

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0048397</u></p> <p>Facility Name: <u>THE TERRACE NH</u></p> <p>Address: <u>1615 SUNSET AVENUE</u> <u>WAUKEGAN</u> <u>60087</u> Number City Zip Code</p> <p>County: <u>LAKE</u></p> <p>Telephone Number: <u>(847) 674-5795</u> Fax # <u>(847) 674-5794</u></p> <p>HFS ID Number: <u>61 1510016-001</u></p> <p>Date of Initial License for Current Owners: <u>11/1/06</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2007</u> to <u>12/31/2007</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="3">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>AVRUM WEINFELD</u></td> <td></td> </tr> <tr> <td>(Title) <u>CEO</u></td> <td></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> <td></td> </tr> <tr> <td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>AVRUM WEINFELD</u>		(Title) <u>CEO</u>		Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>		(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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Facility Name & ID Number THE TERRACE NH

0048397 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	1,529	980	4,479	6,988	8
9	SNF/PED					9
10	ICF	28,736	4,938	30	33,704	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,265	5,918	4,509	40,692	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.94%

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 22 and days of care provided 4,479

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **THE TERRACE NH** # **0048397** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	196,906	11,347	7,359	215,612		215,612		215,612		1
2	Food Purchase		178,358		178,358	(4,146)	174,212	(1,118)	173,094		2
3	Housekeeping	160,384	21,238		181,622		181,622		181,622		3
4	Laundry	62,444	16,359	6,753	85,556		85,556	925	86,481		4
5	Heat and Other Utilities			124,580	124,580		124,580	248	124,828		5
6	Maintenance	66,020	47,238	33,676	146,934		146,934	2,181	149,115		6
7	Other (specify):*			21,264	21,264		21,264	52	21,316		7
8	TOTAL General Services	485,754	274,540	193,632	953,926	(4,146)	949,780	2,288	952,068		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,158,011	91,452	8,986	2,258,449		2,258,449		2,258,449		10
10a	Therapy	102,207		3,069	105,276		105,276		105,276		10a
11	Activities	80,592	14,260	479	95,331		95,331		95,331		11
12	Social Services			6,109	6,109		6,109		6,109		12
13	CNA Training										13
14	Program Transportation			3,903	3,903		3,903		3,903		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,340,810	105,712	40,546	2,487,068		2,487,068		2,487,068		16
	C. General Administration										
17	Administrative	73,500		81,089	154,589		154,589	(36,526)	118,063		17
18	Directors Fees										18
19	Professional Services			51,845	51,845		51,845	5,773	57,618		19
20	Dues, Fees, Subscriptions & Promotions			27,258	27,258		27,258	(16,424)	10,834		20
21	Clerical & General Office Expenses	117,368	19,294	63,125	199,787		199,787	(20,981)	178,806		21
22	Employee Benefits & Payroll Taxes			554,418	554,418	4,146	558,564		558,564		22
23	Inservice Training & Education							31	31		23
24	Travel and Seminar			2,539	2,539		2,539		2,539		24
25	Other Admin. Staff Transportation			14,515	14,515		14,515	373	14,888		25
26	Insurance-Prop.Liab.Malpractice			67,991	67,991		67,991	377	68,368		26
27	Other (specify):*			43,993	43,993		43,993	(40,664)	3,329		27
28	TOTAL General Administration	190,868	19,294	906,773	1,116,935	4,146	1,121,081	(108,041)	1,013,040		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,017,432	399,546	1,140,951	4,557,929		4,557,929	(105,753)	4,452,176		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	5,940
	REPAIRS & MAINTENANCE	1,419
		0
		7,359
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	6,753
		0
		6,753
5	HEAT & OTHER UTILITIES	
	GAS HEAT	53,840
	ELECTRICITY	51,805
	WATER	18,935
	CABLE TV - LOBBY	0
		0
		124,580
6	MAINTENANCE	
	GROUNDS MAINTENANCE	8,550
	PAINTING & DECORATING	2,627
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	9,942
	ELEVATOR MAINTENANCE & REPAIR	5,428
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,246
	FIRE SERVICE	4,883
		0
		0
		0
		0
		33,676
7	OTHER	
	SCAVENGER	14,976
	SECURITY SERVICE	6,288
		0
		0
		21,264
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	18,000
		18,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	5,527
	PHARMACY CONSULTANT XVIII B 39-2	3,459
	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
		8,986
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	1,957
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	1,112
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		3,069
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	479
		0
		479
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	6,109
	SOCIAL WORKER XVIII B 45-2	0
		0
		6,109
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	3,903
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	81,089
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	22,805
	ADMINISTRATIVE CONSULTANTS XIX C	6,313
	PROFESSIONAL FEES XIX C	22,727
		0
		51,845
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	6,856
	EMPLOYEE WANT ADS XIX F	528
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	6,105
	LICENSES & PERMITS XIX F	2,327
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	9,727
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,580
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	135
	PATIENT BACKGROUND CHECKS XIX F	0
		27,258
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,712
	EQUIPMENT REPAIR & MAINTENANCE	8,209
	OUTSIDE CLERICAL SERVICES	35,000
	PENALTIES / OVERDRAFT CHARGES VI 18	8
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	17,196
	MESSENGER SERVICE	0
		0
		63,125

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	224,480
	UNEMPLOYMENT COMPENSATION XIX D	27,331
	WORKERS COMPENSATION INSURANC XIX D	72,940
	HOSPITALIZATION INSURANCE XIX D	207,660
	EMPLOYEE BENEFITS - OTHER XIX D	0
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	22,007
	CHICAGO HEAD TAX XIX D	0
		0
		554,418
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	2,539
	TRAVEL XIX G	0
		2,539
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	14,515
		14,515
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	67,991
		67,991
27	OTHER	
	BAD DEBTS VI 24	43,993
		43,993

GRAND TOTAL COLUMN 3 OTHER

1,140,951

**THE TERRACE NH
SCHEDULES
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	178,358
LESS SALES TAX	<u>(1,118)</u>
NET FOOD	177,240

TOTAL PATIENT CENSUS	40,692
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	122,076

ADD # EMPLOYEE MEALS/DAY	8
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	2,920

PATIENT MEALS	122,076
ADD EMPLOYEE MEALS	<u>2,920</u>
TOTAL MEALS/YEAR	124,996

NET FOOD	177,240
DIVIDE TOTAL MEALS/YEAR	<u>124,996</u>

COST PER MEAL	1.42
TIME EMPLOYEE MEALS	<u>2,920</u>
EMPLOYEE MEAL RECLASSIFICATION	4,146

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			2,122	2,122		2,122	(375)	1,747		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			29,992	29,992		29,992	(5,856)	24,136		32
33	Real Estate Taxes			76,808	76,808		76,808	1,113	77,921		33
34	Rent-Facility & Grounds			730,851	730,851		730,851		730,851		34
35	Rent-Equipment & Vehicles			66,879	66,879		66,879	863	67,742		35
36	Other (specify):* IME			8,970	8,970		8,970	(8,970)			36
37	TOTAL Ownership			915,622	915,622		915,622	(13,225)	902,397		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		137,160	355,128	492,288		492,288		492,288		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			62,963	62,963		62,963		62,963		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		137,160	418,091	555,251		555,251		555,251		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,017,432	536,706	2,474,664	6,028,802		6,028,802	(118,978)	5,909,824		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 **THE TERRACE NH**

0048397

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	BHF 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	(1,364)	30		9
10	Interest and Other Investment Income	(7,351)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,118)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(8)	21		18
19	Entertainment		20		19
20	Contributions	(1,580)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(43,993)	27		24
25	Fund Raising, Advertising and Promotional	(6,856)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(9,727)	20		28
29	Other-Attach Schedule	(3,889)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (75,886)		\$	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)	(43,092)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (43,092)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (118,978)		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

THE TERRACE NHID# 0048397Report Period Beginning: 01/01/2007Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	BANK CHARGES	(2,712)	21	2
3	AUTO LEASE	(1,177)	35	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	(3,889)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE TERRACE NH

0048397

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,118)	0	0	0	0	0	0	0	0	0	0	(1,118)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	925	0	0	0	0	0	0	0	0	925	4
5	Heat and Other Utilities	0	0	0	248	0	0	0	0	0	0	0	248	5
6	Maintenance	0	0	1,231	950	0	0	0	0	0	0	0	2,181	6
7	Other (specify):*	0	0	24	28	0	0	0	0	0	0	0	52	7
8	TOTAL General Services	(1,118)	0	2,180	1,226	0	2,288	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(42,433)	5,907	0	0	0	0	0	0	0	0	(36,526)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	5,727	46	0	0	0	0	0	0	0	5,773	19
20	Fees, Subscriptions & Promotions	(18,163)	0	1,739	0	0	0	0	0	0	0	0	(16,424)	20
21	Clerical & General Office Expenses	(2,720)	0	(18,301)	40	0	0	0	0	0	0	0	(20,981)	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	31	0	0	0	0	0	0	0	0	31	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	373	0	0	0	0	0	0	0	0	373	25
26	Insurance-Prop.Liab.Malpractice	0	0	322	55	0	0	0	0	0	0	0	377	26
27	Other (specify):*	(43,993)	0	3,329	0	0	0	0	0	0	0	0	(40,664)	27
28	TOTAL General Administration	(64,876)	(42,433)	(873)	141	0	(108,041)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(65,994)	(42,433)	1,307	1,367	0	(105,753)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE TERRACE NH# 0048397

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(1,364)	0	194	795	0	0	0	0	0	0	0	(375)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,351)	0	0	1,495	0	0	0	0	0	0	0	(5,856)	32
33	Real Estate Taxes	0	0	0	1,113	0	0	0	0	0	0	0	1,113	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(1,177)	0	1,775	265	0	0	0	0	0	0	0	863	35
36	Other (specify):*	0	0	0	(8,970)	0	0	0	0	0	0	0	(8,970)	36
37	TOTAL Ownership	(9,892)	0	1,969	(5,302)	0	(13,225)	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)	(75,886)	(42,433)	3,276	(3,935)	0	(118,978)	45						

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>LIST ATTACHED</u>		<u>LIST ATTACHED</u>		<u>6865 Financial Inc</u>	<u>LINCOLNWOOD</u>	<u>MANAGEMENT</u>
				<u>EKS MANAGEMENT</u>	<u>LINCOLNWOOD</u>	<u>BOOKKEEPING</u>
				<u>IME REALTY</u>	<u>LINCOLNWOOD</u>	<u>HOME OFFICE</u>

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 <u>MANAGEMENT FEES</u>	\$ <u>81,089</u>	<u>6865 FINANCIAL INC</u>		\$		\$ <u>(81,089)</u> 1
2	V	17 <u>SALARY - M. ESFORMES</u>					<u>13,029</u>	<u>13,029</u> 2
3	V	17 <u>SALARY - P. ESFORMES</u>					<u>13,029</u>	<u>13,029</u> 3
4	V	17 <u>SALARY - D. WEISS</u>					<u>1,974</u>	<u>1,974</u> 4
5	V	17 <u>SALARY - A. WEINFELD</u>					<u>10,624</u>	<u>10,624</u> 5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>81,089</u>			\$	<u>38,656</u>	\$ * <u>(42,433)</u> 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 OUTSIDE CLERICAL	\$ 35,000	EKS MANAGEMENT		\$	\$(35,000)
16	V	4 HOUSEKEEPING SALARIES				925	925
17	V	6 PAINTER SALARIES				1,231	1,231
18	V	7 SCAVENGER				24	24
19	V	17 CFO SALARY - A. WEINFELD				5,907	5,907
20	V	19 PROFESSIONAL FEES				5,727	5,727
21	V	20 WANT ADS/BACKGR CKS				1,739	1,739
22	V	21 OFFICE				16,699	16,699
23	V	23 SEMINARS				31	31
24	V	25 TRANSPORTATION				373	373
25	V	26 INSURANCE				322	322
26	V	27 EMPLOYEE BENEFITS				3,329	3,329
27	V	30 DEPRECIATION (SL)				194	194
28	V	35 EQUIPMENT RENT				1,775	1,775
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 35,000			\$ 38,276	\$ * 3,276

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	36 OFFICE RENT	\$ 8,970	IME REALTY		\$	(8,970)
16	V	5 UTILITIES				248	248
17	V	6 PAINTERS FEES				295	295
18	V	6 REPAIRS / MAINT				655	655
19	V	7 ALARM SERVICE				28	28
20	V	19 PROFESSIONAL FEES				46	46
21	V	21 OFFICE EXPENSE				40	40
22	V	26 INSURANCE				55	55
23	V	30 DEPRECIATION (SL)				795	795
24	V	32 INTEREST				1,495	1,495
25	V	33 R/E TAX				1,113	1,113
26	V	35 STORAGE FEES				265	265
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			\$ 5,035	\$ * (3,935)

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

Facility Name & ID Number

THE TERRACE NH

0048397

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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		Aministrative			List		Comp fr	\$ 13,029	17-7	1
2						Attached		6865 Fin			2
3								ADM CONS	6,313	19-3	3
4	PHILIP ESFORMES		Aministrative			List		Comp fr	13,029	17-7	4
5						Attached		6865 Fin			5
6	DANIEL WEISS		Aministrative			List		Comp fr	1,974	17-7	6
7						Attached		6865 Fin			7
8	AVRUM WEINFELD		Aministrative			List		Comp fr	10,624	17-7	8
9						Attached		6865 Fin			9
10								Salary fr EKS	5,907	17-7	10
11	FLORA WEISS		CLERICAL					Comp fr EKS	793	21-7	11
12											12
13								TOTAL	\$ 51,669		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 **THE TERRACE NH**

0048397 Report Period Beginning: **01/01/2007**

Ending: **2/31/2007**

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 6865 FINANCIAL INC
 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	17	SALARY - M. ESFORMES	PATIENT DAYS	515,342	10	\$ 165,000	\$ 40,692	\$ 13,029	1
2	17	SALARY - P. ESFORMES	PATIENT DAYS	515,342	10	165,000	40,692	13,029	2
3	17	SALARY - D. WEISS	PATIENT DAYS	515,342	10	25,000	40,692	1,974	3
4	17	SALARY - A. WEINFELD	PATIENT DAYS	515,342	10	134,551	40,692	10,624	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					\$ 489,551	\$ 489,551	\$ 38,656	25

Facility Name & ID Number **THE TERRACE NH**

0048397 Report Period Beginning: **01/01/2007**

Ending: **2/31/2007**

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)674-5795
 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	4	HOUSKEEPING SALARIES	PATIENT DAYS	857,979	14	\$ 19,500	\$ 40,692	\$ 925	1
2	6	PAINTER SALARIES	PATIENT DAYS	857,979	14	25,953	40,692	1,231	2
3	7	SCAVENGER	PATIENT DAYS	857,979	14	512	40,692	24	3
4	17	CFO SALARY - A. WEINFELD	PATIENT DAYS	857,979	14	124,552	40,692	5,907	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	857,979	14	120,756	40,692	5,727	5
6	20	WANT ADS/ BACKGR CKS	PATIENT DAYS	857,979	14	36,665	40,692	1,739	6
7	21	OFFICE	PATIENT DAYS	857,979	14	352,089	40,692	16,699	7
8	23	SEMINARS	PATIENT DAYS	857,979	14	659	40,692	31	8
9	25	TRANSPORTATION	PATIENT DAYS	857,979	14	7,865	40,692	373	9
10	26	INSURANCE	PATIENT DAYS	857,979	14	6,798	40,692	322	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	857,979	14	70,186	40,692	3,329	11
12	30	DEPRECIATION (SL)	PATIENT DAYS	857,979	14	4,096	40,692	194	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	857,979	14	37,419	40,692	1,775	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					\$ 807,050	\$ 403,408	\$ 38,276	25

Facility Name & ID Number **THE TERRACE NH**

0048397 Report Period Beginning: **01/01/2007** Ending: **2/31/2007**

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	187,059	15	\$ 5,162	\$ 8,970	\$ 248	1
2	6	PAINTERS FEES	INCOME	187,059	15	6,152	8,970	295	2
3	6	REPAIRS / MAINT	INCOME	187,059	15	13,651	8,970	655	3
4	7	ALARM SERVICE	INCOME	187,059	15	575	8,970	28	4
5	19	PROFESSIONAL FEES	INCOME	187,059	15	952	8,970	46	5
6	21	OFFICE EXPENSE	INCOME	187,059	15	831	8,970	40	6
7	26	INSURANCE	INCOME	187,059	15	1,150	8,970	55	7
8	30	DEPRECIATION (SL)	INCOME	187,059	15	16,570	8,970	795	8
9	32	INTEREST	INCOME	187,059	15	31,178	8,970	1,495	9
10	33	RE TAX	INCOME	187,059	15	23,213	8,970	1,113	10
11	35	STORAGE UNITS	INCOME	187,059	15	5,519	8,970	265	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					\$ 104,953	\$	\$ 5,035	25

Facility Name & ID Number

THE TERRACE NH

0048397

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4	RELATED PARTY - IME								1,495											
5																				
Working Capital																				
6	LASALLE BANK		X	WORKING CAPITAL	INTEREST	REVOLV			27,792	6										
7	THE PRIVATE BANK		X	WORKING CAPITAL	INTEREST	REVOLV		447,000	2,200	7										
8										8										
9	TOTAL Facility Related						\$	\$ 447,000	\$	31,487 9										
B. Non-Facility Related*																				
10	IRS, IDR, ETC		X	LATE FEES						10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related						\$	\$	\$	14										
15	TOTALS (line 9+line14)						\$	\$ 447,000	\$	31,487 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 2006 report.		\$	12,420	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.)		\$	12,777	2
3. Under or (over) accrual (line 2 minus line 1).		\$	357	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	76,451	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.		\$	76,808	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	70,177	8
	2003	72,205	9
	2004	73,219	10
	2005	74,497	11
	2006	76,451	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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 2006 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THE TERRACE NH COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0048397

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 2006 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 2006.

(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>76,451.38</u>	\$ <u>76,451.38</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>76,451.38</u>	\$ <u>76,451.38</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 THE TERRACE NH

0048397

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

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					\$	\$		\$	\$	\$	4
5	Related										5
6	Party										6
7	Home										7
8	Office IME				26,461	763	39	763			8
	Improvement Type**										
9	DOORS		2007		16,876	281	27.5	281		281	9
10	RAIL GAURDS & KICK PLATES		2007		11,890	18	27.5	18		18	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

*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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 55,227	\$ 1,062		\$ 1,062	\$	\$ 299	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,114	\$ 431	\$ 111	\$ (320)	10 YRS	\$ 167	71
72	Current Year Purchases	\$ 6,958	\$ 1,392	\$ 348	\$ (1,044)	10 YRS	\$ 348	72
73	Fully Depreciated Assets							73
74	Related Party		226	226				74
75	TOTALS	\$ 8,072	\$ 2,049	\$ 685	\$ (1,364)		\$ 515	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 63,299	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 3,111	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,747	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,364)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 814	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? YES NO

If NO, see instructions.

	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:	<u>115</u>	<u>11/01/06</u>	\$ <u>730,851</u>	<u>5.5</u>	<u>5</u>	3
4	Additions						4
5							5
6							6
7	TOTAL	115		\$ 730,851			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: \$ 45195 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ <u>21,684</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ 21,684	21

10. Effective dates of current rental agreement:

Beginning 10/01/06

Ending 04/30/12

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

Fiscal Year Ending Annual Rent

12. /2008 \$ 732,678

13. /2009 \$ 741,814

14. /2010 \$ 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><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER 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>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 157,042	\$		\$ 157,042	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			13,119			13,119	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			184,967			184,967	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				125,202		125,202	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): supplies,radiology,lab	39-2					11,958		11,958	13
14	TOTAL			\$		\$ 355,128	\$ 137,160		\$ 492,288	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 THE TERRACE NH

0048397

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 78,820	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (20,000))	909,017		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	106,240		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): real estate tax escrow	72,320		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,166,397	\$	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	28,766		15
16	Equipment, at Historical Cost	8,072		16
17	Accumulated Depreciation (book methods)	(2,159)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	229,671		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): ADVANCE RENT	6,885		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 271,235	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,437,632	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 334,041	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	447,000		29
30	Accrued Salaries Payable	101,714		30
31	Accrued Taxes Payable (excluding real estate taxes)	41,384		31
32	Accrued Real Estate Taxes(Sch.IX-B)	76,451		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,000,590	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,000,590	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 437,042	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,437,632	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 470,400	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 470,400	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(33,358)	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)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (33,358)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 437,042	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	\$ 5,638,543	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,638,543	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	308,876	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 308,876	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,351	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,351	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,954,770	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	953,926	31
32	Health Care	2,487,068	32
33	General Administration	1,116,935	33
	B. Capital Expense		
34	Ownership	915,622	34
	C. Ancillary Expense		
35	Special Cost Centers	492,288	35
36	Provider Participation Fee	62,963	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES - WORKERS COMP AUDIT	(40,674)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,988,128	40
41	Income before Income Taxes (line 30 minus line 40)**	(33,358)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (33,358)	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 THE TERRACE NH

0048397

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	4,160	5,518	\$ 115,224	\$ 20.88	1
2	Assistant Director of Nursing					2
3	Registered Nurses	31,148	33,108	925,216	27.95	3
4	Licensed Practical Nurses	3,626	4,123	82,436	19.99	4
5	CNAs & Orderlies	82,340	88,851	954,315	10.74	5
6	CNA Trainees					6
7	Licensed Therapist	2,689	2,894	28,766	9.94	7
8	Rehab/Therapy Aides	5,941	6,581	73,441	11.16	8
9	Activity Director					9
10	Activity Assistants	7,693	8,385	80,592	9.61	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,253	22,505	196,906	8.75	15
16	Dishwashers					16
17	Maintenance Workers	4,930	5,075	66,020	13.01	17
18	Housekeepers	17,107	19,221	160,384	8.34	18
19	Laundry	6,635	7,335	62,444	8.51	19
20	Administrator	2,080	2,352	73,500	31.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,062	10,918	117,368	10.75	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	2,206	2,294	23,462	10.23	31
32	Other Health C: <u>MDS, Q.A.</u>	2,520	2,620	57,358	21.89	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	203,390	221,780	\$ 3,017,432 *	\$ 13.61	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	18,000	9-3	36
37	Medical Records Consultant	N	5,527	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	3,459	10-3	39
40	Physical Therapy Consultant	L	1,957	10a-3	40
41	Occupational Therapy Consultant	Y	1,112	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	479	11-3	44
45	Social Service Consultant	E	6,109	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 42,583		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. 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 SHULTZ	ADMINISTRATOR	0	\$ 73,500	Workers' Compensation Insurance	\$ 72,940	IDPH License Fee	\$ 1,518	
	ASST ADMIN		0	Unemployment Compensation Insurance	27,331	Advertising: Employee Recruitment	528	
	OTHER ADMIN		0	FICA Taxes	224,480	Health Care Worker Background Check	135	
				Employee Health Insurance	207,660	(Indicate # of checks performed)		
				Employee Meals	4,146	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,580	
				EMPLOYEE BENEFITS - OTHER	0	MARKETING/ADV/PROMO	16,583	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	6,914	
				PENSION/PROFIT SHARING PLANS	22,007	MGMT CO ALLOC	1,739	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(1,580)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense (0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(6,856)	
						Yellow page advertising	(9,727)	
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)	\$ 558,564	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,834	
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
6865 FINANCIAL INC - MANAGEMENT FEE			\$ 81,089				Out-of-State Travel	\$
							In-State Travel	0
							Seminar Expense	2,539
							Entertainment Expense (
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 81,089	TOTAL			(agree to Sch. V, line 24, col. 8)	\$ 2,539
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			51,845					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 51,845					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number THE TERRACE NH

0048397

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$5,113
- (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. \$ 227 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO _____ 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. \$ 4,146 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 \$5,000, 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