

Facility Name & ID Number WEST CHICAGO TERRACE

0048405 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	120	Intermediate (ICF)	120	43,800	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	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					8
9	SNF/PED					9
10	ICF	39,896	1,641		41,537	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,896	1,641		41,537	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.83%

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

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

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

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

NONE

F. Does the facility maintain a daily midnight census?

YES

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

YES NO

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

YES NO

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

Date started 11/01/2006

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

YES Date 11/01/2006 NO

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

WEST CHICAGO TERRACE

0048405

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	156,658	13,467	11,880	182,005		182,005		182,005		1
2	Food Purchase		192,564		192,564		192,564	(484)	192,080		2
3	Housekeeping	165,550	18,057		183,607		183,607		183,607		3
4	Laundry	64,743	10,774		75,517		75,517	3,627	79,144		4
5	Heat and Other Utilities			111,496	111,496		111,496	306	111,802		5
6	Maintenance	134,224	31,148	25,495	190,867		190,867	4,550	195,417		6
7	Other (specify):*			15,527	15,527		15,527	56	15,583		7
8	TOTAL General Services	521,175	266,010	164,398	951,583		951,583	8,055	959,638		8
	B. Health Care and Programs										
9	Medical Director			19,000	19,000		19,000		19,000		9
10	Nursing and Medical Records	1,312,013	34,992	9,360	1,356,365		1,356,365		1,356,365		10
10a	Therapy	152,213			152,213		152,213		152,213		10a
11	Activities	89,671		3,762	93,433		93,433		93,433		11
12	Social Services	28,592		3,999	32,591		32,591		32,591		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,582,489	34,992	36,121	1,653,602		1,653,602		1,653,602		16
	C. General Administration										
17	Administrative	93,935		28,830	122,765		122,765	124,908	247,673		17
18	Directors Fees										18
19	Professional Services			49,624	49,624		49,624	3,144	52,768		19
20	Dues, Fees, Subscriptions & Promotions			15,115	15,115		15,115	(5,330)	9,785		20
21	Clerical & General Office Expenses	153,401	20,196	88,532	262,129		262,129	(52,814)	209,315		21
22	Employee Benefits & Payroll Taxes			253,802	253,802		253,802		253,802		22
23	Inservice Training & Education			3,900	3,900		3,900	9	3,909		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			10,450	10,450		10,450	513	10,963		25
26	Insurance-Prop.Liab.Malpractice			55,019	55,019		55,019	829	55,848		26
27	Other (specify):*			75,600	75,600		75,600	(67,280)	8,320		27
28	TOTAL General Administration	247,336	20,196	580,872	848,404		848,404	3,979	852,383		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,351,000	321,198	781,391	3,453,589		3,453,589	12,034	3,465,623		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	11,880
	REPAIRS & MAINTENANCE	0
		0
		11,880
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	24,771
	ELECTRICITY	36,545
	WATER	50,180
	CABLE TV - LOBBY	0
		0
		111,496
6	MAINTENANCE	
	GROUNDS MAINTENANCE	8,127
	PAINTING & DECORATING	604
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	9,141
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,583
	FIRE SERVICE	4,040
		0
		0
		0
		0
		25,495
7	OTHER	
	SCAVENGER	15,227
	SECURITY SERVICE	300
		0
		0
		15,527
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	19,000
		19,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	5,760
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL CONSULTANT	3,600
		0
		9,360
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,762
		0
		3,762
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,999
		0
		3,999
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	28,830
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	16,048
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	33,576
		0
		49,624
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	3,022
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	500
	DUES & SUBSCRIPTIONS XIX F	5,511
	LICENSES & PERMITS XIX F	2,120
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	380
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,537
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	45
	PATIENT BACKGROUND CHECKS XIX F	0
		15,115
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	858
	EQUIPMENT REPAIR & MAINTENANCE	714
	OUTSIDE CLERICAL SERVICES	66,000
	PENALTIES / OVERDRAFT CHARGES VI 18	3,241
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	304
	TELEPHONE	17,415
	MESSENGER SERVICE	0
		0
		88,532

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	178,511
	UNEMPLOYMENT COMPENSATION XIX D	11,765
	WORKERS COMPENSATION INSURANCE XIX D	27,205
	HOSPITALIZATION INSURANCE XIX D	21,134
	EMPLOYEE BENEFITS - OTHER XIX D	0
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	15,187
	CHICAGO HEAD TAX XIX D	0
		0
		253,802
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	3,900
		3,900
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	10,450
		10,450
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	55,019
		55,019
27	OTHER	
	BAD DEBTS VI 24	75,600
		75,600

GRAND TOTAL COLUMN 3 OTHER 781,391

**WEST CHICAGO TERRACE
SCHEDULES
12/31/2009**

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

TOTAL FOOD PURCHASE	192,564
LESS SALES TAX	<u>(484)</u>
NET FOOD	192,080

TOTAL PATIENT CENSUS	41,537
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	124,611

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

PATIENT MEALS	124,611
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	124,611

NET FOOD	192,080
DIVIDE TOTAL MEALS/YEAR	<u>124,611</u>

COST PER MEAL	1.54
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0
	=====

Facility Name & ID Number

WEST CHICAGO TERRACE

#0048405

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			8,148	8,148		8,148	(2,192)	5,956			30
31	Amortization of Pre-Op. & Org.			500	500		500		500			31
32	Interest			15,709	15,709		15,709	(23,638)	(7,929)			32
33	Real Estate Taxes			104,352	104,352		104,352	1,197	105,549			33
34	Rent-Facility & Grounds			457,491	457,491		457,491		457,491			34
35	Rent-Equipment & Vehicles			48,739	48,739		48,739	2,332	51,071			35
36	Other (specify):* IME			9,360	9,360		9,360	(9,360)				36
37	TOTAL Ownership			644,299	644,299		644,299	(31,661)	612,638			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			65,700	65,700		65,700		65,700			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,351,000	321,198	1,491,390	4,163,588		4,163,588	(19,627)	4,143,961			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	(3,184)	30		9
10	Interest and Other Investment Income	(25,179)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(484)	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	(3,241)	21		18
19	Entertainment		20		19
20	Contributions	(4,037)	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	(75,600)	27		24
25	Fund Raising, Advertising and Promotional	(3,022)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(380)	20		28
29	Other-Attach Schedule	(5,723)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (120,850)		\$	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)	101,223		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 101,223		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (19,627)		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

ID# 0048405
Report Period Beginning: 01/01/2009
Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	MARKETING SALARY	\$ -4125	21	1
2	NON ALLOWABLE PROFESSIONAL FEES	(1,598)	19	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(5,723)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WEST CHICAGO TERRACE

0048405

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	(484)	0	0	0	0	0	0	0	0	0	0	(484)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	3,627	0	0	0	0	0	0	0	0	3,627	4
5	Heat and Other Utilities	0	0	0	306	0	0	0	0	0	0	0	306	5
6	Maintenance	0	0	1,273	1,410	1,867	0	0	0	0	0	0	4,550	6
7	Other (specify):*	0	0	41	15	0	0	0	0	0	0	0	56	7
8	TOTAL General Services	(484)	0	4,941	1,731	1,867	0	0	0	0	0	0	8,055	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	105,415	5,639	0	13,854	0	0	0	0	0	0	124,908	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,598)	94	4,267	45	336	0	0	0	0	0	0	3,144	19
20	Fees, Subscriptions & Promotions	(7,439)	0	2,086	23	0	0	0	0	0	0	0	(5,330)	20
21	Clerical & General Office Expenses	(7,366)	0	(50,080)	7	4,625	0	0	0	0	0	0	(52,814)	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	352	0	161	0	0	0	0	0	0	513	25
26	Insurance-Prop.Liab.Malpractice	0	0	142	81	606	0	0	0	0	0	0	829	26
27	Other (specify):*	(75,600)	0	3,042	0	5,278	0	0	0	0	0	0	(67,280)	27
28	TOTAL General Administration	(92,003)	105,509	(34,543)	156	24,860	0	0	0	0	0	0	3,979	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(92,487)	105,509	(29,602)	1,887	26,727	0	0	0	0	0	0	12,034	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WEST CHICAGO TERRACE# 0048405

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	(3,184)	0	87	867	38	0	0	0	0	0	0	(2,192)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25,179)	0	0	1,541	0	0	0	0	0	0	0	(23,638)	32
33	Real Estate Taxes	0	0	0	1,197	0	0	0	0	0	0	0	1,197	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	1,644	382	306	0	0	0	0	0	0	2,332	35
36	Other (specify):*	0	0	0	(9,360)	0	0	0	0	0	0	0	(9,360)	36
37	TOTAL Ownership	(28,363)	0	1,731	(5,373)	344	0	0	0	0	0	0	(31,661)	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)	(120,850)	105,509	(27,871)	(3,486)	27,071	0	0	0	0	0	0	(19,627)	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
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				6865 FINANCIAL INC	LINCOLNWOOD	MGMT CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT

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	\$ 28,830	6865 FINANCIAL INC	100.00%	\$	\$ (28,830)	1
2	V								2
3	V	17	SHELDON NEIDICH						3
4	V	17	EMI ENTERPRISES			52,578		52,578	4
5	V	17	PHILIP ESFORMES INC			62,136		62,136	5
6	V	17	DANIEL WEISS			3,983		3,983	6
7	V	17	AVRUM WEINFELD			15,548		15,548	7
8	V	19	ACCOUNTING FEES			94		94	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 28,830			\$ 134,339	\$ *	105,509	14

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

Facility Name & ID Number WEST CHICAGO TERRACE# 0048405Report Period Beginning: 01/01/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21	BOOKKEEPING	\$ 66,000	EKS MANAGEMENT	100.00%	\$ (66,000)
16	V						
17	V	4	HOUSEKEEPING SALARIES			3,627	3,627
18	V	6	PAINTERS SALARIES			1,273	1,273
19	V	7	SCAVENGER			41	41
20	V	17	CFO SALARY			5,639	5,639
21	V	19	PROFESSIONAL FEES			4,267	4,267
22	V	20	WANT ADS/BACKGR CKS			2,086	2,086
23	V	21	OFFICE EXPENSE			15,920	15,920
24	V	23	SEMINARS			9	9
25	V	25	TRANSPORTATION			352	352
26	V	26	INSURANCE			142	142
27	V	27	EMPLOYEE BENEFITS			3,042	3,042
28	V	30	DEPRECIATION			87	87
29	V	35	EQUIPMENT RENT			1,644	1,644
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 66,000			\$ 38,129	\$ * (27,871)

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

Facility Name & ID Number WEST CHICAGO TERRACE# 0048405Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	\$ 9,360	IME REALTY CORP	100.00%	\$	\$ (9,360)	15
16	V							16
17	V	5 UTILITIES				306	306	17
18	V	6 PAINTERS FEES				616	616	18
19	V	6 REPAIR & MAINTENANCE				794	794	19
20	V	7 ALARM SERVICE				15	15	20
21	V	19 PROFESSIONAL FEES				45	45	21
22	V	20 LICENSES & PERMITS				23	23	22
23	V	21 OFFICE EXPENSE				7	7	23
24	V	26 INSURANCE				81	81	24
25	V	30 DEPRECIATION				867	867	25
26	V	32 INTEREST				1,541	1,541	26
27	V	33 RE TAX				1,197	1,197	27
28	V	35 STORAGE FEES				382	382	28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 9,360			\$ 5,874	\$ * (3,486)	39

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

Facility Name & ID Number WEST CHICAGO TERRACE# 0048405Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	\$		\$	\$
16	V						
17	V	6	DRIVERS SALARIES			1,867	1,867
18	V	17	MESFORMES,OFFICER			9,563	9,563
19	V	17	REGIONAL DIRECTOR			4,291	4,291
20	V	19	ACCOUNTING FEES			336	336
21	V	21	OFFICE			4,625	4,625
22	V	25	TRANSPORTATION			161	161
23	V	26	INSURANCE			606	606
24	V	27	EMPLOYEE BENEFITS			5,278	5,278
25	V	30	DEPRECIATION			38	38
26	V	35	AUTO LEASE			306	306
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		\$			\$ 27,071	\$ * 27,071

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

Facility Name & ID Number

WEST CHICAGO TERRACE

#

0048405

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES				SCHEDULE ATTACHED			SALARY	\$ 9,563	17-7	1
2	AVRUM WEINFELD	CFO						SALARY	5,639	17-7	2
3	AVRUM WEINFELD	CFO						SALARY	15,548	17-7	3
4	PHILIP ESFORMES							SALARY	62,136	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 92,886		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 WEST CHICAGO TERRACE

0048405

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)674-1946
 Fax Number (847)674-1962

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	SHELDON NEIDICH	PATIENT DAYS	538,796	10	\$ 22,500	\$ 22,500		\$ 0	1
2	17	EMI ENTERPRISES	PATIENT DAYS	538,796	10	396,000	396,000	71,537	52,578	2
3	17	PHILIP ESFORMES INC	PATIENT DAYS	538,796	10	468,000	468,000	71,537	62,136	3
4	17	DANIEL WEISS	PATIENT DAYS	538,796	10	30,000	30,000	71,537	3,983	4
5	17	AVRUM WEINFELD	PATIENT DAYS	538,796	10	117,111	117,111	71,537	15,548	5
6	19	ACCOUNTING FEES	PATIENT DAYS	538,796	10	700		71,537	94	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,034,311	\$ 1,033,611		\$ 134,339	25

Facility Name & ID Number WEST CHICAGO TERRACE

0048405

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)674-1946
 Fax Number (847)674-1962

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	4	HOUSEKEEPING SALARIES	PATIENT DAYS	847,051	14	\$ 73,923	\$ 73,923	41,537	\$ 3,627	1
2	6	PAINTERS SALARIES	PATIENT DAYS	847,051	14	25,953	25,953	41,537	1,273	2
3	7	SCAVENGER	PATIENT DAYS	847,051	14	842		41,537	41	3
4	17	CFO SALARY	PATIENT DAYS	847,051	14	114,971	114,971	41,537	5,639	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	847,051	14	86,967	74,170	41,537	4,267	5
6	20	WANT ADS/BACKGR CKS	PATIENT DAYS	847,051	14	42,556		41,537	2,086	6
7	21	OFFICE EXPENSE	PATIENT DAYS	847,051	14	324,660	230,236	41,537	15,920	7
8	23	SEMINARS	PATIENT DAYS	847,051	14	190		41,537	9	8
9	25	TRANSPORTATION	PATIENT DAYS	847,051	14	7,194		41,537	352	9
10	26	INSURANCE	PATIENT DAYS	847,051	14	2,872		41,537	142	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	62,031		41,537	3,042	11
12	30	DEPRECIATION	PATIENT DAYS	847,051	14	1,757		41,537	87	12
13	35	EQUIPMENT RENT	PATIENT DAYS	847,051	14	33,562		41,537	1,644	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 777,478	\$ 519,253		\$ 38,129	25

Facility Name & ID Number WEST CHICAGO TERRACE

0048405

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 AVE.
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847)674-1946
 Fax Number (847)674-1962

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	187,059	15	\$ 6,106	\$ 9,360	\$ 306	1
2	6	PAINTERS FEES	RENTAL INCOME	187,059	15	12,303	9,360	616	2
3	6	REPAIR & MAINTENANCE	RENTAL INCOME	187,059	15	15,863	9,360	794	3
4	7	ALARM SERVICE	RENTAL INCOME	187,059	15	301	9,360	15	4
5	19	PROFESSIONAL FEES	RENTAL INCOME	187,059	15	897	9,360	45	5
6	20	LICENSES & PERMITS	RENTAL INCOME	187,059	15	468	9,360	23	6
7	21	OFFICE EXPENSE	RENTAL INCOME	187,059	15	136	9,360	7	7
8	26	INSURANCE	RENTAL INCOME	187,059	15	1,627	9,360	81	8
9	30	DEPRECIATION	RENTAL INCOME	187,059	15	17,336	9,360	867	9
10	32	INTEREST	RENTAL INCOME	187,059	15	30,806	9,360	1,541	10
11	33	RE TAX	RENTAL INCOME	187,059	15	23,914	9,360	1,197	11
12	35	STORAGE FEES	RENTAL INCOME	187,059	15	7,635	9,360	382	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	\$	\$ 5,874	25

Facility Name & ID Number WEST CHICAGO TERRACE

0048405

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	DRIVERS SALARIES	PATIENT DAYS	847,051	14	\$ 38,060	\$ 41,537	\$ 1,867	1
2	17	M ESFORMES,OFFICER	PATIENT DAYS	847,051	14	195,000	41,537	9,563	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	847,051	14	87,500	41,537	4,291	3
4	19	ACCOUNTING FEES	PATIENT DAYS	847,051	14	6,850	41,537	336	4
5	21	OFFICE	PATIENT DAYS	847,051	14	94,319	41,537	4,625	5
6	25	TRANSPORTATION	PATIENT DAYS	847,051	14	3,276	41,537	161	6
7	26	INSURANCE	PATIENT DAYS	847,051	14	12,367	41,537	606	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	107,628	41,537	5,278	8
9	30	DEPRECIATION	PATIENT DAYS	847,051	14	765	41,537	38	9
10	35	AUTO LEASE	PATIENT DAYS	847,051	14	6,253	41,537	306	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	\$ 27,071	25

Facility Name & ID Number WEST CHICAGO TERRACE

0048405

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	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																			
2																			
3																			
4																			
5																			
Working Capital																			
6	PRIVATE BANK	X	WORKING CAPITAL							15,709									
7																			
8	RELATED PARTY									1,541									
9	TOTAL Facility Related									17,250									
B. Non-Facility Related*																			
10																			
11																			
12																			
13																			
14	TOTAL Non-Facility Related																		
15	TOTALS (line 9+line14)									17,250									

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.		\$	94,800	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.)		\$	98,652	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3,852	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	100,500	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.		\$	104,352	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004		8
	2005		9
	2006	87,073	10
	2007	92,684	11
	2008	98,652	12

2009 REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE 2008 REAL ESTATE 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:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 WEST CHICAGO TERRACE COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0048405

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>04-16-202-008</u>	<u>NURSING HOME</u>	\$ <u>98,651.80</u>	\$ <u>98,651.80</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>98,651.80</u>	\$ <u>98,651.80</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 providecopies of their original **second installment** tax bill.

Facility Name & ID Number WEST CHICAGO TERRACE

0048405

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,898 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

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

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8	RELATED PARTY		2003		27,612	833	39	833			8
	Improvement Type**										
9	SIDEWALK		2007		1,500	100	15	100		250	9
10	COVE BASE		2007		2,643	96	27.5	96		260	10
11	ELECTRICAL WORK		2008		12,415	453	27.5	453		660	11
12	TILE WORK		2008		19,022	689	27.5	689		1,006	12
13	ROOF		2008		18,396	670	27.5	670		977	13
14	ROOF AND GUTTER REPAIRS		2009		3,650	59	27.5	59		59	14
15	TILE AND COVE BASE IN BATHROOMS AND KITCHEN		2009		11,414	192	27.5	192		192	15
16	ROOFTOP AC UNITS		2009		8,453	141	27.5	141		141	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number **WEST CHICAGO TERRACE**

0048405

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)	\$	105,105	\$	3,233	\$	3,233	\$	3,545	70

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

Facility Name & ID Number WEST CHICAGO TERRACE

0048405

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	\$ 23,163	\$ 4,448	\$ 2,316	\$ (2,132)		\$ 6,948	71
72	Current Year Purchases	2,476	1,300	248	(1,052)		248	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		159	159				74
75	TOTALS	\$ 25,639	\$ 5,907	\$ 2,723	\$ (3,184)		\$ 7,196	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 130,744	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 9,140	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 5,956	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,184)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,741	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: GRANITE WEST CHICAGO TERRACE LLC

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1976</u>	<u>120</u>	<u>11/06</u>	\$ <u>457,491</u>	<u>5.5</u>	<u>5</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 457,491			7

10. Effective dates of current rental agreement:

Beginning 11/01/2006

Ending 04/01/2012

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

Fiscal Year Ending Annual Rent

12.	<u>12/2010</u>	\$ <u> </u>
13.	<u>12/2011</u>	\$ <u> </u>
14.	<u>12/2012</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: \$ 23,732 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>09 FORD E350SD</u>	\$ <u>850.00</u>	\$ <u>11,582</u>	17
18		<u>09 FORD CARGO VAN</u>	<u>550.00</u>	<u>7,490</u>	18
19		<u>NISSAN</u>	<u>650.00</u>	<u>7,802</u>	19
20				<u>(1,867)</u>	20
21	TOTAL		\$ #####	\$ 25,007	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>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			
		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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39-3	hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39-2	# of prescripts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$		\$	\$		\$	14	

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

Facility Name & ID Number WEST CHICAGO TERRACE

0048405

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	\$ 5,804	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 50,720)	574,465		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	94,124		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	84,096		8
9	Other(specify): RE TAX/INS ESCROW	57,523		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 816,012	\$	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	77,493		15
16	Equipment, at Historical Cost	25,639		16
17	Accumulated Depreciation (book methods)	(21,338)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,500		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,584)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): ADV RENT/REPL RESV	58,402		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 141,112	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 957,124	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 194,899	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	125,000		29
30	Accrued Salaries Payable	79,076		30
31	Accrued Taxes Payable (excluding real estate taxes)	28,456		31
32	Accrued Real Estate Taxes(Sch.IX-B)	100,500		32
33	Accrued Interest Payable	493		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)	\$ 528,424	\$	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)	\$ 528,424	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 428,700	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 957,124	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 488,408	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 488,408	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	72,061	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	(131,769)	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)	\$ (59,708)	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)	\$ 428,700	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	\$ 4,203,076	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,203,076	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	25,179	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 25,179	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)	\$ 4,228,255	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	951,583	31
32	Health Care	1,653,602	32
33	General Administration	848,404	33
B. Capital Expense			
34	Ownership	644,299	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	65,700	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES	(7,394)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,156,194	40
41	Income before Income Taxes (line 30 minus line 40)**	72,061	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 72,061	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 WEST CHICAGO TERRACE

0048405

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	2,048	2,088	\$ 60,975	\$ 29.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,805	13,080	399,787	30.56	3
4	Licensed Practical Nurses	3,491	4,259	103,566	24.32	4
5	CNAs & Orderlies	49,895	52,711	610,010	11.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,540	9,701	152,213	15.69	8
9	Activity Director					9
10	Activity Assistants	8,583	9,265	89,671	9.68	10
11	Social Service Workers	2,072	2,088	28,592	13.69	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,112	15,244	156,658	10.28	15
16	Dishwashers					16
17	Maintenance Workers	11,139	12,401	134,224	10.82	17
18	Housekeepers	15,607	17,155	165,550	9.65	18
19	Laundry	7,186	7,747	64,743	8.36	19
20	Administrator	2,513	2,513	93,935	37.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,776	15,428	153,401	9.94	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					31
32	Other Health Care(specify)	6,340	6,548	137,675	21.03	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	159,107	170,228	\$ 2,351,000 *	\$ 13.81	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	\$ 11,880	1-3	35
36	Medical Director	O	19,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,760	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	3,762	11-3	44
45	Social Service Consultant	E	3,999	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 44,401		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 **WEST CHICAGO TERRACE**

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. ICLTC \$ 5,319
- (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 _____ NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,700
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.