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: 0048397

Facility Name: THE TERRACE NH

Address: 1615 SUNSET (Number) WAUKEGAN (City) 60087 (Zip Code)

County: LAKE

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

HFS ID Number:

Date of Initial License for Current Owners: 11/01/06

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) CEO

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,375	341	4,584	7,300	8
9	SNF/PED					9
10	ICF	28,849	4,465	120	33,434	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,224	4,806	4,704	40,734	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.04%

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 11/01/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 22 and days of care provided 4,584

Medicare Intermediary ADMINISTAR

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 THE TERRACE NH # 0048397 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	243,618	13,652	7,593	264,863		264,863		264,863			1
2	Food Purchase		220,416		220,416		220,416	(687)	219,729			2
3	Housekeeping	183,983	18,525		202,508		202,508	578	203,086			3
4	Laundry	66,885	16,325	6,061	89,271		89,271		89,271			4
5	Heat and Other Utilities			95,816	95,816		95,816	277	96,093			5
6	Maintenance	74,517	62,529	36,400	173,446		173,446	5,212	178,658			6
7	Other (specify):*			17,100	17,100		17,100	50	17,150			7
8	TOTAL General Services	569,003	331,447	162,970	1,063,420		1,063,420	5,430	1,068,850			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,212,845	100,240	13,096	2,326,181		2,326,181		2,326,181			10
10a	Therapy	133,129		8,807	141,936		141,936		141,936			10a
11	Activities	110,676	8,149		118,825		118,825		118,825			11
12	Social Services			2,449	2,449		2,449		2,449			12
13	CNA Training											13
14	Program Transportation			980	980		980		980			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,456,650	108,389	43,332	2,608,371		2,608,371		2,608,371			16
	C. General Administration											
17	Administrative	75,001		82,000	157,001		157,001	25,839	182,840			17
18	Directors Fees											18
19	Professional Services			54,965	54,965		54,965	(7,989)	46,976			19
20	Dues, Fees, Subscriptions & Promotions			35,320	35,320		35,320	(23,963)	11,357			20
21	Clerical & General Office Expenses	140,567	20,356	57,522	218,445		218,445	(5,191)	213,254			21
22	Employee Benefits & Payroll Taxes			605,678	605,678		605,678		605,678			22
23	Inservice Training & Education			1,835	1,835		1,835	8	1,843			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			17,345	17,345		17,345	685	18,030			25
26	Insurance-Prop.Liab.Malpractice			63,296	63,296		63,296	807	64,103			26
27	Other (specify):*			31,788	31,788		31,788	(22,811)	8,977			27
28	TOTAL General Administration	215,568	20,356	949,749	1,185,673		1,185,673	(32,615)	1,153,058			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,241,221	460,192	1,156,051	4,857,464		4,857,464	(27,185)	4,830,279			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#: THE TERRACE NH **#0048397** **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		1,653	
			0	7,593
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		6,061	
			0	6,061
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		32,793	
	ELECTRICITY		43,304	
	WATER		19,719	
	CABLE TV - LOBBY		0	
			0	95,816
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		7,480	
	PAINTING & DECORATING		2,025	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		13,487	
	ELEVATOR MAINTENANCE & REPAIR		5,948	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,619	
	FIRE SERVICE		5,841	
			0	
			0	
			0	
			0	36,400
7	**OTHER**			
	SCAVENGER		17,100	
	SECURITY SERVICE		0	
			0	
			0	17,100
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	18,000	18,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		2,990	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,432	
	PHARMACY CONSULTANT	XVIII B 39-2	5,540	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	134	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	13,096
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	4,186	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	3,603	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	1,018	
				8,807
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,449	
			0	2,449
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number THE TERRACE NH **#0048397** **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		980	980
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	82,000	82,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	14,755	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	40,210	
			0	54,965
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	6,523	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	7,214	
	LICENSES & PERMITS	XIX F	1,689	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	14,837	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3,957	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	600	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				35,320
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,277	
	EQUIPMENT REPAIR & MAINTENANCE		5,772	
	OUTSIDE CLERICAL SERVICES		30,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	65	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		20,408	
	MESSENGER SERVICE		0	
			0	57,522

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	242,519	
	UNEMPLOYMENT COMPENSATION	XIX D	23,555	
	WORKERS COMPENSATION INSURANC	XIX D	70,326	
	HOSPITALIZATION INSURANCE	XIX D	234,020	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,115	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	34,143	
	CHICAGO HEAD TAX	XIX D	0	
			0	605,678
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,835	
				1,835
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		17,345	
				17,345
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		63,296	
				63,296
27	**OTHER**			
	BAD DEBTS	VI 24	31,788	
				31,788

GRAND TOTAL COLUMN 3 OTHER **1,156,051**

THE TERRACE NH
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	220,416
LESS SALES TAX	(687)
NET FOOD	219,729
TOTAL PATIENT CENSUS	40,734
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	122,202
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	122,202
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	122,202
NET FOOD	219,729
DIVIDE TOTAL MEALS/YEAR	122,202
COST PER MEAL	1.80
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number THE TERRACE NH #0048397 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			5,450	5,450		5,450	843	6,293			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,194	1,194		1,194	(1,194)				32
33	Real Estate Taxes			86,933	86,933		86,933	1,166	88,099			33
34	Rent-Facility & Grounds			537,950	537,950		537,950		537,950			34
35	Rent-Equipment & Vehicles			72,234	72,234		72,234	839	73,073			35
36	Other (specify):* IME			8,970	8,970		8,970	(8,970)				36
37	**TOTAL Ownership**			712,731	712,731		712,731	(7,316)	705,415			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		119,532	625,598	745,130		745,130		745,130			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,963	62,963		62,963		62,963			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		119,532	688,561	808,093		808,093		808,093			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,241,221	579,724	2,557,343	6,378,288		6,378,288	(34,501)	6,343,787			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 THE TERRACE NH # 0048397 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 Refer-ence	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	(63)	30		9
10	Interest and Other Investment Income	(2,634)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(687)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(65)	21		18
19	Entertainment		20		19
20	Contributions	(4,457)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(31,788)	27		24
25	Fund Raising, Advertising and Promotional	(6,523)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(14,837)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(13,371)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (74,425)		$	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)	39,924		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 39,924		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (34,501)		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

THE TERRACE NH

ID# 0048397

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3	MARKETING AUTO LEASE	(1,177)	35	3
4	OTHER PROFESSIONAL FEES	(12,194)	19	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
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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**	(13,371)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE TERRACE NH # 0048397 **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	(687)	0	0	0	0	0	0	0	0	0	0	(687)	2
3	Housekeeping	0	0	578	0	0	0	0	0	0	0	0	578	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	277	0	0	0	0	0	0	277	5
6	Maintenance	0	0	2,293	1,908	1,011	0	0	0	0	0	0	5,212	6
7	Other (specify):*	0	0	21	0	29	0	0	0	0	0	0	50	7
8	**TOTAL General Services**	(687)	0	2,892	1,908	1,317	0	0	0	0	0	0	5,430	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	17,811	5,540	2,488	0	0	0	0	0	0	0	25,839	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,194)	56	3,787	314	48	0	0	0	0	0	0	(7,989)	19
20	Fees, Subscriptions & Promotions	(25,817)	0	1,807	0	47	0	0	0	0	0	0	(23,963)	20
21	Clerical & General Office Expenses	(65)	0	(10,482)	5,343	13	0	0	0	0	0	0	(5,191)	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	8	0	0	0	0	0	0	0	0	8	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	575	110	0	0	0	0	0	0	0	685	25
26	Insurance-Prop.Liab.Malpractice	0	0	245	504	58	0	0	0	0	0	0	807	26
27	Other (specify):*	(31,788)	0	2,965	6,012	0	0	0	0	0	0	0	(22,811)	27
28	**TOTAL General Administration**	(69,864)	17,867	4,445	14,771	166	0	0	0	0	0	0	(32,615)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(70,551)	17,867	7,337	16,679	1,483	0	0	0	0	0	0	(27,185)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE TERRACE NH # 0048397 **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	(63)	0	74	0	832	0	0	0	0	0	0	843	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,634)	0	0	0	1,440	0	0	0	0	0	0	(1,194)	32
33	Real Estate Taxes	0	0	0	0	1,166	0	0	0	0	0	0	1,166	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(1,177)	0	1,402	232	382	0	0	0	0	0	0	839	35
36	Other (specify):*	0	0	0	0	(8,970)	0	0	0	0	0	0	(8,970)	36
37	**TOTAL Ownership**	(3,874)	0	1,476	232	(5,150)	0	0	0	0	0	0	(7,316)	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)**	(74,425)	17,867	8,813	16,911	(3,667)	0	0	0	0	0	0	(34,501)	45

Facility Name & ID Number THE TERRACE NH # 0048397 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
				6865 FINANCIAL INC	LINCOLNWOOD	MANAGEMENT
				EKS MGMT.	LINCOLNWOOD	BOOKKEEPING
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		EMI ENTERPRISES	LINCOLNWOOD	MANAGEMENT
				IME REALTY	LINCOLNWOOD	HOME OFFICE

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

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

1 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	$ 72,000	6865 FINANCIAL INC		$	$ (72,000)	1
2	V	17	EMI ENTERPRISES				27,416	27,416	2
3	V	17	PHILIP ESFORMES INC				37,516	37,516	3
4	V	17	DANIEL WEISS				2,605	2,605	4
5	V	17	AVRUM WEINFELD				12,173	12,173	5
6	V	17	MICHAEL ROSEN				10,101	10,101	6
7	V	19	ACCOUNTING FEES				56	56	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 72,000			$ 89,867	$ * 17,867	14

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

Facility Name & ID Number THE TERRACE NH # 0048397 Report Period Beginning: 01/01/2010 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	OUTSIDE CLERICAL	$ 30,000	EKS MANAGEMENT		$	$ (30,000)	15
16	V	3	HOUSEKEEPING SALARIES				578	578	16
17	V	6	PAINTER SALARIES				2,293	2,293	17
18	V	7	SCAVENGER				21	21	18
19	V	17	CFO SALARY - A. WEINFELD				5,540	5,540	19
20	V	19	PROFESSIONAL FEES				3,787	3,787	20
21	V	20	WANT ADS/BACKGR CKS				1,807	1,807	21
22	V	21	OFFICE				19,518	19,518	22
23	V	23	SEMINARS				8	8	23
24	V	25	TRANSPORTATION				575	575	24
25	V	26	INSURANCE				245	245	25
26	V	27	EMPLOYEE BENEFITS				2,965	2,965	26
27	V	30	DEPRECIATION (SL)				74	74	27
28	V	35	EQUIPMENT RENT				1,402	1,402	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			$ 30,000			$ 38,813	$ * 8,813	39

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

Facility Name & ID Number THE TERRACE NH # 0048397 Report Period Beginning: 01/01/2010 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	$ 10,000	EMI MANAGEMENT		$	$ (10,000)	15
16	V	6	DRIVERS' SALARY				1,908	1,908	16
17	V	17	OFFICER SALARY				9,397	9,397	17
18	V	17	REGIONAL DIRECTOR				3,091	3,091	18
19	V	19	ACCOUNTING FEES				314	314	19
20	V	21	OFFICE				5,343	5,343	20
21	V	25	TRANSPORTATION				110	110	21
22	V	26	INSURANCE				504	504	22
23	V	27	EMPLOYEE BENEFITS				6,012	6,012	23
24	V	35	AUTO LEASE				232	232	24
25	V								25
26	V								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			$ 10,000			$ 26,911	$ * 16,911	39

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

Facility Name & ID Number THE TERRACE NH # 0048397 Report Period Beginning: 01/01/2010 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	$ 8,970	IME REALTY		$	$ (8,970)	15
16	V	5	UTILITIES				277	277	16
17	V	6	PAINTERS FEES				295	295	17
18	V	6	REPAIRS / MAINT				716	716	18
19	V	7	ALARM SERVICE				29	29	19
20	V	19	ACCOUNTING FEES				48	48	20
21	V	21	OFFICE EXPENSE				13	13	21
22	V	26	INSURANCE				58	58	22
23	V	30	DEPRECIATION				832	832	23
24	V	32	INTEREST				1,440	1,440	24
25	V	33	R/E TAX				1,166	1,166	25
26	V	35	STORAGE FEES				382	382	26
27	V	20	LICENSES & PERMITS				47	47	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			$ 8,970			$ 5,303	$ * (3,667)	39

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

Facility Name & ID Number THE TERRACE NH # 0048397 Report Period Beginning: 01/01/2010 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: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	MORRIS ESFORMES		ADMINISTRATIV	48.00				SALARY	$ 9,397	17-7	1
2								MGT FEE	27,416	17-7	2
3	PHILIP ESFORMES		ADMINISTRATIV	48.00				MGT FEE	37,516	17-7	3
4					SEE						4
5	DANIEL WEISS		ADMINISTRATIVE		ATTACHED			MGT FEE	2,605	17-7	5
6					SCHEDULE						6
7	AVRUM WEINFELD		ADMINISTRATIV	2.00				MGT FEE	12,173	17-7	7
8								SALARY	5,540	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 94,647		13

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

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

Facility Name & ID Number THE TERRACE NH # 0048397 Report Period Beginning: 01/01/2010 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 AVE
City / State / Zip Code: LINCOLNWOOD,IL. 60712
Phone Number: (847)674-5795
Fax Number: (847)674-5794

	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	$	40,734	$ 27,416	1
2	17	PHILIP ESFORMES INC	PATIENT DAYS	508,141	10	468,000		40,734	37,516	2
3	17	DANIEL WEISS	PATIENT DAYS	508,141	10	32,500		40,734	2,605	3
4	17	AVRUM WEINFELD	PATIENT DAYS	508,141	10	151,856		40,734	12,173	4
5	17	MICHAEL ROSEN	PATIENT DAYS	508,141	10	126,000		40,734	10,101	5
6	19	ACCOUNTING FEES	PATIENT DAYS	508,141	10	700		40,734	56	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	$		$ 89,867	25

Facility Name & ID Number THE TERRACE NH # 0048397 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 AVE
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	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	40,734	$ 578	1
2	6	PAINTERS' SALARIES	PATIENT DAYS	845,281	14	47,580	47,580	40,734	2,293	2
3	7	SCAVENGER	PATIENT DAYS	845,281	14	441		40,734	21	3
4	17	CFO SALARY - A. WEINFELD	PATIENT DAYS	845,281	14	114,971	114,971	40,734	5,540	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	845,281	14	78,585	66,116	40,734	3,787	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	845,281	14	37,500		40,734	1,807	6
7	21	OFFICE EXPENSE	PATIENT DAYS	845,281	14	405,027	295,327	40,734	19,518	7
8	23	SEMINAR	PATIENT DAYS	845,281	14	175		40,734	8	8
9	25	TRANSPORTATION	PATIENT DAYS	845,281	14	11,931		40,734	575	9
10	26	INSURANCE	PATIENT DAYS	845,281	14	5,077		40,734	245	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	845,281	14	61,528		40,734	2,965	11
12	30	DEPRECIATION S.L	PATIENT DAYS	845,281	14	1,536		40,734	74	12
13	35	EQUIPMENT RENT	PATIENT DAYS	845,281	14	29,093		40,734	1,402	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		$ 38,813	25

Facility Name & ID Number THE TERRACE NH # 0048397 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 MANAGEMENT
Street Address: 6865 N. LINCOLN AVE
City / State / Zip Code: LINCOLNWOOD , IL. 60712
Phone Number: (847)674-5795
Fax Number: (847)674-5794

	1 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' SALARY	PATIENT DAYS	845,281	14	$ 39,600	$ 39,600	40,734	$ 1,908	1
2	17	OFFICER SALARY	PATIENT DAYS	845,281	14	195,000	195,000	40,734	9,397	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	845,281	14	64,150	64,150	40,734	3,091	3
4	19	ACCOUNTING FEES	PATIENT DAYS	845,281	14	6,525		40,734	314	4
5	21	OFFICE	PATIENT DAYS	845,281	14	110,874	58,558	40,734	5,343	5
6	25	TRANSPORTATION	PATIENT DAYS	845,281	14	2,287		40,734	110	6
7	26	INSURANCE	PATIENT DAYS	845,281	14	10,450		40,734	504	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	845,281	14	124,762		40,734	6,012	8
9	35	AUTO LEASE	PATIENT DAYS	845,281	14	4,824		40,734	232	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					$ 558,472	$ 357,308		$ 26,911	25

Facility Name & ID Number THE TERRACE NH # 0048397 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) 674-5795
Fax Number: (847) 675-5794

	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	INCOME	187,059	14	$ 5,775	$	8,970	$ 277	1
2	6	PAINTERS FEES	INCOME	187,059	14	6,152		8,970	295	2
3	6	REPAIRS / MAINT	INCOME	187,059	14	14,941		8,970	716	3
4	7	ALARM SERVICE	INCOME	187,059	14	601		8,970	29	4
5	19	PROFESSIONAL FEES	INCOME	187,059	14	998		8,970	48	5
6	21	OFFICE EXPENSE	INCOME	187,059	14	274		8,970	13	6
7	26	INSURANCE	INCOME	187,059	14	1,211		8,970	58	7
8	30	DEPRECIATION	INCOME	187,059	14	17,356		8,970	832	8
9	32	INTEREST	INCOME	187,059	14	30,039		8,970	1,440	9
10	33	R/E TAX	INCOME	187,059	14	24,313		8,970	1,166	10
11	35	STORAGE FEES	INCOME	187,059	14	7,961		8,970	382	11
12	20	LICENSES & PERMITS	INCOME	187,059	14	971		8,970	47	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	$		$ 5,303	25

Facility Name & ID Number THE TERRACE NH # 0048397 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	RELATED PARTY										1,440	5
	Working Capital											
6	THE PRIVATE BANK		X	WORKING CAPITAL	INTEREST	REVOLV					1,194	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 2,634	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 2,634	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 THE TERRACE NH # 0048397 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.**	$ 81,014	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.)		$ 83,973	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,960	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 83,973	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.		$ 86,933	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	74,497	8
	2006	76,451	9
	2007	76,756	10
	2008	81,014	11
	2009	83,973	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% 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 THE TERRACE NH COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0048397

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 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.	08-08-403-011	NURSING HOME	$ 83,973.43	$ 83,973.43
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,973.43	$ 83,973.43

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 THE TERRACE NH # 0048397 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [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? [ ] (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).

N/A

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number THE TERRACE NH # 0048397 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	RELATED PARTY					800		800			7
8											8
	Improvement Type**										
9	DOORS			2007	16,876	614	27.5	614		2,123	9
10	RAIL GUARDS & KICK PLATES			2007	11,890	432	27.5	432		1,314	10
11	DRYWALL STAIRWELLS & 2ND FL CORRIDOR			2009	21,652	787	27.5	787		1,082	11
12	INSTALL 5 TON CONDENSER			2009	3,732	136	27.5	136		187	12
13	ANNUNCIATOR & CONYTOL PANEL			2009	9,457	344	27.5	344		473	13
14	COMPRESSOR & 275 AMP CONTRACTOR			2009	9,893	360	27.5	360		495	14
15	SIDEWALK & EMERGENCY EXIT LIGHTING			2009	3,600	240	15	240		360	15
16	FLOOR TILE			2010	8,121	160	27.5	160		160	16
17	4 TO CHILLER WITH VALVES & FREEZE PIPING			2010	5,839	44	27.5	44		44	17
18											18
19											19
20	ROOF- LANDLORD			2009	84,700						20
21	WINDOWS- LANDLORD			2010	32,864						21
22	PARKING LOT- LANDLORD			2010	33,630						22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number THE TERRACE NH # 0048397 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)		$ 242,254	$ 3,917		$ 3,917	$	$ 6,238	70

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

Facility Name & ID Number THE TERRACE NH # 0048397 Report Period Beginning: 01/01/2010 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	$ 22,697	$ 2,333	$ 2,270	$ (63)	10 YRS	$ 6,593	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY		106	106				74
75	TOTALS	$ 22,697	$ 2,439	$ 2,376	$ (63)		$ 6,593	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)	$ 264,951	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 6,356	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 6,293	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (63)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 12,831	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number THE TERRACE NH # 0048397 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 WAUKEGAN TERRACE LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [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:		115	11/01/06	$ 537,950	5.5	5	3
4	Additions							4
5								5
6								6
7	TOTAL		115		$ 537,950 **			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: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 47,252 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	ADMINISTRATOR	2010 Toyota Highlander	$ 499.00	$ 7,863	17
18	MARKETING	2006 MERCEDES BENZ	#######	1,177	18
19	FACILITY	2007 FORD E350 WAGON	#######	15,348	19
20	PAINTERS	2010 FORD TRAN	593.70	594	20
21	TOTAL		$ #######	$ 24,982	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 THE TERRACE NH # 0048397 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 THE TERRACE NH

STATE OF ILLINOIS
0048397 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	$		$ 315,330	$		$ 315,330	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			15,803			15,803	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			287,836			287,836	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				119,532		119,532	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): LABORATORY	39-2				6,629			6,629	13
14	TOTAL			$		$ 625,598	$ 119,532		$ 745,130	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 THE TERRACE NH # 0048397 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	$ 164,928	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (300,000))	421,313		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	123,050		6
7	Other Prepaid Expenses	30,333		7
8	Accounts Receivable (owners or related parties)	102,156		8
9	Other(specify): Real Estate Escrow Deposit	36,246		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 878,026	$	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	91,060		15
16	Equipment, at Historical Cost	22,697		16
17	Accumulated Depreciation (book methods)	(25,522)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	131,447		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 219,682	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,097,708	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 193,378	$	26
27	Officer's Accounts Payable	11,135		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	115,803		30
31	Accrued Taxes Payable (excluding real estate taxes)	44,491		31
32	Accrued Real Estate Taxes(Sch.IX-B)	83,973		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)**	$ 448,780	$	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)**	$ 448,780	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 648,928	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,097,708	$	48

*(See instructions.)

Facility Name & ID Number THE TERRACE NH # 0048397 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**	$ 303,933	1
2	Restatements (describe):		2
3	POST CLOSING LOAN RECLASSIFIED AS CAPITAL	147,037	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 450,970	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	549,111	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	(351,153)	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)**	$ 197,958	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)**	$ 648,928	24 *

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

Facility Name & ID Number THE TERRACE NH # 0048397 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	$ 6,511,376	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,511,376	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	406,708	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 406,708	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***	11,332	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,332	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,929,416	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,063,420	31
32	Health Care	2,608,371	32
33	General Administration	1,185,673	33
	B. Capital Expense		
34	Ownership	712,731	34
	C. Ancillary Expense		
35	Special Cost Centers	745,130	35
36	Provider Participation Fee	62,963	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,378,288	40
41	**Income before Income Taxes (line 30 minus line 40)****	551,128	41
42	**Income Taxes**	(2,017)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 549,111	43

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

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

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

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

Facility Name & ID Number THE TERRACE NH # 0048397 Report Period Beginning: 01/01/2010 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	3,848	4,160	$ 117,698	$ 28.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	30,270	31,970	912,020	28.53	3
4	Licensed Practical Nurses	6,281	6,462	148,352	22.96	4
5	CNAs & Orderlies	80,293	85,867	967,530	11.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,515	12,546	133,129	10.61	8
9	Activity Director					9
10	Activity Assistants	8,051	8,760	110,676	12.63	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,040	25,851	243,618	9.42	15
16	Dishwashers					16
17	Maintenance Workers	5,013	5,201	74,517	14.33	17
18	Housekeepers	18,731	20,049	183,983	9.18	18
19	Laundry	6,445	7,044	66,885	9.50	19
20	Administrator	1,928	2,080	75,001	36.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,067	11,986	140,567	11.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,703	1,881	17,450	9.28	31
32	Other Health C: MDS COORDIN	1,921	2,091	49,795	23.81	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	211,106	225,948	$ 3,241,221 *	$ 14.34	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	18,000	9-3	36
37	Medical Records Consultant	N	4,432	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,540	10-3	39
40	Physical Therapy Consultant	L	4,186	10a-3	40
41	Occupational Therapy Consultant	Y	3,603	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	1,018	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	2,449	12-3	45
46	Other(specify) PHYSICIANS	S	134	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 45,302		49

C. CONTRACT NURSES

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

Facility Name & ID Number THE TERRACE NH # 0048397 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ROSE SHULZ	ADMINISTRATOR	0	$ 75,001
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,001

B. Administrative - Other

Description		Amount
6865 FINANCIAL INS	MANAGEMENT FEES	$ 72,000
EMI ENTERPRISES	MANAGEMENT FEES	10,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 82,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		54,965
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 54,965

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,326
Unemployment Compensation Insurance	23,555
FICA Taxes	242,519
Employee Health Insurance	234,020
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	1,115
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	34,143
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 605,678

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	0
Health Care Worker Background Check	600
(Indicate # of checks performed 15)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	4,457
MARKETING/ADV/PROMO	21,360
LICENSES/DUES/SUBSCRIPTIONS	8,903
MGMT CO ALLOC	1,854
TRUST/FRANCHISE/CONTRIB/ETC	(4,457)
Less: Public Relations Expense	(0)
Non-allowable advertising	(6,523)
Yellow page advertising	(14,837)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,357

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 THE TERRACE NH # 0048397 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							N/A						
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number THE TERRACE NH # 0048397 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. **IL COUNCIL LONG TERM CARE $9,499**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
TERRACE NURSING HOME, LLC 00043943 11/01/06

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **62,963**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.