

Facility Name & ID Number THE TERRACE NH

0048397 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	23,790	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,300	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	115	42,090	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	2,819	631	5,303	8,753	8
9	SNF/PED					9
10	ICF	25,894	5,557	23	31,474	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,713	6,188	5,326	40,227	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.57%

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 5,303

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number **THE TERRACE NH** # **0048397** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

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	212,533	10,988	7,560	231,081		231,081		231,081		1
2	Food Purchase		212,061		212,061		212,061	(1,382)	210,679		2
3	Housekeeping	164,851	19,953		184,804		184,804		184,804		3
4	Laundry	64,549	16,554	5,394	86,497		86,497	913	87,410		4
5	Heat and Other Utilities			126,235	126,235		126,235	268	126,503		5
6	Maintenance	32,027	38,652	35,784	106,463		106,463	4,166	110,629		6
7	Other (specify):*			21,490	21,490		21,490	55	21,545		7
8	TOTAL General Services	473,960	298,208	196,463	968,631		968,631	4,020	972,651		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,199,303	88,889	8,281	2,296,473		2,296,473		2,296,473		10
10a	Therapy	138,707		1,040	139,747		139,747		139,747		10a
11	Activities	69,464	12,829		82,293		82,293		82,293		11
12	Social Services			2,685	2,685		2,685		2,685		12
13	CNA Training										13
14	Program Transportation			4,223	4,223		4,223		4,223		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,407,474	101,718	34,229	2,543,421		2,543,421		2,543,421		16
	C. General Administration										
17	Administrative	74,500		81,089	155,589		155,589	(18,678)	136,911		17
18	Directors Fees										18
19	Professional Services			52,236	52,236		52,236	5,884	58,120		19
20	Dues, Fees, Subscriptions & Promotions			33,489	33,489		33,489	(22,976)	10,513		20
21	Clerical & General Office Expenses	135,911	21,576	50,773	208,260		208,260	(8,943)	199,317		21
22	Employee Benefits & Payroll Taxes			591,205	591,205		591,205		591,205		22
23	Inservice Training & Education							4	4		23
24	Travel and Seminar			1,430	1,430		1,430		1,430		24
25	Other Admin. Staff Transportation			18,266	18,266		18,266	653	18,919		25
26	Insurance-Prop.Liab.Malpractice			66,436	66,436		66,436	707	67,143		26
27	Other (specify):*			149,017	149,017		149,017	(140,377)	8,640		27
28	TOTAL General Administration	210,411	21,576	1,043,941	1,275,928		1,275,928	(183,726)	1,092,202		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,091,845	421,502	1,274,633	4,787,980		4,787,980	(179,706)	4,608,274		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	1,620
		0
		7,560
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	5,394
		0
		5,394
5	HEAT & OTHER UTILITIES	
	GAS HEAT	56,819
	ELECTRICITY	49,610
	WATER	19,806
	CABLE TV - LOBBY	0
		0
		126,235
6	MAINTENANCE	
	GROUNDS MAINTENANCE	7,790
	PAINTING & DECORATING	2,014
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	18,408
	ELEVATOR MAINTENANCE & REPAIR	3,348
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,619
	FIRE SERVICE	2,605
		0
		0
		0
		0
		35,784
7	OTHER	
	SCAVENGER	21,202
	SECURITY SERVICE	288
		0
		0
		21,490
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	241
	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	4,320
	PHARMACY CONSULTANT XVIII B 39-2	3,720
	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
		8,281
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	128
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	285
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	627
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	
		1,040
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	2,685
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,685
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	4,223
		4,223
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	81,089
		81,089
	DIRECTORS FEES	
18	DIRECTORS FEES	0
		0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	19,183
	ADMINISTRATIVE CONSULTANTS XIX C	10,174
	PROFESSIONAL FEES XIX C	22,879
		0
		52,236
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	5,632
	EMPLOYEE WANT ADS XIX F	700
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	5,309
	LICENSES & PERMITS XIX F	3,037
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	13,887
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	4,924
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		33,489
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	926
	EQUIPMENT REPAIR & MAINTENANCE	3,569
	OUTSIDE CLERICAL SERVICES	30,000
	PENALTIES / OVERDRAFT CHARGES VI 18	916
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	15,362
	MESSENGER SERVICE	0
		0
		50,773

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	229,465
	UNEMPLOYMENT COMPENSATION XIX D	23,093
	WORKERS COMPENSATION INSURANC XIX D	83,388
	HOSPITALIZATION INSURANCE XIX D	224,451
	EMPLOYEE BENEFITS - OTHER XIX D	977
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	29,831
	CHICAGO HEAD TAX XIX D	
		0
		591,205
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,430
	TRAVEL XIX G	0
		1,430
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	18,266
		18,266
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	66,436
		66,436
27	OTHER	
	BAD DEBTS VI 24	149,017
		149,017

GRAND TOTAL COLUMN 3 OTHER

1,274,633

**THE TERRACE NH
SCHEDULES
12/31/2008**

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

TOTAL FOOD PURCHASE	212,061
LESS SALES TAX	<u>(1,382)</u>
NET FOOD	210,679

TOTAL PATIENT CENSUS	40,227
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	120,681

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	120,681
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	120,681

NET FOOD	210,679
DIVIDE TOTAL MEALS/YEAR	<u>120,681</u>

COST PER MEAL	1.75
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

=====

Facility Name & ID Number

THE TERRACE NH

#0048397

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			12,306	12,306		12,306	(8,690)	3,616			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,999	27,999		27,999	(8,686)	19,313			32
33	Real Estate Taxes			77,062	77,062		77,062	1,159	78,221			33
34	Rent-Facility & Grounds			732,678	732,678		732,678		732,678			34
35	Rent-Equipment & Vehicles			62,658	62,658		62,658	2,122	64,780			35
36	Other (specify):* IME			8,970	8,970		8,970	(8,970)				36
37	TOTAL Ownership			921,673	921,673		921,673	(23,065)	898,608			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		168,366	418,706	587,072		587,072		587,072			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,136	63,136		63,136		63,136			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		168,366	481,842	650,208		650,208		650,208			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,091,845	589,868	2,678,148	6,359,861		6,359,861	(202,771)	6,157,090			45

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

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	(9,722)	30		9
10	Interest and Other Investment Income	(10,212)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,382)	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	(916)	21		18
19	Entertainment		20		19
20	Contributions	(4,924)	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	(149,017)	27		24
25	Fund Raising, Advertising and Promotional	(5,632)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(13,887)	20		28
29	Other-Attach Schedule	(51)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (195,743)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(7,028)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (7,028)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (202,771)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

THE TERRACE NH

ID# 0048397

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$		1
2	PROFESSIONAL FEES OTHER	(51)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(51)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE TERRACE NH

0048397

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(1,382)	0	0	0	0	0	0	0	0	0	0	(1,382)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	913	0	0	0	0	0	0	0	0	913	4
5	Heat and Other Utilities	0	0	0	0	268	0	0	0	0	0	0	268	5
6	Maintenance	0	0	1,215	1,753	1,198	0	0	0	0	0	0	4,166	6
7	Other (specify):*	0	0	41	0	14	0	0	0	0	0	0	55	7
8	TOTAL General Services	(1,382)	0	2,169	1,753	1,480	0	0	0	0	0	0	4,020	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	(3,897)	5,783	(20,564)	0	0	0	0	0	0	0	(18,678)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	55	5,545	182	102	0	0	0	0	0	0	5,884	19
20	Fees, Subscriptions & Promotions	(24,443)	0	1,467	0	0	0	0	0	0	0	0	(22,976)	20
21	Clerical & General Office Expenses	(967)	0	(12,684)	4,685	23	0	0	0	0	0	0	(8,943)	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	4	0	0	0	0	0	0	0	0	4	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	379	274	0	0	0	0	0	0	0	653	25
26	Insurance-Prop.Liab.Malpractice	0	0	285	361	61	0	0	0	0	0	0	707	26
27	Other (specify):*	(149,017)	0	3,596	5,044	0	0	0	0	0	0	0	(140,377)	27
28	TOTAL General Administration	(174,427)	(3,842)	4,375	(10,018)	186	0	0	0	0	0	0	(183,726)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(175,809)	(3,842)	6,544	(8,265)	1,666	0	0	0	0	0	0	(179,706)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE TERRACE NH

0048397

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

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	(9,722)	0	138	63	831	0	0	0	0	0	0	(8,690)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,212)	0	0	0	1,526	0	0	0	0	0	0	(8,686)	32
33	Real Estate Taxes	0	0	0	0	1,159	0	0	0	0	0	0	1,159	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	1,514	326	282	0	0	0	0	0	0	2,122	35
36	Other (specify):*	0	0	0	0	(8,970)	0	0	0	0	0	0	(8,970)	36
37	TOTAL Ownership	(19,934)	0	1,652	389	(5,172)	0	0	0	0	0	0	(23,065)	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)	(195,743)	(3,842)	8,196	(7,876)	(3,506)	0	0	0	0	0	0	(202,771)	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
PHILIP ESFORMES	48					
AVRUM WEINFELD	2			6865 FINANCIAL INC	LINCOLNWOOD	MANAGEMENT
RIVKIE LAFER	1					
RACHEL ESFORMES	1	SEE ATTACHED SCHEDULE		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
MORRIS ESFORMES	48			EMI ENTERPRISES	LINCOLNWOOD	MANAGEMENT
				IME REALTY	LINCOLNWOOD	HOME OFFICE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
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	\$ 81,089	6865 FINANCIAL INC			(81,089)	1
2	V	17	EMI ENTERPRISES			33,786		33,786	2
3	V	17	PHILIP ESFORMES INC			33,786		33,786	3
4	V	17	DANIEL WEISS			2,346		2,346	4
5	V	17	AVRUM WEINFELD			7,274		7,274	5
6	V	19	ACCOUNTING FEES			55		55	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 81,089			\$ 77,247	\$ *	(3,842)	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	\$ 30,000	EKS MANAGEMENT		\$ 913	\$ (30,000)
16	V	4 HOUSEKEEPING SALARIES				913	913
17	V	6 PAINTER SALARIES				1,215	1,215
18	V	7 SCAVENGER				41	41
19	V	17 CFO SALARY - A. WEINFELD				5,783	5,783
20	V	19 PROFESSIONAL FEES				5,545	5,545
21	V	20 WANT ADS/BACKGR CKS				1,467	1,467
22	V	21 OFFICE				17,316	17,316
23	V	23 SEMINARS				4	4
24	V	25 TRANSPORTATION				379	379
25	V	26 INSURANCE				285	285
26	V	27 EMPLOYEE BENEFITS				3,596	3,596
27	V	30 DEPRECIATION (SL)				138	138
28	V	35 EQUIPMENT RENT				1,514	1,514
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 30,000			\$ 38,196	\$ * 8,196

* 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	17 MANAGEMENT FEES	\$ 33,786	EMI MANAGEMENT		\$	\$(33,786)
16	V	6 DRIVERS' SALARY				1,753	1,753
17	V	17 OFFICER SALARY				9,127	9,127
18	V	17 REGIONAL DIRECTOR				4,095	4,095
19	V	19 ACCOUNTING FEES				182	182
20	V	21 OFFICE				4,685	4,685
21	V	25 TRANSPORTATION				274	274
22	V	26 INSURANCE				361	361
23	V	27 EMPLOYEE BENEFITS				5,044	5,044
24	V	30 DEPRECIATION S/L				63	63
25	V	35 AUTO LEASE				326	326
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		\$ 33,786			\$ 25,910	\$ * (7,876)

* 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				268	268
17	V	6 PAINTERS FEES				590	590
18	V	6 REPAIRS / MAINT				608	608
19	V	7 ALARM SERVICE				14	14
20	V	19 PROFESSIONAL FEES				102	102
21	V	21 OFFICE EXPENSE				23	23
22	V	26 INSURANCE				61	61
23	V	30 DEPRECIATION				831	831
24	V	32 INTEREST				1,526	1,526
25	V	33 R/E TAX				1,159	1,159
26	V	35 STORAGE FEES				282	282
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			\$ 5,464	\$ * (3,506)

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

Facility Name & ID Number

THE TERRACE NH

#

0048397

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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		Administrative	48.00		List		Comp fr EMI	\$ 9,127	17-7	1
2						Attached		ADM CONS	10,174	19-3	2
3											3
4	PHILI ESFORMES		Administrative	48.00		List		Comp fr 6865	33,786	17-7	4
5						Attached					5
6											6
7	DANIEL WEISS		Administrative			List		Comp fr 6865	2,346	17-7	7
8						Attached					8
9											9
10	AVRUM WEINFELD		Administrative	2.00		List		Comp fr 6865	7,274	17-7	10
11						Attached		Comp fr EKS	5,783	17-7	11
12	FLORA WEISS		CLERICAL					Comp fr EKS	783	21-7	12
13								TOTAL	\$ 69,273		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: **01/01/2008** Ending: **2/31/2008**

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	EMI ENTERPRISES	PATIENT DAYS	514,353	10	\$ 432,000	\$ 40,227	\$ 33,786	1
2	17	PHILIP ESFORMES INC	PATIENT DAYS	514,353	10	432,000	40,227	33,786	2
3	17	DANIEL WEISS	PATIENT DAYS	514,353	10	30,000	40,227	2,346	3
4	17	AVRUM WEINFELD	PATIENT DAYS	514,353	10	93,005	40,227	7,274	4
5	19	ACCOUNTING FEES	PATIENT DAYS	514,353	10	700	40,227	55	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					\$ 987,705	\$ 555,005	\$ 77,247	25

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

0048397 Report Period Beginning: **01/01/2008** Ending: **2/31/2008**

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	HOUSEKEEPING SALARIES	PATIENT DAYS	859,462	14	\$ 19,500	\$ 40,227	\$ 913	1
2	6	PAINTERS' SALARIES	PATIENT DAYS	859,462	14	25,953	40,227	1,215	2
3	7	SCAVENGER	PATIENT DAYS	859,462	14	866	40,227	41	3
4	17	CFO SALARY - A. WEINFELD	PATIENT DAYS	859,462	14	123,563	40,227	5,783	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	859,462	14	118,475	40,227	5,545	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	859,462	14	31,349	40,227	1,467	6
7	21	OFFICE EXPENSE	PATIENT DAYS	859,462	14	369,953	256,233	17,316	7
8	23	SEMINAR	PATIENT DAYS	859,462	14	95	40,227	4	8
9	25	TRANSPORTATION	PATIENT DAYS	859,462	14	8,106	40,227	379	9
10	26	INSURANCE	PATIENT DAYS	859,462	14	6,085	40,227	285	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	859,462	14	76,819	40,227	3,596	11
12	30	DEPRECIATION S.L	PATIENT DAYS	859,462	14	2,943	40,227	138	12
13	35	EQUIPMENT RENT	PATIENT DAYS	859,462	14	32,345	40,227	1,514	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					\$ 816,052	\$ 521,578	\$ 38,196	25

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

0048397 Report Period Beginning: **01/01/2008** Ending: **2/31/2008**

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization EMI MANAGEMENT
 Street Address 6865 N. LINCOLN AVE
 City / State / Zip Code LINCOLNWOOD , IL. 60712
 Phone Number (847)674-5795
 Fax Number (847)674-5794

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	6	DRIVERS' SALARY	PATIENT DAYS	859,462	14	\$ 37,451	\$ 37,451	40,227	\$ 1,753	1
2	17	OFFICER SALARY	PATIENT DAYS	859,462	14	195,000	195,000	40,227	9,127	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	859,462	14	87,500	87,500	40,227	4,095	3
4	19	ACCOUNTING FEES	PATIENT DAYS	859,462	14	3,885		40,227	182	4
5	21	OFFICE	PATIENT DAYS	859,462	14	100,089	57,703	40,227	4,685	5
6	25	TRANSPORTATION	PATIENT DAYS	859,462	14	5,861		40,227	274	6
7	26	INSURANCE	PATIENT DAYS	859,462	14	7,710		40,227	361	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	859,462	14	107,763		40,227	5,044	8
9	30	DEPRECIATION S/L	PATIENT DAYS	859,462	14	1,340		40,227	63	9
10	35	AUTO LEASE	PATIENT DAYS	859,462	14	6,960		40,227	326	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					\$ 553,559	\$ 377,654		\$ 25,910	25

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

0048397 Report Period Beginning: **01/01/2008** Ending: **2/31/2008**

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization IME REALTY CORP.
 Street Address 6865 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-5795
 Fax Number (847) 675-5794

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	\$ 5,588	\$ 8,970	\$ 268	1
2	6	PAINTERS FEES	INCOME	187,059	15	12,303	8,970	590	2
3	6	REPAIRS / MAINT	INCOME	187,059	15	12,671	8,970	608	3
4	7	ALARM SERVICE	INCOME	187,059	15	301	8,970	14	4
5	19	PROFESSIONAL FEES	INCOME	187,059	15	2,135	8,970	102	5
6	21	OFFICE EXPENSE	INCOME	187,059	15	489	8,970	23	6
7	26	INSURANCE	INCOME	187,059	15	1,275	8,970	61	7
8	30	DEPRECIATION	INCOME	187,059	15	17,336	8,970	831	8
9	32	INTEREST	INCOME	187,059	15	31,829	8,970	1,526	9
10	33	R/E TAX	INCOME	187,059	15	24,171	8,970	1,159	10
11	35	STORAGE FEES	INCOME	187,059	15	5,882	8,970	282	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					\$ 113,980	\$	\$ 5,464	25

Facility Name & ID Number

THE TERRACE NH

0048397

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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**					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							\$	\$			\$	1					
2												2					
3												3					
4	RELATED PARTY - IME											1,526					
5												5					
Working Capital																	
6	THE PRIVATE BANK		X	WORKING CAPITAL	INTEREST	REVOLV		757,000	REVOLV	PRIME +	27,999	6					
7												7					
8												8					
9	TOTAL Facility Related						\$	757,000			\$	29,525					
B. Non-Facility Related*																	
10	IRS, IDR, ETC		X	LATE FEES								10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$				\$						
15	TOTALS (line 9+line14)						\$	757,000			\$	29,525					

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 2007 report.		\$	76,451	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.)		\$	76,756	2
3. Under or (over) accrual (line 2 minus line 1).		\$	305	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	76,757	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.		\$	77,062	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	72,205	8
	2004	73,219	9
	2005	74,497	10
	2006	76,451	11
	2007	76,756	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>76,756.00</u>	\$ <u>76,756.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>76,756.00</u>	\$ <u>76,756.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/2008 Ending:

12/31/2008

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.

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column (1-3). Row 1: Use, Square Feet, Year Acquired, Cost, 1. Row 2: 2. Row 3: 3 TOTALS

Facility Name & ID Number THE TERRACE NH

0048397

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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											5
6											6
7	RELATED PARTY										7
8	HOME OFFICE				26,461	799	39	799			8
	Improvement Type**										
9	DOORS		2007		16,876	614	27.5	614		895	9
10	RAIL GUARDS & KICK PLATES		2007		11,890	432	27.5	432		450	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	\$ 1,845		\$ 1,845	\$	\$ 1,345	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	\$ 8,072	\$ 2,485	\$ 807	\$ (1,678)	10 YRS	\$ 1,322	71
72	Current Year Purchases	14,625	8,775	731	(8,044)	10 YRS	731	72
73	Fully Depreciated Assets							73
74	Related Party		233	233				74
75	TOTALS	\$ 22,697	\$ 11,493	\$ 1,771	\$ (9,722)		\$ 2,053	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)	\$ 77,924	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 13,338	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 3,616	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (9,722)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,398	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	\$ 732,678	5.5	5	3
4	Additions							4
5								5
6								6
7	TOTAL		115		\$ 732,678			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: \$ 39,582 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			\$	23,076	17
18					18
19					19
20					20
21	TOTAL		\$	23,076	21

10. Effective dates of current rental agreement:

Beginning 10/01/09

Ending 04/30/12

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

Fiscal Year Ending Annual Rent

12. /2009 \$ 741,814

13. /2010 \$ 741,814

14. /2011 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 189,626	\$		\$ 189,626	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			16,744			16,744	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			212,336			212,336	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				156,999		156,999	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>supplies,radiologr,lab</u>	39-2					11,367		11,367	13
14	TOTAL			\$		\$ 418,706	\$ 168,366		\$ 587,072	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: 01/01/2008

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 111,080	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (120,000))	1,158,101		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	92,221		6
7	Other Prepaid Expenses	6,650		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): real estate tax escrow	70,060		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,438,112	\$	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	22,697		16
17	Accumulated Depreciation (book methods)	(14,465)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	244,704		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 281,702	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,719,814	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 345,438	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	757,000		29
30	Accrued Salaries Payable	99,054		30
31	Accrued Taxes Payable (excluding real estate taxes)	40,031		31
32	Accrued Real Estate Taxes(Sch.IX-B)	76,757		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)	\$ 1,318,280	\$	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)	\$ 1,318,280	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 401,534	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,719,814	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 437,042	1
2	Restatements (describe):	6	2
3	ROUNDING		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 437,048	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(35,514)	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)	\$ (35,514)	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)	\$ 401,534	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	\$ 5,952,849	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,952,849	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	361,286	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 361,286	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***	10,212	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,212	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)	\$ 6,324,347	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	968,631	31
32	Health Care	2,543,421	32
33	General Administration	1,275,928	33
	B. Capital Expense		
34	Ownership	921,673	34
	C. Ancillary Expense		
35	Special Cost Centers	587,072	35
36	Provider Participation Fee	63,136	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,359,861	40
41	Income before Income Taxes (line 30 minus line 40)**	(35,514)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (35,514)	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:

01/01/2008

Ending:

12/31/2008

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	4,378	4,808	\$ 122,542	\$ 25.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	33,512	35,688	1,013,940	28.41	3
4	Licensed Practical Nurses	1,085	1,108	22,651	20.44	4
5	CNAs & Orderlies	81,452	87,855	957,892	10.90	5
6	CNA Trainees					6
7	Licensed Therapist	5,695	5,890	72,484	12.31	7
8	Rehab/Therapy Aides	5,372	6,845	66,223	9.67	8
9	Activity Director					9
10	Activity Assistants	6,937	7,782	69,464	8.93	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,929	23,861	212,533	8.91	15
16	Dishwashers					16
17	Maintenance Workers	2,117	2,204	32,027	14.53	17
18	Housekeepers	18,171	19,420	164,851	8.49	18
19	Laundry	6,631	7,377	64,549	8.75	19
20	Administrator	2,082	2,238	74,500	33.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,189	12,126	135,911	11.21	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	1,757	1,868	17,110	9.16	31
32	Other Health C: <u>MDS</u>	2,103	2,866	65,168	22.74	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	204,410	221,936	\$ 3,091,845 *	\$ 13.93	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	4,320	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	3,720	10-3	39
40	Physical Therapy Consultant	L	285	10a-3	40
41	Occupational Therapy Consultant	Y	627	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	2,685	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 35,577		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 SHULZ	ADMINISTRATOR		\$ 74,500	Workers' Compensation Insurance	\$ 83,388	IDPH License Fee	\$	
	ASST ADMIN		0	Unemployment Compensation Insurance	23,093	Advertising: Employee Recruitment	700	
	OTHER ADMIN		0	FICA Taxes	229,465	Health Care Worker Background Check	0	
				Employee Health Insurance	224,451	(Indicate # of checks performed)		
				Employee Meals	0	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	4,924	
				EMPLOYEE BENEFITS - OTHER	977	MARKETING/ADV/PROMO	19,519	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	8,346	
				PENSION/PROFIT SHARING PLANS	29,831	MGMT CO ALLOC	1,467	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(4,924)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(5,632)	
						Yellow page advertising	(13,887)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 74,500	TOTAL (agree to Schedule V, line 22, col.8)	\$ 591,205	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,513	
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 INS - MANAGEMENT FEE			\$ 81,089			\$	Out-of-State Travel	\$
							In-State Travel	0
							Seminar Expense	1,430
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 81,089	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,430
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$			\$		
SEE SCHEDULE ATTACHED			52,236					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 52,236					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number THE TERRACE NH

0048397

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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 \$4,299
- (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. \$ 401 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
TERRACE NURSING HOME,LLC 00043943 11/1/06
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 63,136
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$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