

Facility Name & ID Number THE TERRACE NH

0048397 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	65	Skilled (SNF)	65	23,725	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	115	41,975	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,540	676	4,928	8,144	8
9	SNF/PED					9
10	ICF	27,490	5,076	93	32,659	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,030	5,752	5,021	40,803	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.21%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 11/01/06

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

YES Date 11/01/06 NO

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

YES NO If YES, enter number

of beds certified 22 and days of care provided 4,928

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number

THE TERRACE NH

0048397

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	222,866	13,218	7,662	243,746		243,746		243,746		1
2	Food Purchase		211,169		211,169		211,169	(781)	210,388		2
3	Housekeeping	169,908	30,020		199,928		199,928	3,561	203,489		3
4	Laundry	66,166	18,258	5,438	89,862		89,862		89,862		4
5	Heat and Other Utilities			96,546	96,546		96,546	293	96,839		5
6	Maintenance	36,411	35,807	39,990	112,208		112,208	4,434	116,642		6
7	Other (specify):*			14,362	14,362		14,362	55	14,417		7
8	TOTAL General Services	495,351	308,472	163,998	967,821		967,821	7,562	975,383		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,224,305	91,111	16,714	2,332,130		2,332,130		2,332,130		10
10a	Therapy	119,241		1,102	120,343		120,343		120,343		10a
11	Activities	108,663	8,877		117,540		117,540		117,540		11
12	Social Services			1,871	1,871		1,871		1,871		12
13	CNA Training										13
14	Program Transportation			1,126	1,126		1,126		1,126		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,452,209	99,988	38,813	2,591,010		2,591,010		2,591,010		16
	C. General Administration										
17	Administrative	75,000		74,272	149,272		149,272	(8,543)	140,729		17
18	Directors Fees										18
19	Professional Services			64,612	64,612		64,612	(13,175)	51,437		19
20	Dues, Fees, Subscriptions & Promotions			34,354	34,354		34,354	(24,676)	9,678		20
21	Clerical & General Office Expenses	141,297	20,768	55,328	217,393		217,393	(9,861)	207,532		21
22	Employee Benefits & Payroll Taxes			538,001	538,001		538,001		538,001		22
23	Inservice Training & Education							9	9		23
24	Travel and Seminar			1,542	1,542		1,542		1,542		24
25	Other Admin. Staff Transportation			10,942	10,942		10,942	505	11,447		25
26	Insurance-Prop.Liab.Malpractice			66,627	66,627		66,627	812	67,439		26
27	Other (specify):*			192,586	192,586		192,586	(184,413)	8,173		27
28	TOTAL General Administration	216,297	20,768	1,038,264	1,275,329		1,275,329	(239,342)	1,035,987		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,163,857	429,228	1,241,075	4,834,160		4,834,160	(231,780)	4,602,380		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	5,940
	REPAIRS & MAINTENANCE	1,722
		0
		7,662
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	5,438
		0
		5,438
5	HEAT & OTHER UTILITIES	
	GAS HEAT	36,220
	ELECTRICITY	40,916
	WATER	19,301
	CABLE TV - LOBBY	109
		0
		96,546
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,095
	PAINTING & DECORATING	747
	BUILDING REPAIRS	14,738
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	9,956
	ELEVATOR MAINTENANCE & REPAIR	3,378
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,649
	FIRE SERVICE	4,427
		0
		0
		0
		0
		39,990
7	OTHER	
	SCAVENGER	14,074
	SECURITY SERVICE	288
		0
		0
		14,362
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	18,000
		18,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	7,414
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,320
	PHARMACY CONSULTANT XVIII B 39-2	4,980
	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
		16,714
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	987
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	115
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		1,102
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	1,871
	SOCIAL WORKER XVIII B 45-2	0
		0
		1,871
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	1,126
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	74,272
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	20,179
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	44,433
		0
		64,612
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	8,040
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	500
	DUES & SUBSCRIPTIONS XIX F	6,565
	LICENSES & PERMITS XIX F	1,041
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	14,574
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,634
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		34,354
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	845
	EQUIPMENT REPAIR & MAINTENANCE	7,924
	OUTSIDE CLERICAL SERVICES	30,000
	PENALTIES / OVERDRAFT CHARGES VI 18	50
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	16,509
	MESSENGER SERVICE	0
		0
		55,328

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	235,646
	UNEMPLOYMENT COMPENSATION XIX D	16,197
	WORKERS COMPENSATION INSURANCE XIX D	50,314
	HOSPITALIZATION INSURANCE XIX D	207,025
	EMPLOYEE BENEFITS - OTHER XIX D	929
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	27,890
	CHICAGO HEAD TAX XIX D	0
		0
		538,001
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,542
	TRAVEL XIX G	0
		1,542
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	10,942
		10,942
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	66,627
		66,627
27	OTHER	
	BAD DEBTS VI 24	192,586
		192,586

GRAND TOTAL COLUMN 3 OTHER 1,241,075

**THE TERRACE NH
SCHEDULES
12/31/2009**

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

TOTAL FOOD PURCHASE	211,169
LESS SALES TAX	<u>(781)</u>
NET FOOD	210,388
TOTAL PATIENT CENSUS	40,803
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	122,409
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	122,409
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	122,409
NET FOOD	210,388
DIVIDE TOTAL MEALS/YEAR	<u>122,409</u>
COST PER MEAL	1.72
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0
	=====

Facility Name & ID Number

THE TERRACE NH

#0048397

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			5,607	5,607		5,607	(609)	4,998			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,044	12,044		12,044	(5,180)	6,864			32
33	Real Estate Taxes			85,271	85,271		85,271	1,147	86,418			33
34	Rent-Facility & Grounds			588,916	588,916		588,916		588,916			34
35	Rent-Equipment & Vehicles			66,167	66,167		66,167	1,107	67,274			35
36	Other (specify):* IME			8,970	8,970		8,970	(8,970)				36
37	TOTAL Ownership			766,975	766,975		766,975	(12,505)	754,470			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		144,654	408,451	553,105		553,105		553,105			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,963	62,963		62,963		62,963			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		144,654	471,414	616,068		616,068		616,068			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,163,857	573,882	2,479,464	6,217,203		6,217,203	(244,285)	5,972,918			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,561)	30		9
10	Interest and Other Investment Income	(6,657)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(781)	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	(50)	21		18
19	Entertainment		20		19
20	Contributions	(4,134)	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	(192,586)	27		24
25	Fund Raising, Advertising and Promotional	(8,040)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(14,574)	20		28
29	Other-Attach Schedule	(18,967)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (247,350)		\$	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)	3,065		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 3,065		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (244,285)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

THE TERRACE NH

ID# 0048397

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 6	6	1
2	MARKETING AUTO LEASE	(1,177)	35	2
3	OTHER PROFESSIONAL FEES	(17,790)	19	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	(18,967)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE TERRACE NH

0048397

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	(781)	0	0	0	0	0	0	0	0	0	0	(781)	2
3	Housekeeping	0	0	3,561	0	0	0	0	0	0	0	0	3,561	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	293	0	0	0	0	0	0	293	5
6	Maintenance	0	0	1,250	1,833	1,351	0	0	0	0	0	0	4,434	6
7	Other (specify):*	0	0	41	0	14	0	0	0	0	0	0	55	7
8	TOTAL General Services	(781)	0	4,852	1,833	1,658	0	0	0	0	0	0	7,562	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	2,300	5,538	(16,381)	0	0	0	0	0	0	0	(8,543)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(17,790)	53	4,189	330	43	0	0	0	0	0	0	(13,175)	19
20	Fees, Subscriptions & Promotions	(26,748)	0	2,050	0	22	0	0	0	0	0	0	(24,676)	20
21	Clerical & General Office Expenses	(50)	0	(14,361)	4,543	7	0	0	0	0	0	0	(9,861)	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	9	0	0	0	0	0	0	0	0	9	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	347	158	0	0	0	0	0	0	0	505	25
26	Insurance-Prop.Liab.Malpractice	0	0	138	596	78	0	0	0	0	0	0	812	26
27	Other (specify):*	(192,586)	0	2,988	5,185	0	0	0	0	0	0	0	(184,413)	27
28	TOTAL General Administration	(237,174)	2,353	898	(5,569)	150	0	0	0	0	0	0	(239,342)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(237,955)	2,353	5,750	(3,736)	1,808	0	0	0	0	0	0	(231,780)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE TERRACE NH# 0048397

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

	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	(1,561)	0	84	37	831	0	0	0	0	0	0	(609)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,657)	0	0	0	1,477	0	0	0	0	0	0	(5,180)	32
33	Real Estate Taxes	0	0	0	0	1,147	0	0	0	0	0	0	1,147	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(1,177)	0	1,617	301	366	0	0	0	0	0	0	1,107	35
36	Other (specify):*	0	0	0	0	(8,970)	0	0	0	0	0	0	(8,970)	36
37	TOTAL Ownership	(9,395)	0	1,701	338	(5,149)	0	0	0	0	0	0	(12,505)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(247,350)	2,353	7,451	(3,398)	(3,341)	0	0	0	0	0	0	(244,285)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
PHILIP ESFORMES	48			6865 FINANCIAL INC	LINCOLNWOOD	MANAGEMENT
AVRUM WEINFELD	2				LINCOLNWOOD	
RIVKIE LAFER	1	SEE ATTACHED SCHEDULE		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
RACHEL ESFORMES	1			EMI ENTERPRISES	LINCOLNWOOD	MANAGEMENT
MORRIS ESFORMES	48			IME REALTY	LINCOLNWOOD	HOME OFFICE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 MANAGEMENT FEES	\$ 74,272	6865 FINANCIAL INC		\$	\$ (74,272)	1
2	V	17 EMI ENTERPRISES				29,989	29,989	2
3	V	17 PHILIP ESFORMES INC				35,442	35,442	3
4	V	17 DANIEL WEISS				2,272	2,272	4
5	V	17 AVRUM WEINFELD				8,869	8,869	5
6	V	19 ACCOUNTING FEES				53	53	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 74,272			\$ 76,625	\$ * 2,353	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21	OUTSIDE CLERICAL	\$ 30,000	EKS MANAGEMENT		\$ (30,000)
16	V	3	HOUSEKEEPING SALARIES			3,561	3,561
17	V	6	PAINTER SALARIES			1,250	1,250
18	V	7	SCAVENGER			41	41
19	V	17	CFO SALARY - A. WEINFELD			5,538	5,538
20	V	19	PROFESSIONAL FEES			4,189	4,189
21	V	20	WANT ADS/BACKGR CKS			2,050	2,050
22	V	21	OFFICE			15,639	15,639
23	V	23	SEMINARS			9	9
24	V	25	TRANSPORTATION			347	347
25	V	26	INSURANCE			138	138
26	V	27	EMPLOYEE BENEFITS			2,988	2,988
27	V	30	DEPRECIATION (SL)			84	84
28	V	35	EQUIPMENT RENT			1,617	1,617
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 30,000			\$ 37,451	\$ * 7,451

* 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	\$ 29,989	EMI MANAGEMENT		\$	\$ (29,989)
16	V	6 DRIVERS' SALARY				1,833	1,833
17	V	17 OFFICER SALARY				9,393	9,393
18	V	17 REGIONAL DIRECTOR				4,215	4,215
19	V	19 ACCOUNTING FEES				330	330
20	V	21 OFFICE				4,543	4,543
21	V	25 TRANSPORTATION				158	158
22	V	26 INSURANCE				596	596
23	V	27 EMPLOYEE BENEFITS				5,185	5,185
24	V	30 DEPRECIATION S/L				37	37
25	V	35 AUTO LEASE				301	301
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		\$ 29,989			\$ 26,591	\$ * (3,398)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	36 OFFICE RENT	\$ 8,970	IME REALTY		\$	\$ (8,970)
16	V	5 UTILITIES				293	293
17	V	6 PAINTERS FEES				590	590
18	V	6 REPAIRS / MAINT				761	761
19	V	7 ALARM SERVICE				14	14
20	V	19 PROFESSIONAL FEES				43	43
21	V	21 OFFICE EXPENSE				7	7
22	V	26 INSURANCE				78	78
23	V	30 DEPRECIATION				831	831
24	V	32 INTEREST				1,477	1,477
25	V	33 R/E TAX				1,147	1,147
26	V	35 STORAGE FEES				366	366
27	V	20 LICENSES & PERMITS				22	22
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 8,970			\$ 5,629	\$ * (3,341)

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

Facility Name & ID Number

THE TERRACE NH

#

0048397

Report Period Beginning:

01/01/2009

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		ADMINISTRATIVE					COMP EMI	\$ 9,393	17-7	1
2								ADM CONS		19-3	2
3	PHILIP ESFORMES		ADMINISTRATIVE					COMP 6865	35,442	17-7	3
4											4
5	DANIEL WEISS		ADMINISTRATIVE		SEE			COMP 6865	2,272	17-7	5
6					ATTACHED						6
7	AVRUM WEINFELD		ADMINISTRATIVE		SCHEDULE			COMP 6865	8,869	17-7	7
8								COMP EKS	5,538	17-7	8
9	FLORA WEISS		CLERICAL					COMP EKS	806	21-7	9
10											10
11											11
12											12
13								TOTAL	\$ 62,320		13

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

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

Facility Name & ID Number THE TERRACE NH

0048397

Report Period Beginning:

01/01/2009

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	EMI ENTERPRISES	PATIENT DAYS	538,796	10	\$ 396,000	\$ 40,803	\$ 29,989	1
2	17	PHILIP ESFORMES INC	PATIENT DAYS	538,796	10	468,000	468,000	40,803	35,442
3	17	DANIEL WEISS	PATIENT DAYS	538,796	10	30,000	30,000	40,803	2,272
4	17	AVRUM WEINFELD	PATIENT DAYS	538,796	10	117,111	117,111	40,803	8,869
5	19	ACCOUNTING FEES	PATIENT DAYS	538,796	10	700	40,803	53	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,011,811	\$ 615,111	\$ 76,625	25

Facility Name & ID Number THE TERRACE NH

0048397

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	3	HOUSEKEEPING SALARIES	PATIENT DAYS	847,051	14	\$ 73,923	\$ 73,923	40,803	\$ 3,561	1
2	6	PAINTERS' SALARIES	PATIENT DAYS	847,051	14	25,953	25,953	40,803	1,250	2
3	7	SCAVENGER	PATIENT DAYS	847,051	14	842		40,803	41	3
4	17	CFO SALARY - A. WEINFELD	PATIENT DAYS	847,051	14	114,971	114,971	40,803	5,538	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	847,051	14	86,967	74,170	40,803	4,189	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	847,051	14	42,556		40,803	2,050	6
7	21	OFFICE EXPENSE	PATIENT DAYS	847,051	14	324,660	246,961	40,803	15,639	7
8	23	SEMINAR	PATIENT DAYS	847,051	14	190		40,803	9	8
9	25	TRANSPORTATION	PATIENT DAYS	847,051	14	7,194		40,803	347	9
10	26	INSURANCE	PATIENT DAYS	847,051	14	2,872		40,803	138	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	62,031		40,803	2,988	11
12	30	DEPRECIATION S.L	PATIENT DAYS	847,051	14	1,757		40,803	84	12
13	35	EQUIPMENT RENT	PATIENT DAYS	847,051	14	33,562		40,803	1,617	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	\$ 535,978		\$ 37,451	25

Facility Name & ID Number THE TERRACE NH

0048397

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

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

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

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' SALARY	PATIENT DAYS	847,051	14	\$ 38,060	\$ 38,060	40,803	\$ 1,833	1
2	17	OFFICER SALARY	PATIENT DAYS	847,051	14	195,000	195,000	40,803	9,393	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	847,051	14	87,500	87,500	40,803	4,215	3
4	19	ACCOUNTING FEES	PATIENT DAYS	847,051	14	6,850		40,803	330	4
5	21	OFFICE	PATIENT DAYS	847,051	14	94,319	58,251	40,803	4,543	5
6	25	TRANSPORTATION	PATIENT DAYS	847,051	14	3,276		40,803	158	6
7	26	INSURANCE	PATIENT DAYS	847,051	14	12,367		40,803	596	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	107,628		40,803	5,185	8
9	30	DEPRECIATION S/L	PATIENT DAYS	847,051	14	765		40,803	37	9
10	35	AUTO LEASE	PATIENT DAYS	847,051	14	6,253		40,803	301	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		\$ 26,591	25

Facility Name & ID Number THE TERRACE NH

0048397 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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	187,059	14	\$ 6,106	\$ 8,970	\$ 293	1
2	6	PAINTERS FEES	INCOME	187,059	14	12,303	8,970	590	2
3	6	REPAIRS / MAINT	INCOME	187,059	14	15,863	8,970	761	3
4	7	ALARM SERVICE	INCOME	187,059	14	301	8,970	14	4
5	19	PROFESSIONAL FEES	INCOME	187,059	14	897	8,970	43	5
6	21	OFFICE EXPENSE	INCOME	187,059	14	136	8,970	7	6
7	26	INSURANCE	INCOME	187,059	14	1,627	8,970	78	7
8	30	DEPRECIATION	INCOME	187,059	14	17,336	8,970	831	8
9	32	INTEREST	INCOME	187,059	14	30,806	8,970	1,477	9
10	33	R/E TAX	INCOME	187,059	14	23,914	8,970	1,147	10
11	35	STORAGE FEES	INCOME	187,059	14	7,635	8,970	366	11
12	20	LICENSES & PERMITS	INCOME	187,059	14	468	8,970	22	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	\$	\$ 5,629	25

Facility Name & ID Number

THE TERRACE NH

0048397

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	2	3	4	5	6		8	9	10		
					Amount of Note						
					Original	Balance					
Name of Lender	Related** YES NO	Purpose of Loan	Monthly Payment Required	Date of Note	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
A. Directly Facility Related											
Long-Term											
1						\$			\$	1	
2										2	
3										3	
4									1,477	4	
5										5	
Working Capital											
6		X	WORKING CAPITAL	INTEREST	REVOLV			REVOLD	PRIMES+	12,044	6
7										7	
8										8	
9						\$			\$	13,521	9
B. Non-Facility Related*											
10		X	LATE FEES							10	
11										11	
12										12	
13										13	
14						\$			\$	14	
15						\$			\$	13,521	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.		\$	76,757	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.)		\$	81,014	2
3. Under or (over) accrual (line 2 minus line 1).		\$	4,257	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	81,014	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.		\$	85,271	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	73,219	8
	2005	74,497	9
	2006	76,451	10
	2007	76,756	11
	2008	81,014	12

	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THE TERRACE NH COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0048397

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2008 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2008.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>08-08-403-011</u>	<u>NURSING HOME</u>	\$ <u>81,013.87</u>	\$ <u>81,013.87</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>81,013.87</u>	\$ <u>81,013.87</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 THE TERRACE NH

0048397

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,000 B. General Construction Type: Exterior BRICK Frame MASONRY/STEEL Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

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

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7	RELATED PARTY			26,461	798	39	798		
8	HOME OFFICE								
Improvement Type**									
9	DOORS		2007	16,876	614	27.5	614		1,509
10	RAIL GUARDS & KICK PLATES		2007	11,890	432	27.5	432		882
11	DRYWALL STAIRWELLS & 2ND FL CORRIDOR		2009	21,652	295	27.5	295		295
12	INSTALL 5 TON CONDENSER		2009	3,732	51	27.5	51		51
13	ANNUNCIATOR & CONYTOI PANEL		2009	9,457	129	27.5	129		129
14	COMPRESSOR & 275 AMP CONTRACTOR		2009	9,893	135	27.5	135		135
15	SIDEWALK & EMERGENCY EXIT LIGHTING		2009	3,600	120	15	120		120
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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 THE TERRACE NH

0048397

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)	\$ 103,561	\$ 2,574		\$ 2,574	\$	\$ 3,121	70

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

Facility Name & ID Number THE TERRACE NH

0048397

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	\$ 22,697	\$ 3,831	\$ 2,270	\$ (1,561)	10 YRS	\$ 4,323	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY		154	154				74
75	TOTALS	\$ 22,697	\$ 3,985	\$ 2,424	\$ (1,561)		\$ 4,323	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	2	
	Reference	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)	\$ 126,258	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 6,559	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 4,998	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,561)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,444	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.

Facility Name & ID Number THE TERRACE NH

STATE OF ILLINOIS
0048397

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: GRANITE WAUKEGAN TERRACE, LLC

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>115</u>	<u>11/01/06</u>	\$ <u>588,916</u>	<u>5.5</u>	<u>5</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		115		\$ 588,916			7

10. Effective dates of current rental agreement:

Beginning 10/01/09

Ending 04/30/12

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

Fiscal Year Ending Annual Rent

12.	<u> /2010</u>	\$ <u> </u>
13.	<u> /2011</u>	\$ <u> </u>
14.	<u> /2012</u>	\$ <u> </u>

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?

16. Rental Amount for movable equipment: \$ 43,009 Description: YES NO 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>PAINTERS</u>	<u>2006 CHRYSLER T&C</u>	\$ <u>645.00</u>	\$ <u>645</u>	17
18	<u>ADMINISTRATOR</u>	<u>2006 JEEP CHEROKEE</u>	<u>499.00</u>	<u>5,988</u>	18
19	<u>MARKETING</u>	<u>2006 MERCEDES BENZ</u>	<u>#####</u>	<u>1,177</u>	19
20	<u>FACILITY</u>	<u>2007 FORD E350 WAGON</u>	<u>#####</u>	<u>15,348</u>	20
21	TOTAL		\$ #####	\$ 23,158	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.

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?</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><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service	Cost	Units						Cost	
					Units	Cost						
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	180,067	\$	180,067	1		
2	Licensed Speech and Language Development Therapist	39-3	hrs				14,005		14,005	2		
3	Licensed Recreational Therapist		hrs							3		
4	Licensed Physical Therapist	39-3	hrs				214,379		214,379	4		
5	Physician Care		visits							5		
6	Dental Care		visits							6		
7	Work Related Program		hrs							7		
8	Habilitation		hrs							8		
9	Pharmacy	39-2	# of prescripts				138,188		138,188	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10		
11	Academic Education		hrs							11		
12	Other (specify): <u>supplies,radiology,lab</u>	39-2					6,466		6,466	12		
13	Other (specify): _____									13		
14	TOTAL			\$		\$	408,451	\$	144,654	\$	553,105	14

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

Facility Name & ID Number THE TERRACE NH

0048397

Report Period Beginning: 01/01/2009

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	\$ 88,771	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (270,000))	434,838		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	115,564		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	65,180		8
9	Other(specify): <u>Real Estate tax escrow</u>	39,519		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 743,872	\$	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	77,100		15
16	Equipment, at Historical Cost	22,697		16
17	Accumulated Depreciation (book methods)	(20,072)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	95,947		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 175,672	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 919,544	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 369,432	\$	26
27	Officer's Accounts Payable	14,135		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	108,882		30
31	Accrued Taxes Payable (excluding real estate taxes)	42,148		31
32	Accrued Real Estate Taxes(Sch.IX-B)	81,014		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)	\$ 615,611	\$	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)	\$ 615,611	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 303,933	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 919,544	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 401,534	1
2	Restatements (describe):		2
3	ROUNDING	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 401,532	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	275,231	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	(372,830)	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)	\$ (97,599)	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)	\$ 303,933	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number THE TERRACE NH

0048397

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	\$ 6,166,099	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,166,099	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	319,678	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 319,678	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***	6,657	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,657	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,492,434	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	967,821	31
32	Health Care	2,591,010	32
33	General Administration	1,275,329	33
B. Capital Expense			
34	Ownership	766,975	34
C. Ancillary Expense			
35	Special Cost Centers	553,105	35
36	Provider Participation Fee	62,963	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,217,203	40
41	Income before Income Taxes (line 30 minus line 40)**	275,231	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 275,231	43

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

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

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

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

Facility Name & ID Number THE TERRACE NH

0048397

Report Period Beginning:

01/01/2009

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	3,824	4,160	\$ 117,696	\$ 28.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	31,318	33,411	963,241	28.83	3
4	Licensed Practical Nurses	4,260	4,338	100,040	23.06	4
5	CNAs & Orderlies	80,897	86,885	972,590	11.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,708	11,667	119,241	10.22	8
9	Activity Director					9
10	Activity Assistants	7,837	8,428	108,663	12.89	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,554	24,287	222,866	9.18	15
16	Dishwashers					16
17	Maintenance Workers	2,505	2,671	36,411	13.63	17
18	Housekeepers	17,983	19,247	169,908	8.83	18
19	Laundry	6,609	7,224	66,166	9.16	19
20	Administrator	1,936	2,080	75,000	36.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,969	12,083	141,297	11.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,602	1,727	16,079	9.31	31
32	Other Health C: MDS	1,952	2,064	54,659	26.48	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	204,954	220,272	\$ 3,163,857 *	\$ 14.36	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 5,940	1-3	35
36	Medical Director	O	18,000	9-3	36
37	Medical Records Consultant	N	4,320	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,980	10-3	39
40	Physical Therapy Consultant	L	115	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	0	11-3	44
45	Social Service Consultant	E	1,871	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 35,226		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

Facility Name & ID Number THE TERRACE NH

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

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	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$4,488
- (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. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
TERRACE NURSING HOME, LLC 00043943 11/1/06
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 62,963
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 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.