FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0048413

Facility Name: KANKAKEE TERRACE

Address: 100 BELLE AIRE (Number) BOURBONNAIS (City) 60914 (Zip Code)

County: KANKAKEE

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

HFS ID Number:

Date of Initial License for Current Owners: 11/01/2006

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) AVRUM WEINFELD
(Title) CFO

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number KANKAKEE TERRACE # 0048413 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	146	Intermediate (ICF)	146	53,290	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,290	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	49,098	470	1,613	51,181	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,098	470	1,613	51,181	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.04%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 11/01/2006 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided 0

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] 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 KANKAKEE TERRACE # 0048413 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	227,555	18,005	5,940	251,500		251,500		251,500			1
2	Food Purchase		234,137		234,137		234,137	(523)	233,614			2
3	Housekeeping	230,003	25,319		255,322		255,322	727	256,049			3
4	Laundry	82,287	17,575	2,775	102,637		102,637		102,637			4
5	Heat and Other Utilities			128,935	128,935		128,935	347	129,282			5
6	Maintenance	28,591	24,293	34,359	87,243		87,243	6,545	93,788			6
7	Other (specify):*			5,786	5,786		5,786	63	5,849			7
8	**TOTAL General Services**	568,436	319,329	177,795	1,065,560		1,065,560	7,159	1,072,719			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,360,571	83,611	26,055	1,470,237		1,470,237		1,470,237			10
10a	Therapy	22,164			22,164		22,164		22,164			10a
11	Activities	71,939	1,556	3,278	76,773		76,773		76,773			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation			1,163	1,163		1,163		1,163			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,454,674	85,167	40,096	1,579,937		1,579,937		1,579,937			16
	C. General Administration											
17	Administrative	86,444		293,000	379,444		379,444	(157,504)	221,940			17
18	Directors Fees											18
19	Professional Services			58,205	58,205		58,205	(18,578)	39,627			19
20	Dues, Fees, Subscriptions & Promotions			16,572	16,572		16,572	(11,623)	4,949			20
21	Clerical & General Office Expenses	102,711	18,945	90,149	211,805		211,805	(70,813)	140,992			21
22	Employee Benefits & Payroll Taxes			393,527	393,527		393,527		393,527			22
23	Inservice Training & Education			2,341	2,341		2,341	11	2,352			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			27,756	27,756		27,756	860	28,616			25
26	Insurance-Prop.Liab.Malpractice			56,273	56,273		56,273	1,013	57,286			26
27	Other (specify):*			1,200	1,200		1,200	10,079	11,279			27
28	**TOTAL General Administration**	189,155	18,945	939,023	1,147,123		1,147,123	(246,555)	900,568			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,212,265	423,441	1,156,914	3,792,620		3,792,620	(239,396)	3,553,224			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.

Facility Name & ID#: KANKAKEE TERRACE **#0048413** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,940	
	REPAIRS & MAINTENANCE		0	
			0	5,940
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,775	
			0	2,775
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		34,184	
	ELECTRICITY		45,913	
	WATER		38,223	
	CABLE TV - LOBBY		10,615	
			0	128,935
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,130	
	PAINTING & DECORATING		1,265	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		18,290	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,675	
	FIRE SERVICE		7,999	
			0	
			0	
			0	
			0	34,359
7	**OTHER**			
	SCAVENGER		5,215	
	SECURITY SERVICE		571	
			0	
			0	5,786
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,600	9,600

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		12,258	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	3,773	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	6,424	
	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	26,055
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	3,278	
			0	3,278
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number KANKAKEE TERRACE **#0048413** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,163	1,163
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	293,000	293,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	12,126	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	46,079	
			0	58,205
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	2,881	
	EMPLOYEE WANT ADS	XIX F	323	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	896	
	LICENSES & PERMITS	XIX F	1,249	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,890	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	8,681	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	152	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				16,572
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		83	
	EQUIPMENT REPAIR & MAINTENANCE		443	
	OUTSIDE CLERICAL SERVICES		78,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		11,623	
	MESSENGER SERVICE		0	
			0	90,149

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	166,711	
	UNEMPLOYMENT COMPENSATION	XIX D	19,725	
	WORKERS COMPENSATION INSURANC	XIX D	62,613	
	HOSPITALIZATION INSURANCE	XIX D	105,066	
	EMPLOYEE BENEFITS - OTHER	XIX D	827	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	38,585	
	CHICAGO HEAD TAX	XIX D	0	
			0	393,527
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,341	
				2,341
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		27,756	
				27,756
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		56,273	
				56,273
27	**OTHER**			
	BAD DEBTS	VI 24	1,200	
				1,200

GRAND TOTAL COLUMN 3 OTHER **1,156,914**

KANKAKEE TERRACE
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	234,137
LESS SALES TAX	(523)
NET FOOD	233,614
TOTAL PATIENT CENSUS	51,181
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	153,543
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	153,543
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	153,543
NET FOOD	233,614
DIVIDE TOTAL MEALS/YEAR	153,543
COST PER MEAL	1.52
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number KANKAKEE TERRACE #0048413 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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			13,180	13,180		13,180	(3,238)	9,942			30
31	Amortization of Pre-Op. & Org.			500	500		500		500			31
32	Interest			8,974	8,974		8,974	(3,636)	5,338			32
33	Real Estate Taxes			46,067	46,067		46,067	1,460	47,527			33
34	Rent-Facility & Grounds			1,287,020	1,287,020		1,287,020		1,287,020			34
35	Rent-Equipment & Vehicles			40,383	40,383		40,383	2,532	42,915			35
36	Other (specify):* **OFFICE RENT**			11,232	11,232		11,232	(11,232)				36
37	**TOTAL Ownership**			1,407,356	1,407,356		1,407,356	(14,114)	1,393,242			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,935	79,935		79,935		79,935			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			79,935	79,935		79,935		79,935			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,212,265	423,441	2,644,205	5,279,911		5,279,911	(253,510)	5,026,401			45

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

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,373)	30		9
10	Interest and Other Investment Income	(5,440)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(523)	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				18
19	Entertainment				19
20	Contributions	(9,181)	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	(1,200)	27		24
25	Fund Raising, Advertising and Promotional	(2,881)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,890)	20		28
29	Other-Attach Schedule	(47,928)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (73,416)		$	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 Amount	2 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)	(180,094)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (180,094)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (253,510)		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 Yes	2 No	3 Amount	4 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

KANKAKEE TERRACE

ID# 0048413

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NON ALLOWABLE PROFESSIONAL FEES	$ -23862	19	1
2	MARKETING SALARIES	(24,066)	21	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**	(47,928)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number KANKAKEE TERRACE **#** 0048413 **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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(523)	0	0	0	0	0	0	0	0	0	0	(523)	2
3	Housekeeping	0	0	727	0	0	0	0	0	0	0	0	727	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	347	0	0	0	0	0	0	0	347	5
6	Maintenance	0	0	2,881	1,266	2,398	0	0	0	0	0	0	6,545	6
7	Other (specify):*	0	0	27	36	0	0	0	0	0	0	0	63	7
8	**TOTAL General Services**	(523)	0	3,635	1,649	2,398	0	0	0	0	0	0	7,159	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	(175,156)	6,961	0	10,691	0	0	0	0	0	0	(157,504)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(23,862)	71	4,758	60	395	0	0	0	0	0	0	(18,578)	19
20	Fees, Subscriptions & Promotions	(13,952)	0	2,271	58	0	0	0	0	0	0	0	(11,623)	20
21	Clerical & General Office Expenses	(24,066)	0	(53,476)	16	6,713	0	0	0	0	0	0	(70,813)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	11	0	0	0	0	0	0	0	0	11	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	722	0	138	0	0	0	0	0	0	860	25
26	Insurance-Prop.Liab.Malpractice	0	0	307	73	633	0	0	0	0	0	0	1,013	26
27	Other (specify):*	(1,200)	0	3,725	0	7,554	0	0	0	0	0	0	10,079	27
28	**TOTAL General Administration**	(63,080)	(175,085)	(34,721)	207	26,124	0	0	0	0	0	0	(246,555)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(63,603)	(175,085)	(31,086)	1,856	28,522	0	0	0	0	0	0	(239,396)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number KANKAKEE TERRACE # 0048413 **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

	Capital Expense D. Ownership	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)	
30	Depreciation	(4,373)	0	93	1,042	0	0	0	0	0	0	0	(3,238)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,440)	0	0	1,804	0	0	0	0	0	0	0	(3,636)	32
33	Real Estate Taxes	0	0	0	1,460	0	0	0	0	0	0	0	1,460	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	1,762	478	292	0	0	0	0	0	0	2,532	35
36	Other (specify):*	0	0	0	(11,232)	0	0	0	0	0	0	0	(11,232)	36
37	**TOTAL Ownership**	(9,813)	0	1,855	(6,448)	292	0	0	0	0	0	0	(14,114)	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)**	(73,416)	(175,085)	(29,231)	(4,592)	28,814	0	0	0	0	0	0	(253,510)	45

Facility Name & ID Number KANKAKEE TERRACE # 0048413 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 REALTY	LINCOLNWOOD	HOME OFFICE
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSLT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	MANAGEMENT FEES	$ 288,000	6865 FINANCIAL INC		$	$ (288,000)	1
2	V									2
3	V		17	EMI ENTERPRISES		" " "		34,447	34,447	3
4	V		17	PHILIP ESFORMES INC		" " "		47,138	47,138	4
5	V		17	MICHAEL ROSEN		" " "		12,691	12,691	5
6	V		17	DANIEL WEISS		" " "		3,273	3,273	6
7	V		17	AVRUM WEINFELD		" " "		15,295	15,295	7
8	V		19	ACCOUNTING FEES		" " "		71	71	8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 288,000			$ 112,915	$ * (175,085)	14

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

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING	$ 78,000	EKS MANAGEMENT		$	$ (78,000)	15
16	V								16
17	V	3	HOUSEKEEPING SALARIES		" " "		727	727	17
18	V	6	PAINTERS SALARIES		" " "		2,881	2,881	18
19	V	7	SCAVENGER		" " "		27	27	19
20	V	17	CFO SALARY		" " "		6,961	6,961	20
21	V	19	PROFESSIONAL FEES		" " "		4,758	4,758	21
22	V	20	WANT ADDS/BACKGR CKS		" " "		2,271	2,271	22
23	V	21	OFFICE EXPENSE		" " "		24,524	24,524	23
24	V	23	SEMINARS		" " "		11	11	24
25	V	25	TRANSPORTATION		" " "		722	722	25
26	V	26	INSURANCE		" " "		307	307	26
27	V	27	EMPLOYEE BENEFITS		" " "		3,725	3,725	27
28	V	30	DERPECIATION (SL)		" " "		93	93	28
29	V	35	EQUIPMENT RENT		" " "		1,762	1,762	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 78,000			$ 48,769	$ * (29,231)	39

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

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 11,232	IME REALTY CORP		$	$ (11,232)	15
16	V								16
17	V	5	UTILITIES		" " "		347	347	17
18	V	6	PAINTERS FEES		" " "		369	369	18
19	V	6	REPAIR & MAINTENANCE		" " "		897	897	19
20	V	7	ALARM SERVICE		" " "		36	36	20
21	V	19	PROFESSIONAL FEES		" " "		60	60	21
22	V	20	LICENSES & PERMITS		" " "		58	58	22
23	V	21	OFFICE EXPENSE		" " "		16	16	23
24	V	26	INSURANCE		" " "		73	73	24
25	V	30	DEPRECIATION		" " "		1,042	1,042	25
26	V	32	INTEREST		" " "		1,804	1,804	26
27	V	33	RE TAX		" " "		1,460	1,460	27
28	V	35	STORAGE FEES		" " "		478	478	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			$ 11,232			$ 6,640	$ * (4,592)	39

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

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 5,000	EMI ENTERPRISES		$	$ (5,000)	15
16	V								16
17	V	6	DRIVERS SALARIES		" " "		2,398	2,398	17
18	V	17	M ESFORMES,OFFICER		" " "		11,807	11,807	18
19	V	17	REGIONAL DIRECTOR		" " "		3,884	3,884	19
20	V	19	ACCOUNTING FEES		" " "		395	395	20
21	V	21	OFFICE		" " "		6,713	6,713	21
22	V	25	TRANSPORTATION		" " "		138	138	22
23	V	26	INSURANCE		" " "		633	633	23
24	V	27	EMPLOYEE BENEFITS		" " "		7,554	7,554	24
25	V	30	DEPRECIATION		" " "				25
26	V	35	AUTO LEASE		" " "		292	292	26
27	V								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			$ 5,000			$ 33,814	$ * 28,814	39

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

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES								$ 11,807	17-7	1
2	AVRUM WEINFELD	CFO							15,295	17-7	2
3	AVRUM WEINFELD	CFO							6,961	17-7	3
4	PHILIP ESFORMES		SCHEDULE ATTACHED						47,138	17-7	4
5	DANIEL WEISS								3,273	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 84,474		13

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

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

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] 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
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847)674-1946
Fax Number: (847)674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	EMI ENTERPRISES	PATIENT DAYS	508,141	10	$ 342,000	$	51,181	$ 34,447	1
2	17	PHILIP ESFORMES INC	PATIENT DAYS	508,141	10	468,000	468,000	51,181	47,138	2
3	17	MICHAEL ROSEN	PATIENT DAYS	508,141	10	126,000	126,000	51,181	12,691	3
4	17	DANIEL WEISS	PATIENT DAYS	508,141	10	32,500	32,500	51,181	3,273	4
5	17	AVRUM WEINFELD	PATIENT DAYS	508,141	10	151,856	151,856	51,181	15,295	5
6	19	ACCOUNTING FEES	PATIENT DAYS	508,141	10	700		51,181	71	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		$ 112,915	25

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING SALARIES	PATIENT DAYS	845,281	14	$ 12,000	$ 12,000	51,181	$ 727	1
2	6	PAINTERS SALARIES	PATIENT DAYS	845,281	14	47,580	47,580	51,181	2,881	2
3	7	SCAVENGER	PATIENT DAYS	845,281	14	441		51,181	27	3
4	17	CFO SALARY	PATIENT DAYS	845,281	14	114,971	114,971	51,181	6,961	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	845,281	14	78,585	66,116	51,181	4,758	5
6	20	WANT ADS/BACKGR CKS	PATIENT DAYS	845,281	14	37,500		51,181	2,271	6
7	21	OFFICE EXPENSE	PATIENT DAYS	845,281	14	405,027	295,327	51,181	24,524	7
8	23	SEMINARS	PATIENT DAYS	845,281	14	175		51,181	11	8
9	25	TRANSPORTATION	PATIENT DAYS	845,281	14	11,931		51,181	722	9
10	26	INSURANCE	PATIENT DAYS	845,281	14	5,077		51,181	307	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	845,281	14	61,528		51,181	3,725	11
12	30	DEPRECIATION	PATIENT DAYS	845,281	14	1,536		51,181	93	12
13	35	EQUIPMENT RENT	PATIENT DAYS	845,281	14	29,093		51,181	1,762	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		$ 48,769	25

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	187,059	14	$ 5,775	$	11,232	$ 347	1
2	6	PAINTERS FEES	RENTAL INCOME	187,059	14	6,152		11,232	369	2
3	6	REPAIR & MAINTENANCE	RENTAL INCOME	187,059	14	14,941		11,232	897	3
4	7	ALARM SERVICE	RENTAL INCOME	187,059	14	601		11,232	36	4
5	19	PROFESSIONAL FEES	RENTAL INCOME	187,059	14	998		11,232	60	5
6	20	LICENSE & PERMITS	RENTAL INCOME	187,059	14	971		11,232	58	6
7	21	OFFICE EXPENSE	RENTAL INCOME	187,059	14	274		11,232	16	7
8	26	INSURANCE	RENTAL INCOME	187,059	14	1,211		11,232	73	8
9	30	DEPRECIATION	RENTAL INCOME	187,059	14	17,356		11,232	1,042	9
10	32	INTEREST	RENTAL INCOME	187,059	14	30,039		11,232	1,804	10
11	33	RE TAX	RENTAL INCOME	187,059	14	24,313		11,232	1,460	11
12	35	STORAGE FEES	RENTAL INCOME	187,059	14	7,961		11,232	478	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	$		$ 6,640	25

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	DRIVERS SALARIES	PATIENT DAYS	845,281	14	$ 39,600	$ 39,600	51,181	$ 2,398	1
2	17	M ESFORMES,OFFICER	PATIENT DAYS	845,281	14	195,000	195,000	51,181	11,807	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	845,281	14	64,150	64,150	51,181	3,884	3
4	19	ACCOUNTING FEES	PATIENT DAYS	845,281	14	6,525		51,181	395	4
5	21	OFFICE	PATIENT DAYS	845,281	14	110,874	58,558	51,181	6,713	5
6	25	TRANSPORTATION	PATIENT DAYS	845,281	14	2,287		51,181	138	6
7	26	INSURANCE	PATIENT DAYS	845,281	14	10,450		51,181	633	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	845,281	14	124,762		51,181	7,554	8
9	30	DEPRECIATION	PATIENT DAYS	845,281	14			51,181		9
10	35	AUTO LEASE	PATIENT DAYS	845,281	14	4,824		51,181	292	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		$ 33,814	25

Facility Name & ID Number KANKAKEE TERRACE # 0048413 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	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	PRIVATE BANK		X	WORKING CAPITAL							8,974	6
7	RELATED PARTY	X									1,804	7
8												8
9	TOTAL Facility Related						$	$			$ 10,778	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 10,778	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.)**

Facility Name & ID Number KANKAKEE TERRACE # 0048413 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 45,000	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.)		$ 45,067	2
3. Under or (over) accrual (line 2 minus line 1).		$ 67	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 46,000	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.		$ 46,067	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005		8
2006	45,192	9
2007	43,545	10
2008	44,370	11
2009	45,067	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME KANKAKEE TERRACE COUNTY KANKAKEE

FACILITY IDPH LICENSE NUMBER 0048413

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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-09-20-107-041	NURSING HOME	$ 44,838.02	$ 44,838.02
2.	17-09-20-107-040	NURSING HOME	$ 228.72	$ 228.72
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 45,066.74	$ 45,066.74

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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? [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF			2008	37,800	1,355	27.5	1,355		3,340	9
10	STEEL SUPPORT BEAMS			2008	76,400	2,818	27.5	2,818		6,855	10
11	FLOOR TILE, HANDRAIL			2008	30,268	1,084	27.5	1,084		2,672	11
12	PIPES & FITTINGS			2008	4,594	163	27.5	163		457	12
13	ROOFTOP AC			2009	7,904	287	27.5	287		419	13
14	ACHIITECT FEES LIFE SAFETY			2009	4,614	168	27.5	168		245	14
15	TILE INSTALLATION			2010	12,632	211	27.5	211		211	15
16	ROOFTOP AC UNIT			2010	6,955	117	27.5	117		117	16
17	CONCRETE PAD			2010	3,800	62	27.5	62		62	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27	REPAVE PARKING LOT - LANDLORD			2009	34,980						27
28	FOUNDATION REPAIR - LANDLORD			2009	20,700						28
29	WINDOWS - LANDLORD			2009	11,550						29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		$ 252,197	$ 6,265		$ 6,265	$	$ 14,378	70

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

Facility Name & ID Number KANKAKEE TERRACE # 0048413 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	$ 17,506	$ 2,169	$ 1,751	$ (418)	10 YRS	$ 5,375	71
72	Current Year Purchases	7,910	4,746	791	(3,955)	10 YRS	791	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 25,416	$ 6,915	$ 2,542	$ (4,373)		$ 6,166	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)	$ 277,613	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 13,180	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 8,807	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,373)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 20,544	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: GRANITE KANKAKEE TERRACE LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] 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	146	11/06	$ 1,287,020	5.5	5	3
4	Additions							4
5								5
6								6
7	TOTAL		146		$ 1,287,020 **			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 [X] NO Terms: *

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	$

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: $ 8,835 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	MAINTENANCE	2009 LINCOLN NAVIGAT	$ #######	$ 12,926	17
18	FACILITY	2006 FORD E350	789.00	10,251	18
19		2009 FORD E350	550.00	6,600	19
20		MISC		1,771	20
21	TOTAL		$ #######	$ 31,548	21

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

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

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

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

STATE OF ILLINOIS

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 Ending: 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 242,044	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	329,666		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,495		6
7	Other Prepaid Expenses	78,491		7
8	Accounts Receivable (owners or related parties)	749,838		8
9	Other(specify): RE TAX/INS ESCROW	45,570		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,526,104	$	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	184,967		15
16	Equipment, at Historical Cost	25,415		16
17	Accumulated Depreciation (book methods)	(33,375)		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): REPL RESV/ADV RENT	204,232		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 381,655	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,907,759	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 228,764	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	37,269		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,584		31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,000		32
33	Accrued Interest Payable	909		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)**	$ 318,526	$	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)**	$ 318,526	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,589,233	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,907,759	$	48

***(See instructions.)**

Facility Name & ID Number KANKAKEE TERRACE # 0048413 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,660,903	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,660,903	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	584,865	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	(656,535)	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)**	$ (71,670)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,589,233	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number KANKAKEE TERRACE # 0048413 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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,865,923	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,865,923	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***	5,440	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,440	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,871,363	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,065,560	31
32	Health Care	1,579,937	32
33	General Administration	1,147,123	33
	B. Capital Expense		
34	Ownership	1,407,356	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	79,935	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,279,911	40
41	**Income before Income Taxes (line 30 minus line 40)****	591,452	41
42	**Income Taxes**	(6,587)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 584,865	43

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

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

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

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

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,968	2,088	$ 67,052	$ 32.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,405	2,732	68,693	25.14	3
4	Licensed Practical Nurses	13,812	15,046	300,429	19.97	4
5	CNAs & Orderlies	49,984	54,974	660,366	12.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,181	1,461	22,164	15.17	8
9	Activity Director					9
10	Activity Assistants	6,864	7,213	71,939	9.97	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,676	20,175	227,555	11.28	15
16	Dishwashers					16
17	Maintenance Workers	3,964	4,160	28,591	6.87	17
18	Housekeepers	19,910	22,251	230,003	10.34	18
19	Laundry	5,372	6,263	82,287	13.14	19
20	Administrator	2,004	2,224	86,444	38.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,274	12,828	102,711	8.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	10,601	11,443	177,833	15.54	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	5,962	6,270	86,198	13.75	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	154,977	169,128	$ 2,212,265 *	$ 13.08	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 5,940	1-3	35
36	Medical Director	O	9,600	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,424	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	3,278	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)		$ 25,242		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RANDY LEBEAU	ADMINISTRATOR		$ 46,124
TRACI POWER	ADMINISTRATOR		40,320
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 86,444

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 293,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 293,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		58,205
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 58,205

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,613
Unemployment Compensation Insurance	19,725
FICA Taxes	166,711
Employee Health Insurance	105,066
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	827
	0
PENSION/PROFIT SHARING PLANS	38,585
	0
	0
	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 393,527

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	323
Health Care Worker Background Check	152
(Indicate # of checks performed 15)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	9,181
MARKETING/ADV/PROMO	4,771
LICENSES/DUES/SUBSCRIPTIONS	2,145
MGMT CO ALLOC	2,329
TRUST/FRANCHISE/CONTRIB/ETC	(9,181)
Less: Public Relations Expense	(0)
Non-allowable advertising	(2,881)
Yellow page advertising	(1,890)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,949

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number KANKAKEE TERRACE # 0048413 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number KANKAKEE TERRACE **#** 0048413 **Report Period Beginning:** 01/01/2010 **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. **ALLIANCE FOR LIVING $79**

(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. $ **299** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **79,935**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **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.