		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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.

I. IDPH License ID Number: 0048413

Facility Name: KANKAKEE TERRACE OPERATOR LLC

Address: 100 BELLAIRE (Number) BOURBONNAIS (City) 60491 (Zip Code)

County: KANKAKEE

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

HFS ID Number:

Date of Initial License for Current Owners:

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 01/01/2011 to 12/31/2011 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 OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	48,233	504	2,535	51,272	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,233	504	2,535	51,272	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.21%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	219,570	17,119	5,940	242,629		242,629		242,629			1
2	Food Purchase		259,340		259,340		259,340	(730)	258,610			2
3	Housekeeping	238,762	27,519		266,281		266,281		266,281			3
4	Laundry	90,674	14,333	5,135	110,142		110,142		110,142			4
5	Heat and Other Utilities			130,161	130,161		130,161	311	130,472			5
6	Maintenance	17,544	27,639	30,844	76,027		76,027	5,598	81,625			6
7	Other (specify):*			6,754	6,754		6,754	59	6,813			7
8	TOTAL General Services	566,550	345,950	178,834	1,091,334		1,091,334	5,238	1,096,572			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,376,563	41,878	112,949	1,531,390		1,531,390		1,531,390			10
10a	Therapy	21,056			21,056		21,056		21,056			10a
11	Activities	60,233	3,447	3,016	66,696		66,696		66,696			11
12	Social Services			4,052	4,052		4,052		4,052			12
13	CNA Training											13
14	Program Transportation			3,850	3,850		3,850		3,850			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,457,852	45,325	133,467	1,636,644		1,636,644		1,636,644			16
	C. General Administration											
17	Administrative	81,172		312,000	393,172		393,172	(191,358)	201,814			17
18	Directors Fees											18
19	Professional Services			71,726	71,726		71,726	(13,500)	58,226			19
20	Dues, Fees, Subscriptions & Promotions			14,614	14,614		14,614	(1,782)	12,832			20
21	Clerical & General Office Expenses	101,475	18,714	89,124	209,313		209,313	(73,986)	135,327			21
22	Employee Benefits & Payroll Taxes			357,994	357,994		357,994		357,994			22
23	Inservice Training & Education			1,420	1,420		1,420	7	1,427			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			34,069	34,069		34,069	947	35,016			25
26	Insurance-Prop.Liab.Malpractice			56,717	56,717		56,717	1,003	57,720			26
27	Other (specify):*			1,200	1,200		1,200	8,138	9,338			27
28	TOTAL General Administration	182,647	18,714	938,864	1,140,225		1,140,225	(270,531)	869,694			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,207,049	409,989	1,251,165	3,868,203		3,868,203	(265,293)	3,602,910			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 OPERATOR LLC #0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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		5,135	
			0	5,135
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		30,176	
	ELECTRICITY		45,386	
	WATER		43,486	
	CABLE TV - LOBBY		11,113	
			0	130,161
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,335	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		10,463	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		960	
	EXTERMINATING SERVICE		2,267	
	FIRE SERVICE		12,819	
			0	
			0	
			0	
			0	30,844
7	**OTHER**			
	SCAVENGER		6,754	
	SECURITY SERVICE		0	
			0	
			0	6,754
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		102,341	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	7,008	
	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	112,949
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		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,016	
			0	3,016
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,052	
				4,052
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC **#0048413** **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		3,850	3,850
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	312,000	312,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	12,887	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	58,839	
			0	71,726
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	1,598	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	5,546	
	LICENSES & PERMITS	XIX F	4,829	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,833	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	
	PATIENT BACKGROUND CHECKS	XIX F	308	
				14,614
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		191	
	EQUIPMENT REPAIR & MAINTENANCE		1,565	
	OUTSIDE CLERICAL SERVICES		78,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		9,368	
	MESSENGER SERVICE		0	
			0	89,124

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	166,501	
	UNEMPLOYMENT COMPENSATION	XIX D	14,269	
	WORKERS COMPENSATION INSURANC	XIX D	55,385	
	HOSPITALIZATION INSURANCE	XIX D	100,910	
	EMPLOYEE BENEFITS - OTHER	XIX D	0	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	20,929	
	CHICAGO HEAD TAX	XIX D	0	
			0	357,994
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,420	
				1,420
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		34,069	
				34,069
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		56,717	
				56,717
27	**OTHER**			
	BAD DEBTS	VI 24	1,200	
				1,200

GRAND TOTAL COLUMN 3 OTHER **1,251,165**

KANKAKEE TERRACE OPERATOR LLC
SCHEDULES
12/31/2011

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

TOTAL FOOD PURCHASE	259,340
LESS SALES TAX	(730)
NET FOOD	258,610
TOTAL PATIENT CENSUS	51,272
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	153,816
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	153,816
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	153,816
NET FOOD	258,610
DIVIDE TOTAL MEALS/YEAR	153,816
COST PER MEAL	1.68
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC #0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			9,470	9,470		9,470	915	10,385			30
31	Amortization of Pre-Op. & Org.			416	416		416		416			31
32	Interest			8,712	8,712		8,712	(15,015)	(6,303)			32
33	Real Estate Taxes			48,441	48,441		48,441	1,676	50,117			33
34	Rent-Facility & Grounds			1,287,020	1,287,020		1,287,020		1,287,020			34
35	Rent-Equipment & Vehicles			41,082	41,082		41,082	1,904	42,986			35
36	Other (specify):* OFFICE RENT			11,832	11,832		11,832	(11,832)				36
37	TOTAL Ownership			1,406,973	1,406,973		1,406,973	(22,352)	1,384,621			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)	2,207,049	409,989	2,738,073	5,355,111		5,355,111	(287,645)	5,067,466			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 OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(203)	30		9
10	Interest and Other Investment Income	(16,749)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(730)	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	(500)	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	(1,598)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,833)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(44,609)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (67,422)		$	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)	(220,223)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (220,223)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (287,645)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

KANKAKEE TERRACE OPERATOR LLC

ID# 0048413

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NON ALLOWABLE PROFESSIONAL FEES	$ -19348	19	1
2	MARKETING SALARIES	(24,096)	21	2
3	MARKETING VEHICLE RENTAL	(1,165)	35	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
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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**	(44,609)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC # 0048413 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	(730)	0	0	0	0	0	0	0	0	0	0	(730)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	311	0	0	0	0	0	0	0	311	5
6	Maintenance	0	0	2,355	796	2,447	0	0	0	0	0	0	5,598	6
7	Other (specify):*	0	0	59	0	0	0	0	0	0	0	0	59	7
8	**TOTAL General Services**	(730)	0	2,414	1,107	2,447	0	0	0	0	0	0	5,238	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	(222,265)	6,954	0	23,953	0	0	0	0	0	0	(191,358)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(19,348)	75	5,322	59	392	0	0	0	0	0	0	(13,500)	19
20	Fees, Subscriptions & Promotions	(3,931)	0	2,117	32	0	0	0	0	0	0	0	(1,782)	20
21	Clerical & General Office Expenses	(24,096)	0	(55,161)	0	5,271	0	0	0	0	0	0	(73,986)	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	7	0	0	0	0	0	0	0	0	7	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	805	0	142	0	0	0	0	0	0	947	25
26	Insurance-Prop.Liab.Malpractice	0	0	151	76	776	0	0	0	0	0	0	1,003	26
27	Other (specify):*	(1,200)	0	3,639	0	5,699	0	0	0	0	0	0	8,138	27
28	**TOTAL General Administration**	(48,575)	(222,190)	(36,166)	167	36,233	0	0	0	0	0	0	(270,531)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(49,305)	(222,190)	(33,752)	1,274	38,680	0	0	0	0	0	0	(265,293)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC # 0048413 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(203)	0	93	1,025	0	0	0	0	0	0	0	915	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,749)	0	0	1,734	0	0	0	0	0	0	0	(15,015)	32
33	Real Estate Taxes	0	0	0	1,676	0	0	0	0	0	0	0	1,676	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(1,165)	0	2,229	512	328	0	0	0	0	0	0	1,904	35
36	Other (specify):*	0	0	0	(11,832)	0	0	0	0	0	0	0	(11,832)	36
37	**TOTAL Ownership**	(18,117)	0	2,322	(6,885)	328	0	0	0	0	0	0	(22,352)	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)**	(67,422)	(222,190)	(31,430)	(5,611)	39,008	0	0	0	0	0	0	(287,645)	45

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
SCHEDULE ATTACHED		SCHEDULE ATTACHED		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	$ 312,000	6865 FINANCIAL INC	100.00%	$	$ (312,000)	1
2	V								2
3	V	17	EMI ENTERPRISES				21,681	21,681	3
4	V	17	PHILIP ESFORMES INC				43,362	43,362	4
5	V	17	MICHAEL ROSEN				21,681	21,681	5
6	V	17	DANIEL WEISS				3,011	3,011	6
7	V	19	ACCOUNTING FEES				75	75	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 312,000			$ 89,810	$ * (222,190)	14

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

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	100.00%	$	$ (78,000)	15
16	V								16
17	V								17
18	V	6	PAINTERS SALARIES				2,355	2,355	18
19	V	7	SCAVENGER				59	59	19
20	V	17	CFO SALARY				6,954	6,954	20
21	V	19	PROFESSIONAL FEES				5,322	5,322	21
22	V	20	WANT ADS/BACKGR CKS				2,117	2,117	22
23	V	21	OFFICE EXPENSE				22,839	22,839	23
24	V	23	SEMINARS				7	7	24
25	V	25	TRANSPORTATION				805	805	25
26	V	26	INSURANCE				151	151	26
27	V	27	EMPLOYEE BENEFITS				3,639	3,639	27
28	V	30	DERPECIATION (SL)				93	93	28
29	V	35	EQUIPMENT RENT				2,229	2,229	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			$ 46,570	$ * (31,430)	39

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

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 11,832	IME REALTY CORP	100.00%	$	$ (11,832)	15
16	V								16
17	V	5	UTILITIES				311	311	17
18	V	6	REPAIR & MAINTENANCE				796	796	18
19	V	19	PROFESSIONAL FEES				59	59	19
20	V	20	LICENSES & PERMITS				32	32	20
21	V	26	INSURANCE				76	76	21
22	V	30	DEPRECIATION				1,025	1,025	22
23	V	32	INTEREST				1,734	1,734	23
24	V	33	RE TAX				1,676	1,676	24
25	V	35	STORAGE FEES				512	512	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			$ 11,832			$ 6,221	$ * (5,611)	39

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

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$	EMI ENTERPRISES	100.00%	$	$	15
16	V								16
17	V	6	DRIVERS SALARIES				2,447	2,447	17
18	V	17	M ESFORMES,OFFICER				11,795	11,795	18
19	V	17	REGIONAL DIR-M ROSEN				363	363	19
20	V	17	MGMT CNSLT-P ESFORMES				11,795	11,795	20
21	V	19	ACCOUNTING FEES				392	392	21
22	V	21	OFFICE				5,271	5,271	22
23	V	25	TRANSPORTATION				142	142	23
24	V	26	INSURANCE				776	776	24
25	V	27	EMPLOYEE BENEFITS				5,699	5,699	25
26	V	35	AUTO LEASE				328	328	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			$			$ 39,008	$ * 39,008	39

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

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	ALLOCATION FROM EMI ENTERPRISES				SCHEDULE				$		1
2	MORRIS ESFORMES	PRESIDENT	MGMT	48.00	ATTACHED	4	5.00	SALARY	11,795	17-7	2
3	PHILLIP ESFORMES	ADMIN CNSLT	ADMIN	48.00		1	1.51	CNSLT FEE	11,795	17-7	3
4											4
5											5
6	ALLOCATION FROM EKS MANAGEMENT										6
7	FLORA WEISS	O/S CLERICAL	BOOKEEPING	0.00		0.5	0.89	CNSLT FEE	1,013	21-7	7
8	AVRUM WEINFELD	CFO	FINANCIAL	2.00		3	4.62	SALARY	6,954	17-7	8
9											9
10	6865 FINANCIAL INC										10
11	DANIEL WEISS	ADMIN CNSLT	ADMIN	0.00		0	0.00	CNSLT FEE	3,011	17-7	11
12	PHILIP ESFORMES	ADMIN CNSLT	ADMIN	48.00		2	3.02	CNSLT FEE	43,362	17-7	12
13								TOTAL	$ 77,930		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 OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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	510,807	10	$ 216,000	$	51,272	$ 21,681	1
2	17	PHILIP ESFORMES INC	PATIENT DAYS	510,807	10	432,000		51,272	43,362	2
3	17	MICHAEL ROSEN	PATIENT DAYS	510,807	10	216,000		51,272	21,681	3
4	17	DANIEL WEISS	PATIENT DAYS	510,807	10	30,000		51,272	3,011	4
5	19	ACCOUNTING FEES	PATIENT DAYS	510,807	10	750		51,272	75	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 894,750	$		$ 89,810	25

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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	6	PAINTERS SALARIES	PATIENT DAYS	847,662	14	$ 38,929	$ 38,929	51,272	$ 2,355	1
2	7	SCAVENGER	PATIENT DAYS	847,662	14	971		51,272	59	2
3	17	CFO SALARY	PATIENT DAYS	847,662	14	114,971	114,971	51,272	6,954	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	847,662	14	87,982	76,534	51,272	5,322	4
5	20	WANT ADS/BACKGR CKS	PATIENT DAYS	847,662	14	35,000		51,272	2,117	5
6	21	OFFICE EXPENSE	PATIENT DAYS	847,662	14	377,586	282,348	51,272	22,839	6
7	23	SEMINARS	PATIENT DAYS	847,662	14	115		51,272	7	7
8	25	TRANSPORTATION	PATIENT DAYS	847,662	14	13,315		51,272	805	8
9	26	INSURANCE	PATIENT DAYS	847,662	14	2,501		51,272	151	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,662	14	60,163		51,272	3,639	10
11	30	DEPRECIATION	PATIENT DAYS	847,662	14	1,536		51,272	93	11
12	35	EQUIPMENT RENT	PATIENT DAYS	847,662	14	36,848		51,272	2,229	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					$ 769,917	$ 512,782		$ 46,570	25

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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	195,459	15	$ 5,131	$	11,832	$ 311	1
2	6	REPAIR & MAINTENANCE	RENTAL INCOME	195,459	15	13,157		11,832	796	2
3	19	PROFESSIONAL FEES	RENTAL INCOME	195,459	15	973		11,832	59	3
4	20	LICENSE & PERMITS	RENTAL INCOME	195,459	15	526		11,832	32	4
5	26	INSURANCE	RENTAL INCOME	195,459	15	1,254		11,832	76	5
6	30	DEPRECIATION	RENTAL INCOME	195,459	15	16,930		11,832	1,025	6
7	32	INTEREST	RENTAL INCOME	195,459	15	28,650		11,832	1,734	7
8	33	RE TAX	RENTAL INCOME	195,459	15	27,693		11,832	1,676	8
9	35	STORAGE FEES	RENTAL INCOME	195,459	15	8,451		11,832	512	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					$ 102,765	$		$ 6,221	25

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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	847,662	14	$ 40,460	$ 40,460	51,272	$ 2,447	1
2	17	M ESFORMES,OFFICER	PATIENT DAYS	847,662	14	195,000	195,000	51,272	11,795	2
3	17	REGIONAL DIR-M ROSEN	PATIENT DAYS	847,662	14	6,000		51,272	363	3
4	17	MGMT CNSLT-P ESFORMES	PATIENT DAYS	847,662	14	195,000	195,000	51,272	11,795	4
5	19	ACCOUNTING FEES	PATIENT DAYS	847,662	14	6,480		51,272	392	5
6	21	OFFICE	PATIENT DAYS	847,662	14	87,144	58,016	51,272	5,271	6
7	25	TRANSPORTATION	PATIENT DAYS	847,662	14	2,349		51,272	142	7
8	26	INSURANCE	PATIENT DAYS	847,662	14	12,837		51,272	776	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,662	14	94,218		51,272	5,699	9
10	35	AUTO LEASE	PATIENT DAYS	847,662	14	5,423		51,272	328	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					$ 644,911	$ 488,476		$ 39,008	25

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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				1,334,000	05/14/12	3.2500	8,712	6
7	RELATED PARTY	X									1,734	7
8												8
9	TOTAL Facility Related						$	$ 1,334,000			$ 10,446	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 1,334,000			$ 10,446	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 OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 46,000	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.)		$ 46,441	2
3. Under or (over) accrual (line 2 minus line 1).		$ 441	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 48,000	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.		$ 48,441	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	45,192	8
	2007	43,545	9
	2008	44,370	10
	2009	45,067	11
	2010	46,441	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 2010 TAX BILL.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME KANKAKEE TERRACE OPERATOR LLC 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-09-20-107-041	NURSING HOME	$ 46,205.24	$ 46,205.24
2.	17-09-20-107-040	NURSING HOME	$ 235.70	$ 235.70
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 46,440.94	$ 46,440.94

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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).

N/A

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: 416
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 OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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					985		985			7
8											8
	Improvement Type**										
9	ROOF			2008	37,800	1,355	27.5	1,355		4,695	9
10	STEEL SUPPORT BEAMS			2008	76,400	2,818	27.5	2,818		9,673	10
11	FLOOR TILE, HANDRAIL			2008	30,268	1,084	27.5	1,084		3,756	11
12	PIPES & FITTINGS			2008	4,594	163	27.5	163		620	12
13	ROOFTOP AC			2009	7,904	287	27.5	287		706	13
14	ACHIITECT FEES LIFE SAFETY			2009	4,614	168	27.5	168		413	14
15	TILE INSTALLATION			2010	12,632	459	27.5	459		670	15
16	ROOFTOP AC UNIT			2010	6,955	253	27.5	253		370	16
17	CONCRETE PAD			2010	3,800	138	27.5	138		200	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 OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 7,710		$ 7,710	$	$ 21,103	70

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

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 25,416	$ 2,745	$ 2,542	$ (203)	10YRS	$ 8,708	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY		133	133				74
75	TOTALS	$ 25,416	$ 2,878	$ 2,675	$ (203)		$ 8,708	75

D. Vehicle Costs. (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)	$ 10,588	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 10,385	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (203)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 29,811	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 OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. ☐ 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 ☒ 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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 9,840 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 NAVIGA	$ #######	$ 11,899	17
18	FACILITY	2006 FORD E350	788.54	8,674	18
19	FACILITY	2009 FORD E350	550.00	7,150	19
20		MISC		3,519	20
21	TOTAL		$ #######	$ 31,242	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 OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.

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 ____

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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.

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			N/A				9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

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

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (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	$ 235,335	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 194,299)	1,778,592		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	66,971		6
7	Other Prepaid Expenses	463		7
8	Accounts Receivable (owners or related parties)	768,952		8
9	Other(specify): RE TAX / INS ESCROW	51,332		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,901,645	$	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)	(42,845)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,500		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,500)		20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CONSTRUCTION	66,430		22
23	Other(specify): REPL RESV/ADV RENT	181,602		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 415,569	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,317,214	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 157,190	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,334,000		29
30	Accrued Salaries Payable	48,330		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,143		31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,593,663	$	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)**	$ 1,593,663	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,723,551	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,317,214	$	48

***(See instructions.)**

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,589,239	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,589,239	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	507,512	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	(373,200)	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)**	$ 134,312	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)**	$ 1,723,551	24 *

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

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 5,875,411	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,875,411	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***	16,749	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,749	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)**	$ 5,892,160	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,091,334	31
32	Health Care	1,636,644	32
33	General Administration	1,140,225	33
	B. Capital Expense		
34	Ownership	1,406,973	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)***	$ 5,355,111	40
41	**Income before Income Taxes (line 30 minus line 40)****	537,049	41
42	**Income Taxes**	(29,537)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 507,512	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 OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	1,978	2,096	$ 67,491	$ 32.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,761	2,885	70,222	24.34	3
4	Licensed Practical Nurses	13,803	14,669	293,584	20.01	4
5	CNAs & Orderlies	54,346	58,935	691,599	11.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,054	1,356	21,056	15.53	8
9	Activity Director					9
10	Activity Assistants	5,282	5,494	60,233	10.96	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,151	19,441	219,570	11.29	15
16	Dishwashers					16
17	Maintenance Workers	2,344	2,464	17,544	7.12	17
18	Housekeepers	19,832	22,302	238,762	10.71	18
19	Laundry	6,545	7,200	90,674	12.59	19
20	Administrator	2,088	2,088	81,172	38.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,456	12,019	101,475	8.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,546	10,150	164,800	16.24	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	6,071	6,435	88,867	13.81	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	155,257	167,534	$ 2,207,049 *	$ 13.17	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	7,008	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	3,016	11-3	44
45	Social Service Consultant	E	4,052	12-3	45
46	Other(specify) DENTAL	S	3,600	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 33,216		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 KANKAKEE TERRACE OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TRACI POWER	ADMINISTRATOR	0	$ 81,172
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 81,172

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 312,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 312,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		71,726
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 71,726

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,385
Unemployment Compensation Insurance	14,269
FICA Taxes	166,501
Employee Health Insurance	100,910
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING PLANS	20,929
TOTAL (agree to Schedule V, line 22, col.8)	$ 357,994

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	0
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks 7	308
TRUST/FRANCHISE/CONTRIB/ETC	500
MARKETING/ADV/PROMO	3,431
LICENSES/DUES/SUBSCRIPTIONS	6,395
MGMT CO ALLOC	2,149
TRUST/FRANCHISE/CONTRIB/ETC	(500)
Less: Public Relations Expense	(0)
Non-allowable advertising	(1,598)
Yellow page advertising	(1,833)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,832

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)	$

**See instructions.

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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							N/A						
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number KANKAKEE TERRACE OPERATOR LLC # 0048413 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 $5,256**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(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. $ **2,034** 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 fo
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 Departmen
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
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 othe
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
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