

Facility Name & ID Number JOLIET TERRACE

0048389 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	42,503	12		42,515	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,503	12		42,515	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.07%

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: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number

JOLIET TERRACE

0048389

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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	184,335	19,547	11,880	215,762		215,762		215,762		1
2	Food Purchase		213,787		213,787		213,787	(360)	213,427		2
3	Housekeeping	168,344	29,594		197,938		197,938	604	198,542		3
4	Laundry	78,042	14,810	773	93,625		93,625		93,625		4
5	Heat and Other Utilities			79,654	79,654		79,654	289	79,943		5
6	Maintenance	65,472	46,634	30,364	142,470		142,470	5,441	147,911		6
7	Other (specify):*			9,582	9,582		9,582	52	9,634		7
8	TOTAL General Services	496,193	324,372	132,253	952,818		952,818	6,026	958,844		8
	B. Health Care and Programs										
9	Medical Director			5,000	5,000		5,000		5,000		9
10	Nursing and Medical Records	1,205,965	33,470	15,149	1,254,584		1,254,584		1,254,584		10
10a	Therapy	32,784			32,784		32,784		32,784		10a
11	Activities	157,594	1,928	4,608	164,130		164,130		164,130		11
12	Social Services	26,284			26,284		26,284		26,284		12
13	CNA Training										13
14	Program Transportation			569	569		569		569		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,422,627	35,398	25,326	1,483,351		1,483,351		1,483,351		16
	C. General Administration										
17	Administrative	78,001		74,280	152,281		152,281	38,274	190,555		17
18	Directors Fees										18
19	Professional Services			50,916	50,916		50,916	(8,529)	42,387		19
20	Dues, Fees, Subscriptions & Promotions			16,218	16,218		16,218	(6,845)	9,373		20
21	Clerical & General Office Expenses	87,889	13,136	86,890	187,915		187,915	(48,812)	139,103		21
22	Employee Benefits & Payroll Taxes			283,215	283,215		283,215		283,215		22
23	Inservice Training & Education			1,262	1,262		1,262	9	1,271		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			9,082	9,082		9,082	715	9,797		25
26	Insurance-Prop.Liab.Malpractice			46,336	46,336		46,336	842	47,178		26
27	Other (specify):*							9,370	9,370		27
28	TOTAL General Administration	165,890	13,136	568,199	747,225		747,225	(14,976)	732,249		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,084,710	372,906	725,778	3,183,394		3,183,394	(8,950)	3,174,444		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	773
		0
		773
5	HEAT & OTHER UTILITIES	
	GAS HEAT	26,673
	ELECTRICITY	42,836
	WATER	10,145
	CABLE TV - LOBBY	0
		0
		79,654
6	MAINTENANCE	
	GROUNDS MAINTENANCE	9,854
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	15,467
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,177
	FIRE SERVICE	3,866
		0
		0
		0
		0
		30,364
7	OTHER	
	SCAVENGER	9,582
	SECURITY SERVICE	0
		0
		0
		9,582
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	5,000
		5,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	4,480
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	1,789
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	5,280
	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	3,600
		0
		15,149
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	4,608
		0
		4,608
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	569
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	74,280
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	11,498
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	39,418
		0
		50,916
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	4,151
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	500
	DUES & SUBSCRIPTIONS XIX F	5,663
	LICENSES & PERMITS XIX F	1,775
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	4,129
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		16,218
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	211
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	66,000
	PENALTIES / OVERDRAFT CHARGES VI 18	8,775
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	11,904
	MESSENGER SERVICE	0
		0
		86,890

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	156,741
	UNEMPLOYMENT COMPENSATION XIX D	27,906
	WORKERS COMPENSATION INSURANC XIX D	53,169
	HOSPITALIZATION INSURANCE XIX D	35,419
	EMPLOYEE BENEFITS - OTHER XIX D	426
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	9,554
	CHICAGO HEAD TAX XIX D	0
		0
		283,215
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,262
		1,262
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	9,082
		9,082
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	46,336
		46,336
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

725,778

**JOLIET TERRACE
SCHEDULES
12/31/2010**

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

TOTAL FOOD PURCHASE	213,787
LESS SALES TAX	<u>(360)</u>
NET FOOD	213,427

TOTAL PATIENT CENSUS	42,515
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	127,545

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

PATIENT MEALS	127,545
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	127,545

NET FOOD	213,427
DIVIDE TOTAL MEALS/YEAR	<u>127,545</u>

COST PER MEAL	1.67
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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Facility Name & ID Number **JOLIET TERRACE**

#0048389

Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			22,133	22,133		22,133	(18,744)	3,389			30
31	Amortization of Pre-Op. & Org.			500	500		500		500			31
32	Interest			2,156	2,156		2,156	(2,156)				32
33	Real Estate Taxes			59,963	59,963		59,963	1,217	61,180			33
34	Rent-Facility & Grounds			595,449	595,449		595,449		595,449			34
35	Rent-Equipment & Vehicles			23,661	23,661		23,661	2,104	25,765			35
36	Other (specify):* OFFICE RENT			9,360	9,360		9,360	(9,360)				36
37	TOTAL Ownership			713,222	713,222		713,222	(26,939)	686,283			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)	2,084,710	372,906	1,504,700	3,962,316		3,962,316	(35,889)	3,926,427			45

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

Facility Name & ID Number **JOLIET TERRACE**

0048389

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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	(19,689)	30		9
10	Interest and Other Investment Income	(3,659)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(360)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,775)	21		18
19	Entertainment				19
20	Contributions	(4,629)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,151)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(12,919)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (54,182)		\$	30

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)	18,293		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 18,293		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (35,889)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

JOLIET TERRACEID# 0048389Report Period Beginning: 01/01/2010Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	NON ALLOWABLE PROFESSIONAL FEES	\$ -12919	19	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(12,919)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number JOLIET TERRACE# 0048389

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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	(360)	0	0	0	0	0	0	0	0	0	0	(360)	2
3	Housekeeping	0	0	604	0	0	0	0	0	0	0	0	604	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	289	0	0	0	0	0	0	0	289	5
6	Maintenance	0	0	2,393	1,056	1,992	0	0	0	0	0	0	5,441	6
7	Other (specify):*	0	0	22	30	0	0	0	0	0	0	0	52	7
8	TOTAL General Services	(360)	0	3,019	1,375	1,992	0	0	0	0	0	0	6,026	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	19,456	5,783	0	13,035	0	0	0	0	0	0	38,274	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,919)	59	3,953	50	328	0	0	0	0	0	0	(8,529)	19
20	Fees, Subscriptions & Promotions	(8,780)	0	1,886	49	0	0	0	0	0	0	0	(6,845)	20
21	Clerical & General Office Expenses	(8,775)	0	(45,628)	14	5,577	0	0	0	0	0	0	(48,812)	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	600	0	115	0	0	0	0	0	0	715	25
26	Insurance-Prop.Liab.Malpractice	0	0	255	61	526	0	0	0	0	0	0	842	26
27	Other (specify):*	0	0	3,095	0	6,275	0	0	0	0	0	0	9,370	27
28	TOTAL General Administration	(30,474)	19,515	(30,047)	174	25,856	0	0	0	0	0	0	(14,976)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(30,834)	19,515	(27,028)	1,549	27,848	0	0	0	0	0	0	(8,950)	29

STATE OF ILLINOIS

Facility Name & ID Number JOLIET TERRACE# 0048389

Report Period Beginning:

01/01/2010 Ending:

Summary B

12/31/2010

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	(19,689)	0	77	868	0	0	0	0	0	0	0	(18,744)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,659)	0	0	1,503	0	0	0	0	0	0	0	(2,156)	32
33	Real Estate Taxes	0	0	0	1,217	0	0	0	0	0	0	0	1,217	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	1,463	398	243	0	0	0	0	0	0	2,104	35
36	Other (specify):*	0	0	0	(9,360)	0	0	0	0	0	0	0	(9,360)	36
37	TOTAL Ownership	(23,348)	0	1,540	(5,374)	243	0	0	0	0	0	0	(26,939)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(54,182)	19,515	(25,488)	(3,825)	28,091	0	0	0	0	0	0	(35,889)	45

Facility Name & ID Number

JOLIET TERRACE

0048389

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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 REALITY	LINCOLNWOOD	HOME OFFICE
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSLT

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 MANAGEMENT FEES	\$ 74,280	6865 FINANCIAL INC				
2	V							
3	V	17 EMI ENTERPRISES		" " "		28,614	28,614	3
4	V	17 PHILIP ESFORMES INC		" " "		39,156	39,156	4
5	V	17 MICHAEL ROSEN		" " "		10,542	10,542	5
6	V	17 DANIEL WEISS		" " "		2,719	2,719	6
7	V	17 AVRUM WEINFELD		" " "		12,705	12,705	7
8	V	19 ACCOUNTING FEES		" " "		59	59	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 74,280			\$ 93,795	\$ * 19,515	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING	\$ 66,000	EKS MANAGEMENT		\$ (66,000)	15
16	V							16
17	V							17
18	V	3	HOUSEKEEPING SALARIES		" " "	604	604	18
19	V	6	PAINTERS SALARIES		" " "	2,393	2,393	19
20	V	7	SCAVENGER		" " "	22	22	20
21	V	17	CFO SALARY		" " "	5,783	5,783	21
22	V	19	PROFESSIONAL FEES		" " "	3,953	3,953	22
23	V	20	WANT ADDS/BACKGR CKS		" " "	1,886	1,886	23
24	V	21	OFFICE EXPENSE		" " "	20,372	20,372	24
25	V	23	SEMINARS		" " "	9	9	25
26	V	25	TRANSPORTATION		" " "	600	600	26
27	V	26	INSURANCE		" " "	255	255	27
28	V	27	EMPLOYEE BENEFITS		" " "	3,095	3,095	28
29	V	30	DEPRECIATION		" " "	77	77	29
30	V	35	EQUIPMENT RENT		" " "	1,463	1,463	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		\$ 66,000			\$ 40,512	\$ * (25,488)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	36 OFFICE RENT	\$ 9,360	IME REALTY		\$	\$ (9,360)
16	V						
17	V						
18	V	5 UTILITIES		" " "		289	289
19	V	6 PAINTERS FEES		" " "		308	308
20	V	6 REPAIR & MAINTENANCE		" " "		748	748
21	V	7 ALARM SERVICE		" " "		30	30
22	V	19 PROFESSIONAL FEES		" " "		50	50
23	V	20 LICENSES & PERMITS		" " "		49	49
24	V	21 OFFICE EXPENSE		" " "		14	14
25	V	26 INSURANCE		" " "		61	61
26	V	30 DEPRECIATION		" " "		868	868
27	V	32 INTEREST		" " "		1,503	1,503
28	V	33 RE TAX		" " "		1,217	1,217
29	V	35 STORAGE FEES		" " "		398	398
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 9,360			\$ 5,535	\$ * (3,825)

* 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	\$		\$		15
16	V							16
17	V							17
18	V	6	DRIVERS SALARIES			1,992	1,992	18
19	V	17	MESFORMES, OFFICER			9,808	9,808	19
20	V	17	REGIONAL DIRECTOR			3,227	3,227	20
21	V	19	ACCOUNTING FEES			328	328	21
22	V	21	OFFICE			5,577	5,577	22
23	V	25	TRANSPORTATION			115	115	23
24	V	26	INSURANCE			526	526	24
25	V	27	EMPLOYEE BENEFITS			6,275	6,275	25
26	V	30	DEPRECIATION					26
27	V	35	AUTO LEASE			243	243	27
28	V							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		\$			\$ 28,091	\$ * 28,091	39

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

Facility Name & ID Number

JOLIET TERRACE

0048389

Report Period Beginning:

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Ending:

12/31/2010

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								\$ 9,808	17-7	1
2	AVRUM WEINFELD	CFO							12,705	17-7	2
3	AVRUM WEINFELD	CFO							5,783	17-7	3
4	PHILIP ESFORMES		SCHEDULE ATTACHED						39,156	17-7	4
5	DANIEL WEISS								2,719	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 70,171		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 JOLIET TERRACE

0048389

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01/01/2010

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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	EMI ENTERPRISES	PATIENT DAYS	508,141	10	\$ 342,000	\$ 42,515	\$ 28,614	1	
2	17	PHILIP ESFORMES INC	PATIENT DAYS	508,141	10	468,000	468,000	42,515	39,156	2
3	17	MICHAEL ROSEN	PATIENT DAYS	508,141	10	126,000	126,000	42,515	10,542	3
4	17	DANIEL WEISS	PATIENT DAYS	508,141	10	32,500	32,500	42,515	2,719	4
5	17	AVRUM WEINFELD	PATIENT DAYS	508,141	10	151,856	151,856	42,515	12,705	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	508,141	10	700		42,515	59	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					\$ 1,121,056	\$ 778,356	\$ 93,795		25

Facility Name & ID Number JOLIET TERRACE

0048389

Report Period Beginning:

01/01/2010

Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

EKS MGMT

Street Address

6865 N. LINCOLN AVE.

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(847) 674-1946

Fax Number

(847) 674-1962

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.

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	845,281	14	\$ 12,000	\$ 42,515	\$ 604	1
2	6	PAINTERS SALARIES	PATIENT DAYS	845,281	14	47,580	42,515	2,393	2
3	7	SCAVENGER	PATIENT DAYS	845,281	14	441	42,515	22	3
4	17	CFO SALARY	PATIENT DAYS	845,281	14	114,971	42,515	5,783	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	845,281	14	78,585	42,515	3,953	5
6	20	WANT ADS/BACKGR CKS	PATIENT DAYS	845,281	14	37,500	42,515	1,886	6
7	21	OFFICE EXPENSE	PATIENT DAYS	845,281	14	405,027	42,515	20,372	7
8	23	SEMINARS	PATIENT DAYS	845,281	14	175	42,515	9	8
9	25	TRANSPORTATION	PATIENT DAYS	845,281	14	11,931	42,515	600	9
10	26	INSURANCE	PATIENT DAYS	845,281	14	5,077	42,515	255	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	845,281	14	61,528	42,515	3,095	11
12	30	DEPRECIATION	PATIENT DAYS	845,281	14	1,536	42,515	77	12
13	35	EQUIPMENT RENT	PATIENT DAYS	845,281	14	29,093	42,515	1,463	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					\$ 805,444	\$ 535,994	\$ 40,512	25

Facility Name & ID Number JOLIET TERRACE

0048389

Report Period Beginning:

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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	14	\$ 5,775	\$ 9,360	\$ 289	1
2	6	PAINTERS FEES	RENTAL INCOME	187,059	14	6,152	9,360	308	2
3	6	REPAIR & MAINTENANCE	RENTAL INCOME	187,059	14	14,941	9,360	748	3
4	7	ALARM SERVICE	RENTAL INCOME	187,059	14	601	9,360	30	4
5	19	PROFESSIONAL FEES	RENTAL INCOME	187,059	14	998	9,360	50	5
6	20	LICENSES & PERMITS	RENTAL INCOME	187,059	14	971	9,360	49	6
7	21	OFFICE EXPENSE	RENTAL INCOME	187,059	14	274	9,360	14	7
8	26	INSURANCE	RENTAL INCOME	187,059	14	1,211	9,360	61	8
9	30	DEPRECIATION	RENTAL INCOME	187,059	14	17,356	9,360	868	9
10	32	INTEREST	RENTAL INCOME	187,059	14	30,039	9,360	1,503	10
11	33	RE TAX	RENTAL INCOME	187,059	14	24,313	9,360	1,217	11
12	35	STORAGE FEES	RENTAL INCOME	187,059	14	7,961	9,360	398	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					\$ 110,592	\$	\$ 5,535	25

Facility Name & ID Number JOLIET TERRACE

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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	845,281	14	\$ 39,600	\$ 39,600	42,515	\$ 1,992	1
2	17	M ESFORMES,OFFICER	PATIENT DAYS	845,281	14	195,000	195,000	42,515	9,808	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	845,281	14	64,150	64,150	42,515	3,227	3
4	19	ACCOUNTING FEES	PATIENT DAYS	845,281	14	6,525		42,515	328	4
5	21	OFFICE	PATIENT DAYS	845,281	14	110,874	58,558	42,515	5,577	5
6	25	TRANSPORTATION	PATIENT DAYS	845,281	14	2,287		42,515	115	6
7	26	INSURANCE	PATIENT DAYS	845,281	14	10,450		42,515	526	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	845,281	14	124,762		42,515	6,275	8
9	30	DEPRECIATION	PATIENT DAYS	845,281	14			42,515		9
10	35	AUTO LEASE	PATIENT DAYS	845,281	14	4,824		42,515	243	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					\$ 558,472	\$ 357,308		\$ 28,091	25

Facility Name & ID Number

JOLIET TERRACE

0048389

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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										1									
2										2									
3										3									
4										4									
5										5									
Working Capital																			
6	PRIVATE BANK	X	WORKING CAPITAL						2,156	6									
7	RELATED PARTY	X							1,503	7									
8										8									
9	TOTAL Facility Related								3,659	9									
B. Non-Facility Related*																			
10										10									
11										11									
12										12									
13										13									
14	TOTAL Non-Facility Related									14									
15	TOTALS (line 9+line14)								3,659	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # 36

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2009 report.		\$	57,000		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.)		\$	57,963		2
3. Under or (over) accrual (line 2 minus line 1).		\$	963		3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	59,000		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.		\$	59,963		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005		8	FOR BHF USE ONLY	
	2006	35,055	9	13	FROM R. E. TAX STATEMENT FOR 2009 \$
	2007	55,703	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2008	55,913	11	15	LESS REFUND FROM LINE 6 \$
	2009	57,963	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL					
THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.					

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.

Facility Name & ID Number JOLIET TERRACE

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,836 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).

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:

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

Facility Name & ID Number JOLIET TERRACE

0048389

Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	4	
5									5	
6									6	
7	RELATED PARTY				834		834		7	
8									8	
Improvement Type**										
9	ROOF TOP AC		2007	5,064	184	27.5	184		636	9
10	TILE INSTALLATION		2010	4,300	72	27.5	72		72	10
11									11	
12									12	
13									13	
14									14	
15									15	
16									16	
17									17	
18	ROOF - LANDLORD		2009	18,337						18
19	ROOF - LANDLORD		2010	128,910						19
20	REPAVE PARKING LOT - LANDLORD		2010	28,690						20
21	NURSE CALL SYSTEM - LANDLORD		2010	37,500						21
22									22	
23									23	
24									24	
25									25	
26									26	
27									27	
28									28	
29									29	
30									30	
31									31	
32									32	
33									33	
34									34	
35									35	
36									36	

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 222,801	\$ 1,090		\$ 1,090	\$	\$ 708	70

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

Facility Name & ID Number **JOLIET TERRACE**

0048389

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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	\$ 67,333	\$ 10,748	\$ 1,075	\$ (9,673)	10 YRS	\$ 8,024	71
72	Current Year Purchases	18,548	11,129	1,113	(10,016)	10YRS	1,113	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		111	111				74
75	TOTALS	\$ 85,881	\$ 21,988	\$ 2,299	\$ (19,689)		\$ 9,137	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)	\$ 308,682	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,078	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 3,389	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (19,689)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,845	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 JOLIET 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: 1976	120	11/06	\$ 595,449	5.5	5	3
4	Additions						4
5							5
6							6
7	TOTAL	120		\$ 595,449			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ **14,097** Description: **SEE SCHEDULE ATTACHED**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		2009 FORD VAN	\$ 690.00	\$ 8,970	17
18		MISC		594	18
19					19
20					20
21	TOTAL		\$ 690.00	\$ 9,564	21

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. **11/01/2011** \$ _____

13. **11/01/2012** \$ _____

14. **11/01/2013** \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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 JOLIET TERRACE# 0048389Report Period Beginning: 01/01/2010Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 388,034	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	43,541		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,012		6
7	Other Prepaid Expenses	45,753		7
8	Accounts Receivable (owners or related parties)	263,195		8
9	Other(specify): <u>RE TAX/INS ESC</u>	51,135		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 860,670	\$	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	9,364		15
16	Equipment, at Historical Cost	85,881		16
17	Accumulated Depreciation (book methods)	(63,048)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,500		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,084)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>REPL RESV/ADV RENT</u>	165,208		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 197,821	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,058,491	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 163,819	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	67,550		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,062		31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,000		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)	\$ 317,431	\$	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)	\$ 317,431	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 741,060	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,058,491	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 595,839	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 595,839	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	339,413	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	(194,192)	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)	\$ 145,221	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)	\$ 741,060	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **JOLIET TERRACE**# **0048389**Report Period Beginning: **01/01/2010**Ending: **12/31/2010**

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	\$ 4,291,885	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,291,885	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***	17,808	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,808	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)	\$ 4,309,693	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	952,818	31
32	Health Care	1,483,351	32
33	General Administration	747,225	33
B. Capital Expense			
34	Ownership	713,222	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	65,700	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,962,316	40
41	Income before Income Taxes (line 30 minus line 40)**	347,377	41
42	Income Taxes	(7,964)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 339,413	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 **JOLIET TERRACE**

0048389

Report Period Beginning: **01/01/2010**

Ending:

12/31/2010

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	2,080	2,080	\$ 69,792	\$ 33.55	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,794	6,794	219,896	32.37	3
4	Licensed Practical Nurses	6,704	6,704	167,176	24.94	4
5	CNAs & Orderlies	43,874	49,975	501,190	10.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,969	2,224	32,784	14.74	8
9	Activity Director	2,037	2,037	30,041	14.75	9
10	Activity Assistants	11,059	12,035	127,553	10.60	10
11	Social Service Workers	2,099	2,099	26,284	12.52	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,019	18,344	184,335	10.05	15
16	Dishwashers					16
17	Maintenance Workers	5,943	6,220	65,472	10.53	17
18	Housekeepers	15,913	17,293	168,344	9.73	18
19	Laundry	7,270	7,945	78,042	9.82	19
20	Administrator	2,080	2,080	78,001	37.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,482	7,760	87,889	11.33	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)	12,526	18,999	247,911	13.05	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	143,849	162,589	\$ 2,084,710 *	\$ 12.82	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	5,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,280	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	4,608	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 26,768		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number JOLIET TERRACE# 0048389Report Period Beginning: 01/01/2010 Ending: 12/31/2010**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 \$5,663
- (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.