

Facility Name & ID Number SPRINGFIELD TERRACE

0032961 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	65	Intermediate (ICF)	65	23,725	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,725	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	17,102	422		17,524
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	17,102	422		17,524

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.86%

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 11/06/87

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

YES Date 11/06/87 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	92,715	4,660	6,201	103,576		103,576		103,576	1	
2	Food Purchase		96,881		96,881		96,881	(209)	96,672	2	
3	Housekeeping	47,090	11,025		58,115		58,115		58,115	3	
4	Laundry	20,121	4,833		24,954		24,954		24,954	4	
5	Heat and Other Utilities			53,750	53,750		53,750	126	53,876	5	
6	Maintenance	19,284		30,923	50,207		50,207	(439)	49,768	6	
7	Other (specify):*			5,662	5,662		5,662	1	5,663	7	
8	TOTAL General Services	179,210	117,399	96,536	393,145		393,145	(521)	392,624	8	
	B. Health Care and Programs										
9	Medical Director			17,700	17,700		17,700		17,700	9	
10	Nursing and Medical Records	461,760	28,603	7,335	497,698		497,698	(3,050)	494,648	10	
10a	Therapy			12,119	12,119		12,119		12,119	10a	
11	Activities	17,409	15,723	3,605	36,737		36,737	(3,720)	33,017	11	
12	Social Services	54,721	296		55,017		55,017		55,017	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	533,890	44,622	40,759	619,271		619,271	(6,770)	612,501	16	
	C. General Administration										
17	Administrative	63,215			63,215		63,215		63,215	17	
18	Directors Fees									18	
19	Professional Services			87,597	87,597		87,597	(73,505)	14,092	19	
20	Dues, Fees, Subscriptions & Promotions			12,963	12,963		12,963	(591)	12,372	20	
21	Clerical & General Office Expenses	28,372	5,865	21,434	55,671		55,671	19,283	74,954	21	
22	Employee Benefits & Payroll Taxes			130,788	130,788		130,788		130,788	22	
23	Inservice Training & Education							186	186	23	
24	Travel and Seminar			340	340		340	5,831	6,171	24	
25	Other Admin. Staff Transportation			22,940	22,940		22,940	2,587	25,527	25	
26	Insurance-Prop.Liab.Malpractice			13,693	13,693		13,693		13,693	26	
27	Other (specify):*			80	80		80	7,410	7,490	27	
28	TOTAL General Administration	91,587	5,865	289,835	387,287		387,287	(38,799)	348,488	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	804,687	167,886	427,130	1,399,703		1,399,703	(46,090)	1,353,613	29	

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	6,201
	REPAIRS & MAINTENANCE	0
		0
		6,201
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	6,552
	ELECTRICITY	35,933
	WATER	10,575
	CABLE TV - LOBBY	690
		0
		53,750
6	MAINTENANCE	
	GROUNDS MAINTENANCE	0
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE CONSULTANT	9,984
	EQUIPMENT MAINTENANCE & REPAIR	11,559
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,793
	FIRE SERVICE	7,587
		0
		0
		0
		0
		30,923
7	OTHER	
	SCAVENGER	5,095
	SECURITY SERVICE	567
		0
		0
		5,662
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	17,700
		17,700

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	643
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	5,756
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	156
	PHARMACY CONSULTANT XVIII B 39-2	780
	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
		7,335
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	12,119
	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
		12,119
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,605
		0
		3,605
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		0
			0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B	0
18	DIRECTORS FEES		
	DIRECTORS FEES		0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C	8,933
	ADMINISTRATIVE CONSULTANTS	XIX C	6,480
	PROFESSIONAL FEES	XIX C	22,754
	BOOKKEEPING/ADMINISTRATIVE SERVICE		49,430
			87,597
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	0
	EMPLOYEE WANT ADS	XIX F	1,840
	CONTRIBUTIONS	VI 20 XIX F	680
	DUES & SUBSCRIPTIONS	XIX F	8,475
	LICENSES & PERMITS	XIX F	878
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	820
	PATIENT BACKGROUND CHECKS	XIX F	270
			12,963
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		261
	EQUIPMENT REPAIR & MAINTENANCE		0
	OUTSIDE CLERICAL SERVICES		0
	PENALTIES / OVERDRAFT CHARGES	VI 18	13,082
	HOME OFFICE EXPENSE		
	THEFT & DAMAGE LOSS		0
	TELEPHONE		8,091
	MESSENGER SERVICE		0
			0
			21,434

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D	64,059
	UNEMPLOYMENT COMPENSATION	XIX D	31,612
	WORKERS COMPENSATION INSURANC	XIX D	29,927
	HOSPITALIZATION INSURANCE	XIX D	4,740
	EMPLOYEE BENEFITS - OTHER	XIX D	450
	EMPLOYEE PHYSICAL EXAMS	XIX D	0
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS	XIX D	0
	CHICAGO HEAD TAX	XIX D	0
			0
			130,788
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		0
			0
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G	340
	TRAVEL	XIX G	0
			340
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF		22,940
			22,940
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE		13,693
			13,693
27	OTHER		
	BAD DEBTS	VI 24	80
			80

GRAND TOTAL COLUMN 3 OTHER

427,130

**SPRINGFIELD TERRACE
SCHEDULES
12/31/2009**

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

TOTAL FOOD PURCHASE	96,881
LESS SALES TAX	<u>(209)</u>
NET FOOD	96,672

TOTAL PATIENT CENSUS	17,524
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	52,572

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	52,572
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	52,572

NET FOOD	96,672
DIVIDE TOTAL MEALS/YEAR	<u>52,572</u>

COST PER MEAL	1.84
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

=====

Facility Name & ID Number

SPRINGFIELD TERRACE

#0032961

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			3,309	3,309	3,309	19,681	22,990				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			285	285	285	42,308	42,593				32
33	Real Estate Taxes			16,038	16,038	16,038		16,038				33
34	Rent-Facility & Grounds			69,499	69,499	69,499	(65,244)	4,255				34
35	Rent-Equipment & Vehicles			4,102	4,102	4,102	4,767	8,869				35
36	Other (specify):*											36
37	TOTAL Ownership			93,233	93,233	93,233	1,512	94,745				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			36,849	36,849	36,849		36,849				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,587	35,587	35,587		35,587				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			72,436	72,436	72,436		72,436				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	804,687	167,886	592,799	1,565,372	1,565,372	(44,578)	1,520,794				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 **SPRINGFIELD TERRACE**

0032961

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	939	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(209)	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	(13,082)	21		18
19	Entertainment		20		19
20	Contributions	(680)	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	(80)	27		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (13,112)		\$	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)	(31,466)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (31,466)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (44,578)		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

SPRINGFIELD TERRACE

ID# 0032961

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

Reference

NON-ALLOWABLE EXPENSES

Amount

1	DEFERRED MAINTENANCE	\$	6	1
2				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		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SPRINGFIELD TERRACE# 0032961

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 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	(209)	0	0	0	0	0	0	0	0	0	0	(209)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	126	0	0	0	0	0	0	0	0	126	5
6	Maintenance	0	(9,984)	9,545	0	0	0	0	0	0	0	0	(439)	6
7	Other (specify):*	0	0	1	0	0	0	0	0	0	0	0	1	7
8	TOTAL General Services	(209)	(9,984)	9,672	0	(521)	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	(3,240)	190	0	0	0	0	0	0	0	0	(3,050)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	(3,720)	0	0	0	0	0	0	0	0	0	(3,720)	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	(6,960)	190	0	(6,770)	16							
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(74,614)	1,109	0	0	0	0	0	0	0	0	(73,505)	19
20	Fees, Subscriptions & Promotions	(680)	0	89	0	0	0	0	0	0	0	0	(591)	20
21	Clerical & General Office Expenses	(13,082)	0	32,365	0	0	0	0	0	0	0	0	19,283	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	186	0	0	0	0	0	0	0	0	186	23
24	Travel and Seminar	0	0	5,831	0	0	0	0	0	0	0	0	5,831	24
25	Other Admin. Staff Transportation	0	0	2,587	0	0	0	0	0	0	0	0	2,587	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(80)	0	7,490	0	0	0	0	0	0	0	0	7,410	27
28	TOTAL General Administration	(13,842)	(74,614)	49,657	0	(38,799)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(14,051)	(91,558)	59,519	0	(46,090)	29							

STATE OF ILLINOIS

Facility Name & ID Number SPRINGFIELD TERRACE# 0032961

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	939	0	33	18,709	0	0	0	0	0	0	0	19,681	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	71	42,237	0	0	0	0	0	0	0	42,308	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	4,255	(69,499)	0	0	0	0	0	0	0	(65,244)	34
35	Rent-Equipment & Vehicles	0	0	4,767	0	0	0	0	0	0	0	0	4,767	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	939	0	9,126	(8,553)	0	1,512	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)	(13,112)	(91,558)	68,645	(8,553)	0	0	0	0	0	0	0	(44,578)	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
		ARC OF JACKSONVILLE	JACKSONVILLE	MAVIN	SKOKIE, IL	CONSULTING,
SEE ATTACHED LIST		LITCHFIELD TERRACE	LITCHFIELD	ENTERPRISES, LTD		BOOKKEEPING
		VANDALIA TERRACE	VANDALIA	IDEA ASSOCIATES	SKOKIE, IL	REAL ESTATE
		GOLDEN MOMENTS	JACKSONVILLE			

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	6 MAINTENANCE CONSULTAN	\$ 9,984	MAVIN ENTERPRISES, LTD		\$	\$ (9,984)	1
2	V	10 PSYCHO-SOCIAL CONSULTANT	3,240				(3,240)	2
3	V	11 ACTIVITIES CONSULTANT	3,720				(3,720)	3
4	V	19 ADMIN./BKKP. FEES	68,134				(68,134)	4
5	V	19 ADMIN./CONSULT. FEES	6,480				(6,480)	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 91,558			\$	\$ *	(91,558) 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	5 ELECTRICITY/GAS	\$	MAVIN ENTERPRISES, LTD		\$ 126	\$	126	15
16	V	6 MAINTENANCE SALARIES				9,499		9,499	16
17	V	6 MAINTENANCE & REPAIR				46		46	17
18	V	7 SCAVENGER				1		1	18
19	V	10 PSYCHO-SOCIAL & NURSING CONSULT				190		190	19
20	V	19 PROFESSIONAL FEES				1,109		1,109	20
21	V	20 ADVERTISING				89		89	21
22	V	21 TOTAL OFFICE				32,365		32,365	22
23	V	23 SEMINARS				186		186	23
24	V	24 TRAVEL				5,831		5,831	24
25	V	25 TRANSPORTATION				2,587		2,587	25
26	V	27 EMPLOYEE BENEFITS				7,490		7,490	26
27	V	30 DEPRECIATION (SL)				33		33	27
28	V	32 INTEREST				71		71	28
29	V	34 OFFICE RENT				4,255		4,255	29
30	V	35 EQUIPMENT RENT				4,767		4,767	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		\$			\$ 68,645	\$ *	68,645	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	34 RENT	\$ 69,499	IDEA ASSOCIATES		\$ 18,709	\$ (69,499)
16	V	30 DEPRECIATION				42,237	18,709
17	V	32 INTEREST					42,237
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 69,499			\$ 60,946	\$ * (8,553)

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

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 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	MELVIN SIEGEL	PRESIDENT	ADMINISTR.	18.18	SEE			SALARY	\$ 17,250	17-1	1
2					ATTACHED						2
3					SCHEDULE						3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 17,250		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 SPRINGFIELD TERRACE

0032961 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 MAVIN ENTERPRISES, LTD
 Street Address 3845 OAKTON
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847)-679-0100
 Fax Number (847)-679-0647

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	ELECTRICITY/GAS	PATIENT DAYS	92,428	5	\$ 662	\$ 17,524	\$ 126	1
2	6	MAINTENANCE SALARIES	PATIENT DAYS	92,428	5	50,100	17,524	9,499	2
3	6	MAINTENANCE & REPAIR	PATIENT DAYS	92,428	5	241	17,524	46	3
4	7	SCAVENGER	PATIENT DAYS	92,428	5	6	17,524	1	4
5	10	PSYCHO-SOCIAL & NURSING	PATIENT DAYS	92,428	5	1,000	17,524	190	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	92,428	5	5,848	17,524	1,109	6
7	20	ADVERTISING	PATIENT DAYS	92,428	5	472	17,524	89	7
8	21	TOTAL OFFICE	PATIENT DAYS	92,428	5	170,703	132,625	32,365	8
9	23	SEMINARS	PATIENT DAYS	92,428	5	980	17,524	186	9
10	24	TRAVEL	PATIENT DAYS	92,428	5	30,753	17,524	5,831	10
11	25	TRANSPORTATION	PATIENT DAYS	92,428	5	13,644	17,524	2,587	11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	92,428	5	39,504	17,524	7,490	12
13	30	DEPRECIATION (SL)	PATIENT DAYS	92,428	5	173	17,524	33	13
14	32	INTEREST	PATIENT DAYS	92,428	5	375	17,524	71	14
15	34	OFFICE RENT	PATIENT DAYS	92,428	5	22,445	17,524	4,255	15
16	35	EQUIPMENT RENT	PATIENT DAYS	92,428	5	25,141	17,524	4,767	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 362,047	\$ 182,725		\$ 68,645	25

Facility Name & ID Number

SPRINGFIELD TERRACE

0032961

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	RELATED PARTY						\$	\$			\$	1						
2	IDEA ASSOCIATES											2						
3	BANK FINANCIAL			MORTGAGE	\$6,755.00	01/04	874,500	804,084			42,237	3						
4												4						
5	MGMT ALLOCATIONS										71	5						
	Working Capital																	
6	BANK FINANCIAL	X		LINE OF CREDIT	DEMAND	11/97	150,000	60,000		PRIME+	285	6						
7												7						
8												8						
9	TOTAL Facility Related				\$6,755.00		\$ 1,024,500	\$ 864,084			\$ 42,593	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 1,024,500	\$ 864,084			\$ 42,593	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 report.		\$	14,866	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.)		\$	15,375	2
3. Under or (over) accrual (line 2 minus line 1).		\$	509	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	15,529	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.		\$	16,038	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	14,372	8	
	2005	14,818	9	
	2006	15,053	10	
	2007	14,719	11	
	2008	15,375	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				
THE PAYMENT ON LINE 2 APPLIES TO THE 2008 TAX BILL				
		FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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:

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

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>15,375.20</u>	\$ <u>15,375.20</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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ 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. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>FACILITY</u>		<u>1987</u>	\$ <u>22,340</u>	1
2					2
3	TOTALS			\$ 22,340	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	65	1987		\$ 589,342	\$ 18,709	31.5	\$ 18,709	\$	\$ 359,090	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	VARIOUS		1991	3,905	124	20	196	72	3,504	9
10	VARIOUS		1992	8,184	260	20	409	149	6,795	10
11	VARIOUS		1993	750	19	20	38	19	573	11
12	VARIOUS		1994	540	13	20	27	14	419	12
13	DOOR		1997	1,086	27	20	54	27	671	13
14	SPRINKLER		1997	3,790	97	20	189	92	2,347	14
15	DECORATING		1997	2,281	58	20	114	56	1,425	15
16	EXHAUST SYTEM		1997	1,250	32	20	62	30	791	16
17	TILE		1997	1,944	49	20	97	48	1,261	17
18	TILE		1997	638	16	20	32	16	395	18
19	DOORS		1997	1,327	35	20	66	31	803	19
20	SPRINKLER		1997	705	18	20	35	17	429	20
21	SPRINKLER		1997	1,532	40	20	77	37	941	21
22	REWIRE & REPLACE SECURITY		1997	3,000	77	20	150	73	1,813	22
23	SPRINKLER		1998	2,138	56	20	107	51	1,230	23
24	DOORS		1998	1,896	49	20	95	46	1,092	24
25	SECURITY SYSTEM		1998	1,149	30	20	57	27	684	25
26	FLOOR TILE, LIGHTS		1999	1,468	38	20	73	35	803	26
27	SHINGLE ROOF		2000	26,800	974	27.5	974		9,562	27
28	NEW AIR CONDITIONERS		2000	2,255	82	27.5	82		805	28
29	FRONT DOOR WITH LOCK		2000	1,245	46	27.5	46		451	29
30	REPLACE 3 TON CONDENSING UNIT FOR LUNCH ROOM		2001	3,494	127	27.5	127		1,080	30
31	GUTTERS AND DOWNSPOUTS		2001	2,654	97	27.5	97		824	31
32	INSTALL ALPHA-NUURSE STATION, CENTRAL CONTROL		2007	15,568	566	27.5	566		1,580	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 **SPRINGFIELD TERRACE**

0032961

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)		\$ 678,941	\$ 21,639		\$ 22,479	\$ 840	\$ 399,368	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	\$ 6,685	\$ 379	\$ 478	\$ 99	5-10	\$ 4,437	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	68,342					68,342	73
74	MGMT ALLOCATIONS		33	33				74
75	TOTALS	\$ 75,027	\$ 412	\$ 511	\$ 99		\$ 72,779	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	FACILITY	1998 CHEVROLET VAN	1999	\$ 5,429	\$	\$	\$		\$ 5,429	76
77										77
78										78
79										79
80	TOTALS			\$ 5,429	\$	\$	\$		\$ 5,429	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)	\$ 781,737	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,051	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 22,990	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 939	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 477,576	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: N/A - RELATED PARTY

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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ \$ _____

13. _____ \$ _____

14. _____ \$ _____

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: \$ 4,102 Description: COPIER-\$2,381; DISHWASHER-\$959; ICE MACHINE-\$762

(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			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	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.

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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>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			36,849			36,849	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			\$		\$ 36,849	\$		\$ 36,849	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 **SPRINGFIELD TERRACE**# **0032961**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	\$ (24,418)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	302,574		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,039		6
7	Other Prepaid Expenses	48,756		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 346,951	\$	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	89,599		15
16	Equipment, at Historical Cost	80,455		16
17	Accumulated Depreciation (book methods)	(109,745)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 60,309	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 407,260	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 583,565	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,055,624		29
30	Accrued Salaries Payable	24,528		30
31	Accrued Taxes Payable (excluding real estate taxes)	246,130		31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,529		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)	\$ 1,925,376	\$	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)	\$ 1,925,376	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,518,116)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 407,260	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,663,763)	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	7,617	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,656,146)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	138,030	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)	\$ 138,030	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)	\$ (1,518,116)	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	\$ 1,649,621	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,649,621	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	53,781	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 53,781	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***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	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)	\$ 1,703,402	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	393,145	31
32	Health Care	619,271	32
33	General Administration	387,287	33
B. Capital Expense			
34	Ownership	93,233	34
C. Ancillary Expense			
35	Special Cost Centers	36,849	35
36	Provider Participation Fee	35,587	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,565,372	40
41	Income before Income Taxes (line 30 minus line 40)**	138,030	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 138,030	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.

*** 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 **SPRINGFIELD TERRACE**

0032961

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
2	Assistant Director of Nursing	1,880	2,100	48,970	23.32
3	Registered Nurses	1,074	1,130	22,961	20.32
4	Licensed Practical Nurses	8,768	9,202	156,435	17.00
5	CNAs & Orderlies	21,062	21,879	201,869	9.23
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants	1,925	1,950	17,409	8.93
11	Social Service Workers	3,434	3,567	54,721	15.34
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	9,805	10,280	92,715	9.02
16	Dishwashers				16
17	Maintenance Workers	1,738	1,959	19,284	9.84
18	Housekeepers	5,104	5,484	47,090	8.59
19	Laundry	2,378	2,456	20,121	8.19
20	Administrator	1,968	2,080	45,965	22.10
21	Assistant Administrator				21
22	Other Administrative	550	550	17,250	31.36
23	Office Manager				23
24	Clerical	1,522	1,722	28,372	16.48
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health C: Care Plan Coord	1,414	1,688	31,525	18.68
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	62,622	66,047	\$ 804,687 *	\$ 12.18

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 6,201	1-3	35
36	Medical Director	O	17,700	9-3	36
37	Medical Records Consultant	N	156	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	780	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	3,605	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)		\$ 28,442		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		N/A		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	
JUDITH BORROR	ADMINISTRATOR	0	\$ 45,965	Workers' Compensation Insurance	\$ 29,927	IDPH License Fee	\$	
MELVIN SIEGEL	PRESIDENT	18.18	17,250	Unemployment Compensation Insurance	31,612	Advertising: Employee Recruitment	1,840	
				FICA Taxes	64,059	Health Care Worker Background Check	820	
				Employee Health Insurance	4,740	(Indicate # of checks performed <u>82</u>)		
				Employee Meals	0	Patient Background Checks <u>27</u>	270	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	680	
				EMPLOYEE BENEFITS - OTHER	450	MARKETING/ADV/PROMO	0	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	9,353	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	89	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(680)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(0)	
						Yellow page advertising	(0)	
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)	
\$ 63,215				\$ 130,788			\$ 12,372	
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
			\$ 0			\$	Out-of-State Travel	\$
							In-State Travel	
								0
							MGMT CO ALLOC	5,831
							Seminar Expense	
								340
							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)	
\$				\$			\$ 6,171	
C. Professional Services								
Vendor/Payee	Type		Amount					
NURSING CARE SYATEMS	DATA PROCESSING		\$ 4,504					
ALPHA DATA SERVICES	DATA PROCESSING		2,929					
LTC SOLUTIONS, INC	DATA PROCESSING		1,500					
KOPEC & WHITE	LEGAL FEES		2,794					
KRUPNICK, BOKOR,KAGDA	ACCOUNTING FEES		6,200					
PERSONNEL PLANNERS	UC CONSULTANT		1,609					
MAVIN ENTERPRISES	BOOKKEEPING/ADMIN		49,430					
MAVIN ENTERPRISES	ADMIN. CONSULTANT		6,480					
BURDZINSKI & PARTNERS	LEGAL FEES		12,151					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ 87,597								

* Attach copy of IMRF notifications

**See instructions.

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

1	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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8						N/A						
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number SPRINGFIELD TERRACE# 0032961Report Period Beginning: 01/01/2009Ending: 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. IL COUNCIL ON LONG TERM CARE \$9,350
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (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. \$ _____ 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 X 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. \$ 35,587
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: _____
- (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.