Equipment & Vehicles			84,112	84,112		84,112	2,624	86,736			35
36	Other (specify):* IME			8,970	8,970		8,970	(8,970)	0			36
37	TOTAL Ownership			825,454	825,454	0	825,454	(235,966)	589,488			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		169,144	422,297	591,441		591,441	0	591,441			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			62,963	62,963		62,963	0	62,963			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	169,144	485,260	654,404	0	654,404	0	654,404			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,896,340	570,182	2,478,509	5,945,031	0	5,945,031	(384,162)	5,560,869			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 NURING HOME**

0043943

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	
	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	(271,489)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(746)	2		13
14	Non-Care Related Interest	(35,207)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(20,288)	21		18
19	Entertainment	0	20		19
20	Contributions	(3,256)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(38,455)	27		24
25	Fund Raising, Advertising and Promotional	(3,566)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(11,051)	20		28
29	Other-Attach Schedule	(12,773)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (396,831)		\$ 0	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	12,669		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 12,669		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (384,162)		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 NURING HOME

ID# 0043943

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 742	6	1
2	6865 FINANCIAL INC MANAGEMENT FEE	(13,515)	17	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	(12,773)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TERRACE NURING HOME# 0043943

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	(746)	0	0	0	0	0	0	0	0	0	0	(746)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	887	0	0	0	0	0	0	0	0	887	4
5	Heat and Other Utilities	0	0	0	271	0	0	0	0	0	0	0	271	5
6	Maintenance	742	1,211	1,180	494	0	0	0	0	0	0	0	3,627	6
7	Other (specify):*	0	0	38	28	0	0	0	0	0	0	0	66	7
8	TOTAL General Services	(4)	1,211	2,105	793	0	0	0	0	0	0	0	4,105	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	(13,515)	(61,266)	5,539	0	0	0	0	0	0	0	0	(69,242)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	691	5,881	41	0	0	0	0	0	0	0	6,613	19
20	Fees, Subscriptions & Promotions	(17,873)	0	2,656	0	0	0	0	0	0	0	0	(15,217)	20
21	Clerical & General Office Expenses	(20,288)	7,015	(31,245)	51	0	0	0	0	0	0	0	(44,467)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	5	0	0	0	0	0	0	0	0	5	24
25	Other Admin. Staff Transportation	0	191	290	0	0	0	0	0	0	0	0	481	25
26	Insurance-Prop.Liab.Malpractice	0	111	180	114	0	0	0	0	0	0	0	405	26
27	Other (specify):*	(38,455)	3,372	4,204	0	0	0	0	0	0	0	0	(30,879)	27
28	TOTAL General Administration	(90,131)	(49,886)	(12,490)	206	0	0	0	0	0	0	0	(152,301)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(90,135)	(48,675)	(10,385)	999	0	0	0	0	0	0	0	(148,196)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TERRACE NURING HOME# 0043943

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(271,489)	144	176	793	53,772	0	0	0	0	0	0	(216,604)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(35,207)	0	0	1,595	164,535	0	0	0	0	0	0	130,923	32
33	Real Estate Taxes	0	0	0	1,143	0	0	0	0	0	0	0	1,143	33
34	Rent-Facility & Grounds	0	0	0	0	(145,082)	0	0	0	0	0	0	(145,082)	34
35	Rent-Equipment & Vehicles	0	274	2,088	262	0	0	0	0	0	0	0	2,624	35
36	Other (specify):*	0	0	0	(8,970)	0	0	0	0	0	0	0	(8,970)	36
37	TOTAL Ownership	(306,696)	418	2,264	(5,177)	73,225	0	0	0	0	0	0	(235,966)	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)	(396,831)	(48,257)	(8,121)	(4,178)	73,225	0	0	0	0	0	0	(384,162)	45

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

0043943

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
				EKS MGMT.	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				
				THE TERRACE	LINCOLNWOOD	LANDLORD
				INVESTOR GROUP		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 MANAGEMENT FEES	\$ 69,000	EMI		\$	(69,000)	1
2	V	6 DRIVER'S SALARY				1,211	1,211	2
3	V	17 OFFICER'S SALARY				7,734	7,734	3
4	V	19 ACCOUNTING FEES				691	691	4
5	V	21 OFFICE EXPENSE				7,015	7,015	5
6	V	25 TRANSPORTATION				191	191	6
7	V	26 INSURANCE				111	111	7
8	V	27 EMPLOYEE BENEFITS				3,372	3,372	8
9	V	30 DEPRECIATION				144	144	9
10	V	35 AUTO LEASE				274	274	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 69,000			\$ 20,743	\$ * (48,257)	14

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

Facility Name & ID Number TERRACE NURING HOME# 0043943Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 OUTSIDE CLERICAL	\$ 46,000	EKS MANAGEMENT		\$	\$ (46,000)
16	V	4 HOUSEKEEPING SALARIES				887	887
17	V	6 PAINTERS' SALARIES				1,180	1,180
18	V	7 SCAVENGER				38	38
19	V	17 CFO SALARY - A. WEINFELD				5,539	5,539
20	V	19 PROFESSIONAL FEES				5,881	5,881
21	V	20 WANT ADS / BACKGR CKS				2,656	2,656
22	V	21 OFFICE EXPENSE				14,755	14,755
23	V	24 IN- STATE TRAVEL				5	5
24	V	25 TRANSPORTATION				290	290
25	V	26 INSURANCE				180	180
26	V	27 EMPLOYEE BENEFITS				4,204	4,204
27	V	30 DEPRECIATION S.L				176	176
28	V	35 EQUIPMENT RENT				2,088	2,088
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 46,000			\$ 37,879	\$ * (8,121)

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

Facility Name & ID Number TERRACE NURING HOME

0043943

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	36 OFFICE RENT	\$ 8,970	IME REALTY		\$	\$ (8,970)
16	V	5 UTILITIES				271	271
17	V	6 REPAIRS / MAINT				494	494
18	V	7 ALARM SERVICE				28	28
19	V	19 PROFESSIONAL FEES				41	41
20	V	21 OFFICE EXPENSE				51	51
21	V	26 INSURANCE				114	114
22	V	30 DEPRECIATION				793	793
23	V	32 INTEREST				1,595	1,595
24	V	33 R/E TAX				1,143	1,143
25	V	35 STORAGE FEES				262	262
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			\$ 4,792	\$ * (4,178)

* 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	\$ 145,082	TERRACE INVESTOR GROUP		\$	(145,082)
16	V	30 DEPRECIATION				53,772	53,772
17	V	32 INTEREST				164,535	164,535
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
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		\$ 145,082			\$ 218,307	\$ * 73,225

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

Facility Name & ID Number

TERRACE NURING HOME

#

0043943

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	OFFICER	ADMINISTRATIVE		SEE			SALARY	\$ 7,734	17-7	1
2											2
3	AVRUM WEINFELD	CFO	FINANCE OFFICER	2.00	ATTACHED			SALARY	5,539	17-7	3
4											4
5	PHILIP ESFORMES	ADMINISTRATIVE	ADMINISTRATIVE	96.00				MNGMT FEE	13,500	17-3	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 26,773		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 NURING HOME**

0043943

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
 Street Address 6865 N. LINCOLN AVE.
 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	DRIVER'S SALARY	PATIENT DAYS	778,042	14	\$ 28,965	\$ 32,525	\$ 1,211	1
2	17	OFFICER'S SALARY	PATIENT DAYS	778,042	14	185,000	32,525	7,734	2
3	19	ACCOUNTING FEES	PATIENT DAYS	778,042	14	16,537	32,525	691	3
4	21	OFFICE EXPENSE	PATIENT DAYS	778,042	14	167,811	32,525	7,015	4
5	25	TRANSPORTATION	PATIENT DAYS	778,042	14	4,565	32,525	191	5
6	26	INSURANCE	PATIENT DAYS	778,042	14	2,648	32,525	111	6
7	27	EMPLOYEE BENEFITS	PATIENT DAYS	778,042	14	80,669	32,525	3,372	7
8	30	DEPRECIATION	PATIENT DAYS	778,042	14	3,451	32,525	144	8
9	35	AUTO LEASE	PATIENT DAYS	778,042	14	6,544	32,525	274	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	\$ 20,743	25

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

0043943

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

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	\$ 39,272	\$ 887	1
2	6	PAINTERS' SALARIES	PATIENT DAYS	863,827	14	25,953	39,272	1,180	2
3	7	SCAVENGER	PATIENT DAYS	863,827	14	825	39,272	38	3
4	17	CFO SALARY - A. WEINFELD	PATIENT DAYS	863,827	14	121,844	39,272	5,539	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	863,827	14	129,352	39,272	5,881	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	863,827	14	58,423	39,272	2,656	6
7	21	OFFICE EXPENSE	PATIENT DAYS	863,827	14	324,544	39,272	14,755	7
8	24	IN- STATE TRAVEL	PATIENT DAYS	863,827	14	112	39,272	5	8
9	25	TRANSPORTATION	PATIENT DAYS	863,827	14	6,388	39,272	290	9
10	26	INSURANCE	PATIENT DAYS	863,827	14	3,958	39,272	180	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	863,827	14	92,462	39,272	4,204	11
12	30	DEPRECIATION S.L	PATIENT DAYS	863,827	14	3,880	39,272	176	12
13	35	EQUIPMENT RENT	PATIENT DAYS	863,827	14	45,937	39,272	2,088	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 833,178	\$ 496,665	\$ 37,879	25

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

0043943

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 AVE.
 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	INCOME	344,402	16	\$ 10,404	\$ 8,970	\$ 271	1
2	6	REPAIRS / MAINT	INCOME	344,402	16	18,957	8,970	494	2
3	7	ALARM SERVICE	INCOME	344,402	16	1,056	8,970	28	3
4	19	PROFESSIONAL FEES	INCOME	344,402	16	1,575	8,970	41	4
5	21	OFFICE EXPENSE	INCOME	344,402	16	1,942	8,970	51	5
6	26	INSURANCE	INCOME	344,402	16	4,387	8,970	114	6
7	30	DEPRECIATION	INCOME	344,402	16	30,446	8,970	793	7
8	32	INTEREST	INCOME	344,402	16	61,229	8,970	1,595	8
9	33	R/E TAX	INCOME	344,402	16	43,904	8,970	1,143	9
10	35	STORAGE FEES	INCOME	344,402	16	10,073	8,970	262	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	\$	\$ 4,792	25

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

0043943 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 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	164,535	1	164,535	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					\$ 218,307	\$	\$ 218,307	25

Facility Name & ID Number

TERRACE NURING HOME

0043943

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			
A. Directly Facility Related																		
Long-Term																		
1	LASALLE BANK		X	MORTGAGE	\$26,007.00	7/15/03	\$ 3,916,674	\$ 0		0.0543	\$ 164,535	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	LASALLE BANK		X	WORKING CAPITAL	INTEREST	REVOLV		124,000	REVOLV	PRIME+	18,986	6						
7												7						
8												8						
9	TOTAL Facility Related				\$26,007.00		\$ 3,916,674	\$ 124,000			\$ 183,521	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11	TERRACE INVESTMENT GROU[						1,143,964	0			35,207	11
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 1,143,964	\$ 0			\$ 35,207	14						
15	TOTALS (line 9+line14)						\$ 5,060,638	\$ 124,000			\$ 218,728	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.		\$	73,218	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.)		\$	136,338	2
3. Under or (over) accrual (line 2 minus line 1).		\$	63,120	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	12,420	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.		\$	75,540	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	8
	2002	9
	2003	10
	2004	11
	2005	74,497

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

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 16.7% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO \$74,497 FOR 2005 AND \$61,841 FOR 2006

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 TERRACE NURING 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 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>08-08-403-011</u>	<u>NURSING HOME</u>	\$ <u>74,496.57</u>	\$ <u>74,496.57</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>74,496.57</u>	\$ <u>74,496.57</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 TERRACE NURING HOME

0043943

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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).

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number TERRACE NURING HOME

0043943

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	112	1989		\$ 2,088,222	\$ 53,772	31.5	\$ 53,772	\$	\$ 1,055,879	4
5										5
6										6
7	RELATED PARTY			26,461	762	39	762			7
8	OFFICE									8
	Improvement Type**									
9	DOOR BYPASS ALARM		1998	3,453	2,826	39	89	(2,737)	716	9
10	BOILER		2000	32,900	25,873	27.5	1,196	(24,677)	8,226	10
11	DOORS AND FRAMES		2000	3,366	2,676	27.5	123	(2,553)	812	11
12	FIRE DOOR		2000	5,039	4,007	27.5	183	(3,824)	1,213	12
13	FIRE DAMPERS		2000	12,123	9,716	27.5	441	(9,275)	2,848	13
14	NURSING STATION		2001	15,200	12,689	27.5	553	(12,136)	3,064	14
15	EJECTOR PUMPS		2001	5,898	4,924	27.5	215	(4,709)	1,191	15
16	OVER THE BED LIGHTS		2001	6,142	5,127	27.5	223	(4,904)	1,236	16
17	FURNISHINGS - FLOORING		2001	81,365	4,686	10	8,137	3,451	44,751	17
18	FURNISHINGS - CUBICLE CURTAINS & BLINDS		2001	43,874	2,527	10	4,387	1,860	24,129	18
19	TILING		2002	8,448	7,361	27.5	307	(7,054)	1,394	19
20	HOT WATER TANK		2002	8,916	7,768	27.5	324	(7,444)	1,472	20
21	REPLACE PARKING LOT		2003	16,980	14,150	15	1,132	(13,018)	3,962	21
22	REPLACE PATIO & REPAIR STAIRS		2003	15,450	12,875	15	1,030	(11,845)	3,605	22
23	FENCE		2003	3,600	3,000	15	240	(2,760)	840	23
24	EJECTOR PUMPS		2003	8,780	7,969	27.5	319	(7,650)	1,130	24
25	5 TON AIR COOLING SYSTEM		2003	25,353	23,010	27.5	922	(22,088)	3,265	25
26	PANIC ALARM		2003	1,222	1,109	27.5	44	(1,065)	156	26
27	200 AMP ELECTRICAL PANEL		2003	6,975	6,330	27.5	254	(6,076)	900	27
28	FLOORING		2004	5,544	5,233	27.5	202	(5,031)	513	28
29	SLIDING DOOR		2004	9,024	8,518	27.5	328	(8,190)	834	29
30	BOILER REPAIR		2004	1,308	1,235	27.5	47	(1,188)	120	30
31	EXPANSION TANKS FOR HOT WATER HEATING SYSTEM		2004	2,134	2,014	27.5	78	(1,936)	198	31
32	CARPETTING		2005	9,123	7,298	10	912	(6,386)	1,095	32
33	DOORS		2005	3,030	2,980	27.5	110	(2,870)	161	33
34	WATER HEATER		2005	1,885	1,854	27.5	69	(1,785)	100	34
35	FIREALARM SYSTEM		2005	67,823	66,692	27.5	2,466	(64,226)	3,596	35
36	BOILER		2005	4,602	4,525	27.5	384	(4,141)	461	36

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

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

See Page 12A, Line 70 for total

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	\$ 1,761	27.5	\$ 65	\$ (1,696)	\$ 95	37
38 WINDOWS	2006	21,152	21,152	27.5	385	(20,767)	385	38
39 FIRE SPRINKLING SYSTEM	2006	4,745	4,745	27.5	86	(4,659)	86	39
40 CARPETING & FLOOR TILE	2006	2,569	2,569	10	128	(2,441)	128	40
41 VERTICAL BLINDS	2006	7,828	7,828	10	391	(7,437)	391	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)		\$ 2,562,325	\$ 351,561		\$ 80,304	\$ (271,257)	\$ 1,168,952	70

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

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

0043943

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	\$ 384,332	\$ 38,685	\$ 38,434	\$ (251)	10 YRS	\$ 213,010	71
72	Current Year Purchases	1,114	37	56	19	10 YRS	56	72
73	Fully Depreciated Assets	2,851			0	10 YRS	2,851	73
74	RELATED PARTIES		351	351	0			74
75	TOTALS	\$ 388,297	\$ 39,073	\$ 38,841	\$ (232)		\$ 215,917	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,032,674	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 390,634	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 119,145	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (271,489)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,384,869	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **GRANITE WAUKEGAN 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:	115	11/01/06	\$ 121,809	5.5	5	3
4	Additions						4
5							5
6							6
7	TOTAL	115		\$ 121,809			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: \$ **60,568** 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	FACILITY	2003 FORD E350 WAGON	\$ 686.00	\$ 7,859	17
18	FACILITY	2006 FORD E350 WAGON	705.00	9,145	18
19	PAINTERS	2003 CHEVY ASTRO VAN	645.00	645	19
20	ADMINISTRATOR	2006 JEEP GRD CHEROKEE	469.00	5,895	20
21	TOTAL		\$ #####	\$ 23,544	21

10. Effective dates of current rental agreement:

Beginning 11/01/06

Ending 04/30/12

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

Fiscal Year Ending Annual Rent

12. 12/31/2007 \$ 730,851

13. 12/31/2008 \$ 732,678

14. 12/31/2009 \$ 741,814

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
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	39-3	hrs	\$		\$ 198,105	\$		\$ 198,105	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			14,447			14,447	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			209,745			209,745	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 prescripts				152,337		152,337	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	39-2					16,807		16,807	13
14	TOTAL			\$		\$ 422,297	\$ 169,144		\$ 591,441	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 NURING HOME

0043943

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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 36,622	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	591,908		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	90,390		6
7	Other Prepaid Expenses	13,599		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 732,519	\$ 0	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			15
16	Equipment, at Historical Cost	1,114		16
17	Accumulated Depreciation (book methods)	(37)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	189,421		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): ADVANCED RENT	6,885		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 197,383	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 929,902	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 187,727	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	124,000		29
30	Accrued Salaries Payable	95,362		30
31	Accrued Taxes Payable (excluding real estate taxes)	39,993		31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,420		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)	\$ 459,502	\$ 0	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)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 459,502	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ 470,400	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 929,902	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 0	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	32,255	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) CAPITAL CONTRIBUTED	500,000	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 532,255	17
	B. Transfers (Itemize):		
18			18
19	DEDUCT INCOME FROM PRIOR RELATED OPERATOR	(61,855)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (61,855)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 470,400	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	\$ 5,742,448	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,742,448	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	229,495	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 229,495	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)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	343	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 343	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	PRIOR YEAR EXP	5,000	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,977,286	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	938,842	31
32	Health Care	2,390,126	32
33	General Administration	1,136,205	33
	B. Capital Expense		
34	Ownership	825,454	34
	C. Ancillary Expense		
35	Special Cost Centers	591,441	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)*	\$ 5,945,031	40
41	Income before Income Taxes (line 30 minus line 40)**	32,255	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 32,255	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 TERRACE NURING HOME

0043943

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	4,315	4,631	\$ 119,303	\$ 25.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	28,503	30,497	841,573	27.60	3
4	Licensed Practical Nurses	4,215	4,906	96,421	19.65	4
5	CNAs & Orderlies	81,180	88,079	919,091	10.43	5
6	CNA Trainees					6
7	Licensed Therapist	2,860	3,174	24,440	7.70	7
8	Rehab/Therapy Aides	4,620	5,169	60,641	11.73	8
9	Activity Director					9
10	Activity Assistants	7,238	8,049	81,785	10.16	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,285	22,452	188,661	8.40	15
16	Dishwashers					16
17	Maintenance Workers	4,815	4,850	67,705	13.96	17
18	Housekeepers	17,499	19,546	163,046	8.34	18
19	Laundry	9,717	7,297	59,765	8.19	19
20	Administrator	2,080	2,399	73,500	30.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,114	11,895	107,764	9.06	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	1,642	1,759	24,803	14.10	31
32	Other Health C: Q.A. & MDS	4,160	4,278	67,842	15.86	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	204,243	218,981	\$ 2,896,340 *	\$ 13.23	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	\$ 6,435	1-3	35
36	Medical Director	O	18,000	9-3	36
37	Medical Records Consultant	N	5,424	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	3,912	10-3	39
40	Physical Therapy Consultant	L	1,952	10a-3	40
41	Occupational Therapy Consultant	Y	1,981	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	717	11-3	44
45	Social Service Consultant	E	5,648	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 44,069		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	4	\$ 124	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	4	\$ 124		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 SCHULTZ	ADMINISTRATOR		\$ 73,500	Workers' Compensation Insurance	\$ 79,672	IDPH License Fee	\$ 1,990	
	ASST ADMIN		0	Unemployment Compensation Insurance	34,052	Advertising: Employee Recruitment	1,209	
				FICA Taxes	217,802	Health Care Worker Background Check	180	
				Employee Health Insurance	194,882	(Indicate # of checks performed)		
				Employee Meals	3,913	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	3,256	
				EMPLOYEE BENEFITS - OTHER	4,202	MARKETING/ADV/PROMO	14,617	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	7,649	
				PENSION/PROFIT SHARING PLANS	18,294	MGMT CO ALLOC	2,656	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(3,256)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense (	0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(3,566)	
						Yellow page advertising	(11,051)	
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)	\$ 552,817	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 13,684	
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 MANAGEMENT FEE			\$ 69,000				Out-of-State Travel	\$
PHILIP ESFORMES INC - MANAGEMENT FEE			13,500					
6865 FINANCIAL INC MANAGEMENT FEE			13,515				In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 96,015				Seminar Expense	1,984
							MANAGEMENT FEES	5
C. Professional Services							Entertainment Expense (
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
			\$				TOTAL	\$ 1,989
SEE SCHEDULE ATTACHED			48,316					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 48,316	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 Amount of Expense Amortized Per Year															
					6									7	8	9	10	11	12	13
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011							
1	PAINT/DECORATING	07/05	\$ 2,227	3 YRS	\$	\$	\$ 372	\$ 742	\$ 742	\$ 371	\$	\$	\$							
2																				
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18																				
19																				
20	TOTALS		\$ 2,227		\$	\$	\$ 372	\$ 742	\$ 742	\$ 371	\$	\$	\$							

Facility Name & ID Number TERRACE NURING HOME

0043943

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. IL COUNCIL LONG TERM CARE \$3,437
- (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. \$ 49 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? YES
If YES, give effective date of lease. 11/1/6
- (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 _____ 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. \$ 3,913 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