

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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>0048413</u></p> <p>Facility Name: <u>KANKAKEE TERRACE</u></p> <p>Address: <u>100 BELLE AIRE</u> <u>BOURBONNAIS</u> <u>60914</u> Number City Zip Code</p> <p>County: <u>KANKAKEE</u></p> <p>Telephone Number: <u>(847) 674-5795</u> Fax # <u>(847) 674-5794</u></p> <p>HFS ID Number: <u>364594593-001</u></p> <p>Date of Initial License for Current Owners: <u>11/01/2006</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> Email Address: <u>kvanstockum@kbkbcpa.com</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>01/01/2009</u> to <u>12/31/2009</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>AVRUM WEINFELD</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>CFO</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></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) _____	(Type or Print Name) <u>AVRUM WEINFELD</u> (Date) _____		(Title) <u>CFO</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 KANKAKEE TERRACE

0048413 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	146	Intermediate (ICF)	146	53,290	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,290	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	48,777	571	1,475	50,823	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,777	571	1,475	50,823	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.37%

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 11/01/2006

J. Was the facility purchased or leased after January 1, 1978?

YES Date 11/01/2006 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided 0

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

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	229,147	16,623	5,940	251,710		251,710	251,710		1	
2	Food Purchase		223,990		223,990	(10,220)	213,770	213,205		2	
3	Housekeeping	218,513	21,424		239,937		239,937	239,937		3	
4	Laundry	80,917	9,995	2,923	93,835		93,835	98,270		4	
5	Heat and Other Utilities			114,852	114,852		114,852	115,219		5	
6	Maintenance	13,190	21,317	29,184	63,691		63,691	69,223		6	
7	Other (specify):*			5,989	5,989		5,989	6,058		7	
8	TOTAL General Services	541,767	293,349	158,888	994,004	(10,220)	983,784	993,622		8	
	B. Health Care and Programs										
9	Medical Director			6,900	6,900		6,900	6,900		9	
10	Nursing and Medical Records	1,325,774	75,218	25,226	1,426,218		1,426,218	1,426,218		10	
10a	Therapy	21,702			21,702		21,702	21,702		10a	
11	Activities	84,987	4,872	3,969	93,828		93,828	93,828		11	
12	Social Services									12	
13	CNA Training									13	
14	Program Transportation			228	228		228	228		14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	1,432,463	80,090	36,323	1,548,876		1,548,876	1,548,876		16	
	C. General Administration										
17	Administrative	80,862		253,769	334,631		334,631	162,732		17	
18	Directors Fees									18	
19	Professional Services			45,283	45,283		45,283	36,214		19	
20	Dues, Fees, Subscriptions & Promotions			16,384	16,384		16,384	7,133		20	
21	Clerical & General Office Expenses	95,068	15,209	93,271	203,548		203,548	126,629		21	
22	Employee Benefits & Payroll Taxes			358,150	358,150	10,220	368,370	368,370		22	
23	Inservice Training & Education			2,197	2,197		2,197	2,208		23	
24	Travel and Seminar									24	
25	Other Admin. Staff Transportation			24,906	24,906		24,906	25,535		25	
26	Insurance-Prop.Liab.Malpractice			57,255	57,255		57,255	58,267		26	
27	Other (specify):*			113,747	113,747		113,747	10,180		27	
28	TOTAL General Administration	175,930	15,209	964,962	1,156,101	10,220	1,166,321	797,268		28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,150,160	388,648	1,160,173	3,698,981		3,698,981	3,339,766		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	0
		0
		5,940
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	2,923
		0
		2,923
5	HEAT & OTHER UTILITIES	
	GAS HEAT	28,932
	ELECTRICITY	39,520
	WATER	36,558
	CABLE TV - LOBBY	9,842
		0
		114,852
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,690
	PAINTING & DECORATING	249
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	13,619
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,187
	FIRE SERVICE	8,439
		0
		0
		0
		0
		29,184
7	OTHER	
	SCAVENGER	4,968
	SECURITY SERVICE	1,021
		0
		0
		5,989
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,900
		6,900

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	5,420
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	8,698
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	7,008
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL	4,100
		0
		25,226
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,969
		0
		3,969
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
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		228
			0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B	253,769
	DIRECTORS FEES		
18	DIRECTORS FEES		0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C	13,129
	ADMINISTRATIVE CONSULTANTS	XIX C	0
	PROFESSIONAL FEES	XIX C	32,154
			0
			45,283
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	1,820
	EMPLOYEE WANT ADS	XIX F	1,290
	CONTRIBUTIONS	VI 20 XIX F	500
	DUES & SUBSCRIPTIONS	XIX F	108
	LICENSES & PERMITS	XIX F	3,134
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	936
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	8,576
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	20
	PATIENT BACKGROUND CHECKS	XIX F	0
			16,384
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		752
	EQUIPMENT REPAIR & MAINTENANCE		340
	OUTSIDE CLERICAL SERVICES		78,000
	PENALTIES / OVERDRAFT CHARGES	VI 18	0
	HOME OFFICE EXPENSE		0
	THEFT & DAMAGE LOSS		0
	TELEPHONE		14,179
	MESSENGER SERVICE		0
			0
			93,271

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D	162,183
	UNEMPLOYMENT COMPENSATION	XIX D	15,571
	WORKERS COMPENSATION INSURANC	XIX D	63,789
	HOSPITALIZATION INSURANCE	XIX D	92,126
	EMPLOYEE BENEFITS - OTHER	XIX D	3,185
	EMPLOYEE PHYSICAL EXAMS	XIX D	0
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS	XIX D	21,296
	CHICAGO HEAD TAX	XIX D	0
			0
			358,150
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		2,197
			2,197
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G	0
	TRAVEL	XIX G	0
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF		24,906
			24,906
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE		57,255
			57,255
27	OTHER		
	BAD DEBTS	VI 24	113,747
			113,747

GRAND TOTAL COLUMN 3 OTHER **1,160,173**

**KANKAKEE TERRACE
SCHEDULES
12/31/2009**

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

TOTAL FOOD PURCHASE	223,990
LESS SALES TAX	<u>(565)</u>
NET FOOD	223,425

TOTAL PATIENT CENSUS	50,823
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	152,469

ADD # EMPLOYEE MEALS/DAY	20
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	7,300

PATIENT MEALS	152,469
ADD EMPLOYEE MEALS	<u>7,300</u>
TOTAL MEALS/YEAR	159,769

NET FOOD	223,425
DIVIDE TOTAL MEALS/YEAR	<u>159,769</u>

COST PER MEAL	1.40
TIME EMPLOYEE MEALS	<u>7,300</u>
EMPLOYEE MEAL RECLASSIFICATION	10,220

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Facility Name & ID Number KANKAKEE TERRACE

#0048413

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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			11,405	11,405		11,405	(2,834)	8,571			30
31	Amortization of Pre-Op. & Org.			500	500		500		500			31
32	Interest			17,871	17,871		17,871	(36,428)	(18,557)			32
33	Real Estate Taxes			43,625	43,625		43,625	1,436	45,061			33
34	Rent-Facility & Grounds			1,226,467	1,226,467		1,226,467		1,226,467			34
35	Rent-Equipment & Vehicles			41,303	41,303		41,303	2,847	44,150			35
36	Other (specify):* IME			11,232	11,232		11,232	(11,232)				36
37	TOTAL Ownership			1,352,403	1,352,403		1,352,403	(46,211)	1,306,192			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,935	79,935		79,935		79,935			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			79,935	79,935		79,935		79,935			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,150,160	388,648	2,592,511	5,131,319		5,131,319	(405,426)	4,725,893			45

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

Facility Name & ID Number **KANKAKEE TERRACE**

0048413

Report Period Beginning: **01/01/2009**

Ending: **12/31/2009**

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	(4,026)	30		9
10	Interest and Other Investment Income	(38,278)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(565)	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		21		18
19	Entertainment		20		19
20	Contributions	(9,076)	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	(113,747)	27		24
25	Fund Raising, Advertising and Promotional	(1,820)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(936)	20		28
29	Other-Attach Schedule	(38,884)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (207,332)		\$	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)	(198,094)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (198,094)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (405,426)		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

KANKAKEE TERRACE

ID# 0048413

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MARKETING SALARY	\$ -24066	21	1
2	NON ALLOWABLE PROFESSIONAL FEES	(14,818)	19	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		(38,884)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number KANKAKEE TERRACE# 0048413

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(565)	0	0	0	0	0	0	0	0	0	0	(565)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	4,435	0	0	0	0	0	0	0	0	4,435	4
5	Heat and Other Utilities	0	0	0	367	0	0	0	0	0	0	0	367	5
6	Maintenance	0	0	1,557	1,691	2,284	0	0	0	0	0	0	5,532	6
7	Other (specify):*	0	0	51	18	0	0	0	0	0	0	0	69	7
8	TOTAL General Services	(565)	0	6,043	2,076	2,284	0	0	0	0	0	0	9,838	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	(158,394)	6,898	0	(20,403)	0	0	0	0	0	0	(171,899)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,818)	66	5,218	54	411	0	0	0	0	0	0	(9,069)	19
20	Fees, Subscriptions & Promotions	(11,832)	0	2,553	28	0	0	0	0	0	0	0	(9,251)	20
21	Clerical & General Office Expenses	(24,066)	0	(58,520)	8	5,659	0	0	0	0	0	0	(76,919)	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	11	0	0	0	0	0	0	0	0	11	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	432	0	197	0	0	0	0	0	0	629	25
26	Insurance-Prop.Liab.Malpractice	0	0	172	98	742	0	0	0	0	0	0	1,012	26
27	Other (specify):*	(113,747)	0	3,722	0	6,458	0	0	0	0	0	0	(103,567)	27
28	TOTAL General Administration	(164,463)	(158,328)	(39,514)	188	(6,936)	0	0	0	0	0	0	(369,053)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(165,028)	(158,328)	(33,471)	2,264	(4,652)	0	0	0	0	0	0	(359,215)	29

STATE OF ILLINOIS

Facility Name & ID Number KANKAKEE TERRACE# 0048413

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(4,026)	0	105	1,041	46	0	0	0	0	0	0	(2,834)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(38,278)	0	0	1,850	0	0	0	0	0	0	0	(36,428)	32
33	Real Estate Taxes	0	0	0	1,436	0	0	0	0	0	0	0	1,436	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	2,014	458	375	0	0	0	0	0	0	2,847	35
36	Other (specify):*	0	0	0	(11,232)	0	0	0	0	0	0	0	(11,232)	36
37	TOTAL Ownership	(42,304)	0	2,119	(6,447)	421	0	0	0	0	0	0	(46,211)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(207,332)	(158,328)	(31,352)	(4,183)	(4,231)	0	0	0	0	0	0	(405,426)	45

Facility Name & ID Number

KANKAKEE TERRACE

0048413

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				6865 FINANCIAL INC	LINCOLNWOOD	MGMT CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSLT

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	\$ 253,769	6865 FINANCIAL INC	100.00%	\$	\$ (253,769)	1
2	V								2
3	V	17	SHELDON NEIDICH						3
4	V	17	EMI ENTERPRISES			37,353		37,353	4
5	V	17	PHILIP ESFORMES INC			44,145		44,145	5
6	V	17	DANIEL WEISS			2,830		2,830	6
7	V	17	AVRUM WEINFELD			11,047		11,047	7
8	V	19	ACCOUNTING FEES			66		66	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 253,769			\$ 95,441	\$ *	(158,328)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING	\$ 78,000	EKS MANAGEMENT	100.00%	\$ (78,000)	15
16	V							16
17	V	4	HOUSEKEEPING SALARIES			4,435	4,435	17
18	V	6	PAINTERS SALARIES			1,557	1,557	18
19	V	7	SCAVENGER			51	51	19
20	V	17	CFO SALARY			6,898	6,898	20
21	V	19	PROFESSIONAL FEES			5,218	5,218	21
22	V	20	WANT ADDS/BACKGR CKS			2,553	2,553	22
23	V	21	OFFICE EXPENSE			19,480	19,480	23
24	V	23	SEMINARS			11	11	24
25	V	25	TRANSPORTATION			432	432	25
26	V	26	INSURANCE			172	172	26
27	V	27	EMPLOYEE BENEFITS			3,722	3,722	27
28	V	30	DERPECIATION (SL)			105	105	28
29	V	35	EQUIPMENT RENT			2,014	2,014	29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 78,000			\$ 46,648	\$ * (31,352)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	36 OFFICE RENT	\$ 11,232	IME REALTY CORP	100.00%	\$	\$ (11,232)
16	V						
17	V	5 UTILITIES				367	367
18	V	6 PAINTERS FEES				739	739
19	V	6 REPAIR & MAINTENANCE				952	952
20	V	7 ALARM SERVICE				18	18
21	V	19 PROFESSIONAL FEES				54	54
22	V	20 LICENSES & PERMITS				28	28
23	V	21 OFFICE EXPENSE				8	8
24	V	26 INSURANCE				98	98
25	V	30 DEPRECIATION				1,041	1,041
26	V	32 INTEREST				1,850	1,850
27	V	33 RE TAX				1,436	1,436
28	V	35 STORAGE FEES				458	458
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 11,232			\$ 7,049	\$ * (4,183)

* 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	\$ 37,353	EMI ENTERPRISES	100.00%	\$	\$ (37,353)
16	V						
17	V	6 DRIVERS SALARIES				2,284	2,284
18	V	17 MESFORMES,OFFICER				11,700	11,700
19	V	17 REGIONAL DIRECTOR				5,250	5,250
20	V	19 ACCOUNTING FEES				411	411
21	V	21 OFFICE				5,659	5,659
22	V	25 TRANSPORTATION				197	197
23	V	26 INSURANCE				742	742
24	V	27 EMPLOYEE BENEFITS				6,458	6,458
25	V	30 DEPRECIATION				46	46
26	V	35 AUTO LEASE				375	375
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		\$ 37,353			\$ 33,122	\$ * (4,231)

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

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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				SCHEDULE ATTACHED			SALARY	\$ 11,700	17-7	1
2	AVRUM WEINFELD	CFO						SALARY	6,898	17-7	2
3	AVRUM WEINFELD	CFO						SALARY	11,047	17-7	3
4	PHILIP ESFORMES							SALARY	44,145	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 73,790		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number KANKAKEE TERRACE

0048413

Report Period Beginning: 01/01/2009

Ending: 2/31/2009

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	SHELDON NEIDICH	PATIENT DAYS	538,796	10	\$ 22,500	\$ 22,500	0	1
2	17	MORRIS ESFORMES	PATIENT DAYS	538,796	10	396,000	396,000	50,823	2
3	17	PHILIP ESFORMES INC	PATIENT DAYS	538,796	10	468,000	468,000	50,823	3
4	17	DANIEL WEISS	PATIENT DAYS	538,796	10	30,000	30,000	50,823	4
5	17	AVRUM WEINFELD	PATIENT DAYS	538,796	10	117,111	117,111	50,823	5
6	19	ACCOUNTING FEES	PATIENT DAYS	538,796	10	700	50,823	66	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					\$ 1,034,311	\$ 1,033,611	\$ 95,441	25

Facility Name & ID Number KANKAKEE TERRACE

0048413 Report Period Beginning: 01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	4	HOUSEKEEPING SALARIES	PATIENT DAYS	847,051	14	\$ 73,923	\$ 73,923	50,823	\$ 4,435	1
2	6	PAINTERS SALARIES	PATIENT DAYS	847,051	14	25,953	25,953	50,823	1,557	2
3	7	SCAVENGER	PATIENT DAYS	847,051	14	842		50,823	51	3
4	17	CFO SALARY	PATIENT DAYS	847,051	14	114,971	114,971	50,823	6,898	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	847,051	14	86,967	74,170	50,823	5,218	5
6	20	WANT ADDS/BACKGR CKS	PATIENT DAYS	847,051	14	42,556		50,823	2,553	6
7	21	OFFICE EXPENSE	PATIENT DAYS	847,051	14	324,660	230,236	50,823	19,480	7
8	23	SEMINARS	PATIENT DAYS	847,051	14	190		50,823	11	8
9	25	TRANSPORTATION	PATIENT DAYS	847,051	14	7,194		50,823	432	9
10	26	INSURANCE	PATIENT DAYS	847,051	14	2,872		50,823	172	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	62,031		50,823	3,722	11
12	30	DERPECIATION (SL)	PATIENT DAYS	847,051	14	1,757		50,823	105	12
13	35	EQUIPMENT RENT	PATIENT DAYS	847,051	14	33,562		50,823	2,014	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					\$ 777,478	\$ 519,253		\$ 46,648	25

Facility Name & ID Number KANKAKEE TERRACE

0048413 Report Period Beginning: 01/01/2009

Ending: 2/31/2009

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	187,059	15	\$ 6,106	\$ 11,232	\$ 367	1
2	6	PAINTERS FEES	RENTAL INCOME	187,059	15	12,303	11,232	739	2
3	6	REPAIR & MAINTENANCE	RENTAL INCOME	187,059	15	15,863	11,232	952	3
4	7	ALARM SERVICE	RENTAL INCOME	187,059	15	301	11,232	18	4
5	19	PROFESSIONAL FEES	RENTAL INCOME	187,059	15	897	11,232	54	5
6	20	LICENSES & PERMITS	RENTAL INCOME	187,059	15	468	11,232	28	6
7	21	OFFICE EXPENSE	RENTAL INCOME	187,059	15	136	11,232	8	7
8	26	INSURANCE	RENTAL INCOME	187,059	15	1,627	11,232	98	8
9	30	DEPRECIATION	RENTAL INCOME	187,059	15	17,336	11,232	1,041	9
10	32	INTEREST	RENTAL INCOME	187,059	15	30,806	11,232	1,850	10
11	33	RE TAX	RENTAL INCOME	187,059	15	23,914	11,232	1,436	11
12	35	STORAGE FEES	RENTAL INCOME	187,059	15	7,635	11,232	458	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					\$ 117,392	\$	\$ 7,049	25

Facility Name & ID Number KANKAKEE TERRACE

0048413

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	DRIVERS SALARIES	PATIENT DAYS	847,051	14	\$ 38,060	\$ 38,060	50,823	\$ 2,284	1
2	17	MESFORMES,OFFICER	PATIENT DAYS	847,051	14	195,000	195,000	50,823	11,700	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	847,051	14	87,500	87,500	50,823	5,250	3
4	19	ACCOUNTING FEES	PATIENT DAYS	847,051	14	6,850		50,823	411	4
5	21	OFFICE	PATIENT DAYS	847,051	14	94,319	58,251	50,823	5,659	5
6	25	TRANSPORTATION	PATIENT DAYS	847,051	14	3,276		50,823	197	6
7	26	INSURANCE	PATIENT DAYS	847,051	14	12,367		50,823	742	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	107,628		50,823	6,458	8
9	30	DEPRECIATION	PATIENT DAYS	847,051	14	765		50,823	46	9
10	35	AUTO LEASE	PATIENT DAYS	847,051	14	6,253		50,823	375	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					\$ 552,018	\$ 378,811		\$ 33,122	25

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>44,370.09</u>	\$ <u>44,370.09</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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

Facility Name & ID Number KANKAKEE TERRACE

0048413 Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,663 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred: 2,500 2. Number of Years Over Which it is Being Amortized: 5
 3. Current Period Amortization: 50 4. Dates Incurred: 11/06

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

Facility Name & ID Number **KANKAKEE TERRACE**

0048413

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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										7	
8		RELATED PARTY			33,594	1,000	39	1,000			8
		Improvement Type**									
9		ROOF		2008	37,800	1,355	27.5	1,355		1,985	9
10		STEEL SUPPORT BEAMS		2008	76,400	2,764	27.5	2,764		4,037	10
11		FLOOR TILE, HANDRAIL		2008	30,268	1,084	27.5	1,084		1,588	11
12		PIPES & FITTINGS		2008	4,594	217	27.5	217		294	12
13		ROOFTOP AC		2009	7,904	132	27.5	132		132	13
14		ARCHITECT FEES LIFE SAFETY		2009	4,614	77	27.5	77		77	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

Facility Name & ID Number **KANKAKEE TERRACE**

0048413

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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)		\$ 195,174	\$ 6,629		\$ 6,629	\$	\$ 8,113	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	\$ 11,024	\$ 1,887	\$ 1,102	\$ (785)	10 YRS	\$ 2,976	71
72	Current Year Purchases	6,482	3,889	648	(3,241)	10 YRS	648	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		192	192				74
75	TOTALS	\$ 17,506	\$ 5,968	\$ 1,942	\$ (4,026)		\$ 3,624	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)	\$ 212,680	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,597	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 8,571	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,026)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 11,737	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 KANKAKEE TERRACE LLC

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1976</u>	<u>146</u>	<u>11/06</u>	\$ <u>1,226,467</u>	<u>5.5</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		<u>146</u>		\$ <u>1,226,467</u>			7

10. Effective dates of current rental agreement:

Beginning 11/01/2006

Ending 04/01/2012

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

Fiscal Year Ending Annual Rent

12. 12/2010 \$ _____

13. 12/2011 \$ _____

14. 12/2012 \$ _____

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: \$ 7,084 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>09 LINCOLN NAVIGATOR</u>	\$ <u>#####</u>	\$ <u>14,729</u>	17
18		<u>06 FORD VAN</u>	<u>550.00</u>	<u>6,600</u>	18
19		<u>06 FORD E350SD</u>	<u>789.00</u>	<u>9,462</u>	19
20		<u>MISC</u>		<u>3,428</u>	20
21	TOTAL		\$ <u>#####</u>	\$ <u>34,219</u>	21

* 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.

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2009 Ending: 12/31/2009
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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$			\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$			\$	14

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

Facility Name & ID Number **KANKAKEE TERRACE**

0048413

Report Period Beginning: **01/01/2009**

Ending:

12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2009**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 511	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>221,332</u>)	1,672,242		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	87,688		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	564,551		8
9	Other(specify): <u>RE TAX/INS ESCROW</u>	38,008		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,363,000	\$	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	161,580		15
16	Equipment, at Historical Cost	17,506		16
17	Accumulated Depreciation (book methods)	(20,195)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,500		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,584)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>ADV RENT/REPL RESV</u>	160,432		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 320,239	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,683,239	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 214,448	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	725,000		29
30	Accrued Salaries Payable	30,670		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,836		31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,000		32
33	Accrued Interest Payable	2,387		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)	\$ 1,022,341	\$	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)	\$ 1,022,341	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,660,898	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,683,239	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,487,323	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,487,323	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	695,864	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	(522,289)	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)	\$ 173,575	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)	\$ 1,660,898	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	\$ 5,812,022	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,812,022	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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***	38,278	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 38,278	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)	\$ 5,850,300	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	994,004	31
32	Health Care	1,548,876	32
33	General Administration	1,156,101	33
B. Capital Expense			
34	Ownership	1,352,403	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	79,935	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES	22,578	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,153,897	40
41	Income before Income Taxes (line 30 minus line 40)**	696,403	41
42	Income Taxes	(539)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 695,864	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
 TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number KANKAKEE TERRACE

0048413

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	1,964	2,160	\$ 67,512	\$ 31.26	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,513	3,864	94,964	24.58	3
4	Licensed Practical Nurses	13,137	14,362	270,926	18.86	4
5	CNAs & Orderlies	51,284	58,398	690,966	11.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,115	1,548	21,702	14.02	8
9	Activity Director					9
10	Activity Assistants	7,464	8,337	84,987	10.19	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,657	21,504	229,147	10.66	15
16	Dishwashers					16
17	Maintenance Workers	2,232	2,320	13,190	5.69	17
18	Housekeepers	18,663	20,614	218,513	10.60	18
19	Laundry	5,213	5,927	80,917	13.65	19
20	Administrator	2,104	2,160	80,862	37.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,565	12,272	95,068	7.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	13,100	13,827	190,477	13.78	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>QUALITY ASSUR</u>	2,160	2,160	10,929	5.06	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,171	169,453	\$ 2,150,160 *	\$ 12.69	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	6,900	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	7,008	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,969	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 23,817		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				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						
RANDY LEBEAU	ADMINISTRATOR		\$ 80,862	Workers' Compensation Insurance	\$ 63,789	IDPH License Fee	\$ 1,990						
			0	Unemployment Compensation Insurance	15,571	Advertising: Employee Recruitment	1,290						
			0	FICA Taxes	162,183	Health Care Worker Background Check	20						
				Employee Health Insurance	92,126	(Indicate # of checks performed <u>2</u>)							
				Employee Meals	10,220	Patient Background Checks	0						
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	9,076						
				EMPLOYEE BENEFITS - OTHER	3,185	MARKETING/ADV/PROMO	2,756						
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	1,252						
				PENSION/PROFIT SHARING PLANS	21,296	MGMT CO ALLOC	2,581						
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(9,076)						
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)						
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(1,820)						
						Yellow page advertising	(936)						
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)						
\$ 80,862				\$ 368,370			\$ 7,133						
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					
MANAGEMENT FEES			\$ 253,769				Out-of-State Travel	\$					
							In-State Travel	0					
							Seminar Expense	0					
							Entertainment Expense	()					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)						
\$ 253,769				\$			\$						
C. Professional Services				* Attach copy of IMRF notifications									
Vendor/Payee	Type		Amount						**See instructions.				
			\$										
SEE SCHEDULE ATTACHED			45,283										
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)													
\$ 45,283													

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number **KANKAKEE TERRACE**# **0048413**Report Period Beginning: **01/01/2009**Ending: **12/31/2009****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. ALLIANCE FOR LIVING \$184
- (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. \$ 1,667 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. \$ 79,935
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 10,220 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: _____
- (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.