

		FOR BHF USE					

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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.

<p>I. IDPH License ID Number: <u>0048371</u></p> <p>Facility Name: <u>FRANKFORT TERRACE OPERATOR LLC</u></p> <p>Address: <u>40 N SMITH ST</u> <u>FRANKFORT</u> <u>60423</u> <small>Number City Zip Code</small></p> <p>County: <u>WILL</u></p> <p>Telephone Number: <u>(847) 674-5795</u> Fax # <u>(847) 674-5794</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>11/01/2006</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Type or Print Name) <u>AVRUM WEINFELD</u> (Title) <u>CFO</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>AVRUM WEINFELD</u> (Title) <u>CFO</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number FRANKFORT TERRACE OPERATOR LLC

0048371 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,800	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	42,815	151		42,966	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,815	151		42,966	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.10%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 11/01/2006

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/01/2006 NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number **FRANKFORT TERRACE OPERATOR LLC** # **0048371** 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	159,314	14,336	5,940	179,590		179,590		179,590		1
2	Food Purchase		239,626		239,626		239,626	(624)	239,002		2
3	Housekeeping	165,147	18,496		183,643		183,643		183,643		3
4	Laundry	66,466	7,858	1,381	75,705		75,705		75,705		4
5	Heat and Other Utilities			77,589	77,589		77,589	261	77,850		5
6	Maintenance	132,983	14,658	35,514	183,155		183,155	4,694	187,849		6
7	Other (specify):*			9,183	9,183		9,183	49	9,232		7
8	TOTAL General Services	523,910	294,974	129,607	948,491		948,491	4,380	952,871		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	1,218,779	45,890	11,206	1,275,875		1,275,875		1,275,875		10
10a	Therapy	23,897			23,897		23,897		23,897		10a
11	Activities	120,215	4,006	5,858	130,079		130,079		130,079		11
12	Social Services	120,499			120,499		120,499		120,499		12
13	CNA Training										13
14	Program Transportation			1,574	1,574		1,574		1,574		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,483,390	49,896	21,638	1,554,924		1,554,924		1,554,924		16
	C. General Administration										
17	Administrative	117,089		80,470	197,559		197,559	20,628	218,187		17
18	Directors Fees										18
19	Professional Services			74,126	74,126		74,126	(16,580)	57,546		19
20	Dues, Fees, Subscriptions & Promotions			18,872	18,872		18,872	(2,954)	15,918		20
21	Clerical & General Office Expenses	80,641	13,400	84,573	178,614		178,614	(31,660)	146,954		21
22	Employee Benefits & Payroll Taxes			274,881	274,881		274,881		274,881		22
23	Inservice Training & Education			280	280		280	6	286		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			9,466	9,466		9,466	794	10,260		25
26	Insurance-Prop.Liab.Malpractice			45,455	45,455		45,455	842	46,297		26
27	Other (specify):*			11,100	11,100		11,100	(3,274)	7,826		27
28	TOTAL General Administration	197,730	13,400	599,223	810,353		810,353	(32,198)	778,155		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,205,030	358,270	750,468	3,313,768		3,313,768	(27,818)	3,285,950		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	5,940
	REPAIRS & MAINTENANCE	0
		0
		5,940
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,381
		0
		1,381
5	HEAT & OTHER UTILITIES	
	GAS HEAT	31,544
	ELECTRICITY	15,301
	WATER	30,744
	CABLE TV - LOBBY	0
		0
		77,589
6	MAINTENANCE	
	GROUNDS MAINTENANCE	8,345
	PAINTING & DECORATING	2,209
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	15,248
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	1,050
	EXTERMINATING SERVICE	1,987
	FIRE SERVICE	6,675
		0
		0
		0
		0
		35,514
7	OTHER	
	SCAVENGER	8,929
	SECURITY SERVICE	254
		0
		0
		9,183
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	3,000
		3,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	5,760
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	1,846
	DENTAL	3,600
		0
		11,206
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 CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT 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	5,858
		0
		5,858
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	1,574
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	80,470
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	13,372
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	60,754
		0
		74,126
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	984
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	500
	DUES & SUBSCRIPTIONS XIX F	8,461
	LICENSES & PERMITS XIX F	4,680
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,271
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	600
	PATIENT BACKGROUND CHECKS XIX F	376
		18,872
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	193
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	78,000
	PENALTIES / OVERDRAFT CHARGES VI 18	250
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	6,130
	MESSENGER SERVICE	0
		0
		84,573

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	169,246
	UNEMPLOYMENT COMPENSATION XIX D	26,935
	WORKERS COMPENSATION INSURANC XIX D	49,444
	HOSPITALIZATION INSURANCE XIX D	17,411
	EMPLOYEE BENEFITS - OTHER XIX D	1,835
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	10,010
	CHICAGO HEAD TAX XIX D	0
		0
		274,881
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	280
		280
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	9,466
		9,466
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	45,455
		45,455
27	OTHER	
	BAD DEBTS VI 24	11,100
		11,100

GRAND TOTAL COLUMN 3 OTHER

750,468

FRANKFORT TERRACE OPERATOR LLC
SCHEDULES
12/31/2011

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

TOTAL FOOD PURCHASE	239,626
LESS SALES TAX	<u>(624)</u>
NET FOOD	239,002

TOTAL PATIENT CENSUS	42,966
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	128,898

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

PATIENT MEALS	128,898
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	128,898

NET FOOD	239,002
DIVIDE TOTAL MEALS/YEAR	<u>128,898</u>

COST PER MEAL	1.85
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

=====

Facility Name & ID Number

FRANKFORT TERRACE OPERATOR LLC

#0048371

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			14,885	14,885		14,885	(4,196)	10,689			30
31	Amortization of Pre-Op. & Org.			416	416		416		416			31
32	Interest			7,842	7,842		7,842	(1,252)	6,590			32
33	Real Estate Taxes			61,849	61,849		61,849	1,411	63,260			33
34	Rent-Facility & Grounds			710,064	710,064		710,064		710,064			34
35	Rent-Equipment & Vehicles			30,151	30,151		30,151	2,574	32,725			35
36	Other (specify):* OFFICE RENT			9,960	9,960		9,960	(9,960)				36
37	TOTAL Ownership			835,167	835,167		835,167	(11,423)	823,744			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			65,700	65,700		65,700		65,700			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,205,030	358,270	1,651,335	4,214,635		4,214,635	(39,241)	4,175,394			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,137)	30		9
10	Interest and Other Investment Income	(2,712)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(624)	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	(250)	21		18
19	Entertainment				19
20	Contributions	(3,771)	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	(11,100)	27		24
25	Fund Raising, Advertising and Promotional	(984)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	(33,481)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (58,059)		\$	30

BHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	18,818		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 18,818		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (39,241)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID# 0048371

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ -12,000	21	1
2	NON ALLOWABLE PROFESSIONAL FEES	(21,481)	19	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
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13				13
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15				15
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29				29
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32				32
33				33
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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	(33,481)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FRANKFORT TERRACE OPERATOR LLC# 0048371

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	(624)	0	0	0	0	0	0	0	0	0	0	(624)	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	261	0	0	0	0	0	0	0	261	5
6	Maintenance	0	0	1,973	670	2,051	0	0	0	0	0	0	4,694	6
7	Other (specify):*	0	0	49	0	0	0	0	0	0	0	0	49	7
8	TOTAL General Services	(624)	0	2,022	931	2,051	0	0	0	0	0	0	4,380	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	(5,272)	5,828	0	20,072	0	0	0	0	0	0	20,628	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(21,481)	63	4,460	50	328	0	0	0	0	0	0	(16,580)	19
20	Fees, Subscriptions & Promotions	(4,755)	0	1,774	27	0	0	0	0	0	0	0	(2,954)	20
21	Clerical & General Office Expenses	(12,250)	0	(23,827)	0	4,417	0	0	0	0	0	0	(31,660)	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	6	0	0	0	0	0	0	0	0	6	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	675	0	119	0	0	0	0	0	0	794	25
26	Insurance-Prop.Liab.Malpractice	0	0	127	64	651	0	0	0	0	0	0	842	26
27	Other (specify):*	(11,100)	0	3,050	0	4,776	0	0	0	0	0	0	(3,274)	27
28	TOTAL General Administration	(49,586)	(5,209)	(7,907)	141	30,363	0	0	0	0	0	0	(32,198)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(50,210)	(5,209)	(5,885)	1,072	32,414	0	0	0	0	0	0	(27,818)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FRANKFORT TERRACE OPERATOR LLC# 0048371

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	(5,137)	0	78	863	0	0	0	0	0	0	0	(4,196)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,712)	0	0	1,460	0	0	0	0	0	0	0	(1,252)	32
33	Real Estate Taxes	0	0	0	1,411	0	0	0	0	0	0	0	1,411	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	1,868	431	275	0	0	0	0	0	0	2,574	35
36	Other (specify):*	0	0	0	(9,960)	0	0	0	0	0	0	0	(9,960)	36
37	TOTAL Ownership	(7,849)	0	1,946	(5,795)	275	0	0	0	0	0	0	(11,423)	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)	(58,059)	(5,209)	(3,939)	(4,723)	32,689	0	0	0	0	0	0	(39,241)	45

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
				6865 FINANCIAL INC	LINCOLNWOOD	MGMT CONSULT
SCHEDULE ATTACHED		SCHEDULE ATTACHED		IME REALTY	LINCOLNWOOD	HOME OFFICE
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17	\$ 80,470	6865 FINANCIAL INC	100.00%	\$	\$ (80,470)	1
2	V							2
3	V	17				18,169	18,169	3
4	V	17				36,337	36,337	4
5	V	17				18,169	18,169	5
6	V	17				2,523	2,523	6
7	V	19				63	63	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 80,470			\$ 75,261	\$ * (5,209)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 BOOKKEEPING	\$ 42,966	EKS MANAGEMENT	100.00%	\$	\$ (42,966)
16	V						
17	V						
18	V	6 PAINTERS SALARIES				1,973	1,973
19	V	7 SCAVENGER				49	49
20	V	17 CFO SALARY				5,828	5,828
21	V	19 PROFESSIONAL FEES				4,460	4,460
22	V	20 WANT ADS/BACKGR CKS				1,774	1,774
23	V	21 OFFICE EXPENSE				19,139	19,139
24	V	23 SEMINARS				6	6
25	V	25 TRANSPORTATION				675	675
26	V	26 INSURANCE				127	127
27	V	27 EMPLOYEE BENEFITS				3,050	3,050
28	V	30 DEPRECIATION				78	78
29	V	35 EQUIPMENT RENT				1,868	1,868
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 42,966			\$ 39,027	\$ * (3,939)

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	\$ 9,960	IME RENT	100.00%	\$	\$ (9,960)	15
16	V								16
17	V	5	UTILITIES				261	261	17
18	V	6	REPAIR & MAINTENANCE				670	670	18
19	V	19	PROFESSIONAL FEES				50	50	19
20	V	20	LICENSES & PERMITS				27	27	20
21	V	26	INSURANCE				64	64	21
22	V	30	DEPRECIATION				863	863	22
23	V	32	INTEREST				1,460	1,460	23
24	V	33	RE TAX				1,411	1,411	24
25	V	35	STORAGE FEES				431	431	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			\$ 9,960			\$ 5,237	\$ * (4,723)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 MANAGEMENT FEES	\$	EMI ENTERPRISES	100.00%	\$	\$	15	
16	V							16	
17	V	6 DRIVERS SALARIES				2,051	2,051	17	
18	V	17 M ESFORMES, OFFICER				9,884	9,884	18	
19	V	17 REGIONAL DIR-M ROSEN				304	304	19	
20	V	17 MGMT CNSLT-P ESFORMES				9,884	9,884	20	
21	V	19 ACCOUNTING FEES				328	328	21	
22	V	21 OFFICE				4,417	4,417	22	
23	V	25 TRANSPORTATION				119	119	23	
24	V	26 INSURANCE				651	651	24	
25	V	27 EMPLOYEE BENEFITS				4,776	4,776	25	
26	V	35 AUTO LEASE				275	275	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		\$			\$ 32,689	\$ *	32,689	39

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

Facility Name & ID Number **FRANKFORT TERRACE OPERATOR LL** # **0048371** 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ALLOCATION FROM EMI ENTERPRISES				SCHEDULE				\$		1
2	MORRIS ESFORMES	PRESIDENT	MGMT	48.00	ATTACHED	4	5.00	SALARY	9,884	17-7	2
3	PHILLIP ESFORMES	ADMIN CNSLT	ADMIN	48.00		1	1.51	CNSLT FEE	9,884	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	848	21-7	7
8	AVRUM WEINFELD	CFO	FINANCIAL	2.00		3	4.62	SALARY	5,828	17-7	8
9											9
10	6865 FINANCIAL INC										10
11	DANIEL WEISS	ADMIN CNSLT	ADMIN	0.00		0	0.00	CNSLT FEE	2,523	17-7	11
12	PHILIP ESFORMES	ADMIN CNSLT	ADMIN	48.00		2	3.02	CNSLT FEE	36,337	177	12
13								TOTAL	\$ 65,304		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 FRANKFORT TERRACE OPERATOR LLC

0048371

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	EMI ENTERPRISES	PATIENT DAYS	510,807	10	\$ 216,000	\$ 42,966	\$ 18,169	1
2	17	PHILIP ESFORMES INC	PATIENT DAYS	510,807	10	432,000	42,966	36,337	2
3	17	MICHAEL ROSEN	PATIENT DAYS	510,807	10	216,000	42,966	18,169	3
4	17	DANIEL WEISS	PATIENT DAYS	510,807	10	30,000	42,966	2,523	4
5	19	ACCOUNTING FEES	PATIENT DAYS	510,807	10	750	42,966	63	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	\$	\$ 75,261	25

Facility Name & ID Number FRANKFORT TERRACE OPERATOR LLC

0048371

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	PAINTERS SALARIES	847,662	14	\$ 38,929	\$ 38,929	42,966	\$ 1,973	1
2	7	SCAVENGER	847,662	14	971		42,966	49	2
3	17	CFO SALARY	847,662	14	114,971	114,971	42,966	5,828	3
4	19	PROFESSIONAL FEES	847,662	14	87,982	76,534	42,966	4,460	4
5	20	WANT ADS/BACKGR CKS	847,662	14	35,000		42,966	1,774	5
6	21	OFFICE EXPENSE	847,662	14	377,586	282,348	42,966	19,139	6
7	23	SEMINARS	847,662	14	115		42,966	6	7
8	25	TRANSPORTATION	847,662	14	13,315		42,966	675	8
9	26	INSURANCE	847,662	14	2,501		42,966	127	9
10	27	EMPLOYEE BENEFITS	847,662	14	60,163		42,966	3,050	10
11	30	DEPRECIATION	847,662	14	1,536		42,966	78	11
12	35	EQUIPMENT RENT	847,662	14	36,848		42,966	1,868	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		\$ 39,027	25

Facility Name & ID Number FRANKFORT TERRACE OPERATOR LLC

0048371

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	195,459	15	\$ 5,131	\$ 9,960	\$ 261	1
2	6	REPAIR & MAINTENANCE	RENTAL INCOME	195,459	15	13,157	9,960	670	2
3	19	PROFESSIONAL FEES	RENTAL INCOME	195,459	15	973	9,960	50	3
4	20	LICENSE & PERMITS	RENTAL INCOME	195,459	15	526	9,960	27	4
5	26	INSURANCE	RENTAL INCOME	195,459	15	1,254	9,960	64	5
6	30	DEPRECIATION	RENTAL INCOME	195,459	15	16,930	9,960	863	6
7	32	INTEREST	RENTAL INCOME	195,459	15	28,650	9,960	1,460	7
8	33	RE TAX	RENTAL INCOME	195,459	15	27,693	9,960	1,411	8
9	35	STORAGE FEE	RENTAL INCOME	195,459	15	8,451	9,960	431	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	\$	\$ 5,237	25

Facility Name & ID Number FRANKFORT TERRACE OPERATOR LLC

0048371

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 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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	DRIVERS SALARIES	PATIENT DAYS	847,662	14	\$ 40,460	\$ 2,051	42,966	\$ 2,051	1
2	17	M ESFORMES, OFFICER	PATIENT DAYS	847,662	14	195,000	195,000	42,966	9,884	2
3	17	REGIONAL DIR-M ROSEN	PATIENT DAYS	847,662	14	6,000	6,000	42,966	304	3
4	17	MGMT CNSLT-P ESFORMES	PATIENT DAYS	847,662	14	195,000		42,966	9,884	4
5	19	ACCOUNTING FEES	PATIENT DAYS	847,662	14	6,480		42,966	328	5
6	21	OFFICE	PATIENT DAYS	847,662	14	87,144	58,016	42,966	4,417	6
7	25	TRANSPORTATION	PATIENT DAYS	847,662	14	2,349		42,966	119	7
8	26	INSURANCE	PATIENT DAYS	847,662	14	12,837		42,966	651	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,662	14	94,218		42,966	4,776	9
10	35	AUTO LEASE	PATIENT DAYS	847,662	14	5,423		42,966	275	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	\$ 261,067		\$ 32,689	25

Facility Name & ID Number **FRANKFORT TERRACE OPERATOR LLC**

0048371

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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1							\$	\$			\$						
2																	
3																	
4																	
5																	
	Working Capital																
6	PRIVATE BANK		X	WORKING CAPITAL		09/01/11		1,016,000	05/14/12	3.2500	7,842						
7	RELATED PARTY	X									1,460						
8																	
9	TOTAL Facility Related						\$	\$ 1,016,000			\$ 9,302						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$	\$ 1,016,000			\$ 9,302						

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2010 report.	\$	55,200		1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	57,049		2
3.	Under or (over) accrual (line 2 minus line 1).	\$	1,849		3
4.	Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	60,000		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.	\$	61,849		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	51,736	8	
		2007	50,894	9	
		2008	52,254	10	
		2009	53,598	11	
		2010	57,049	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 FRANKFORT TERRACE OPERATOR LLC COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0048371

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>19-09-21-410-021-0000</u>	<u>NURSING HOME</u>	\$ <u>53,401.56</u>	\$ <u>53,401.56</u>
2. <u>19-09-21-410-007-0000</u>	<u>NURSING HOME</u>	\$ <u>3,647.02</u>	\$ <u>3,647.02</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>57,048.58</u></u>	\$ <u><u>57,048.58</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,373 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

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

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

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

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

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

N/A

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

1. Total Amount Incurred: 2,500 2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 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:

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7	RELATED PARTY				829		829		
8									
Improvement Type**									
9	SIDEWALK		2007	35,500	2,367	15	2,367		10,652
10	FLOOR TILE/LIGHT FIXTURES		2008	7,634	278	27.5	278		961
11	FIRE SAFETY CODE PROJECT		2009	8,045	293	27.5	293		720
12	TILE INSTALLATION		2010	4,200	153	27.5	153		236
13	TILE LOBBY FLOOR		2011	5,950	99	27.5	99		99
14									
15									
16									
17									
18									
19									
20	WINDOWS - LANDLORD		2009	14,900					
21	REPAVE PARKING LOT - LANDLORD		2009	33,925					
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	110,154	\$	4,019	\$	4,019	\$	12,668	70

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

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	\$ 62,571	\$ 5,677	\$ 6,257	\$ 580	10 YRS	\$ 21,431	71
72	Current Year Purchases	6,018	6,018	301	(5,717)	10 YRS	301	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		112	112				74
75	TOTALS	\$ 68,589	\$ 11,807	\$ 6,670	\$ (5,137)		\$ 21,732	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)	\$ 178,743	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,826	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 10,689	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,137)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 34,400	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: GRANITE FRANKFORT TERRACE OPERATOR LLC

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1976</u>	<u>120</u>	<u>11/06</u>	\$ <u>710,064</u>	<u>5.5</u>	<u>5</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 710,064			7

**

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 19,671 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	<u>FACILITY</u>	<u>06 FORD ECONOLINE</u>	\$ <u>690.00</u>	\$ <u>7,590</u>	17
18	<u>ACTIVITY</u>	<u>11 FORD SHUTTLE BUS</u>	<u>851.50</u>	<u>1,703</u>	18
19	<u>FACILITY</u>	<u>09 FORD XL 15 VAN</u>	<u>593.70</u>	<u>1,187</u>	19
20					20
21	TOTAL		\$ #####	\$ 10,480	21

10. Effective dates of current rental agreement:

Beginning 11/01/2006

Ending 01/01/2012

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

Fiscal Year Ending Annual Rent

12.	<u>/2012</u>	\$ _____
13.	<u>/2013</u>	\$ _____
14.	<u>/2014</u>	\$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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	<input style="width: 50px;" type="text"/>
2. From other facilities (f)	<input style="width: 50px;" type="text"/>
DROP-OUTS	
1. From this facility	<input style="width: 50px;" type="text"/>
2. From other facilities (f)	<input style="width: 50px;" type="text"/>
TOTAL TRAINED	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)							
					Units	Cost										
1	Licensed Occupational Therapist	39-3	hrs	\$		\$		\$								1
2	Licensed Speech and Language Development Therapist	39-3	hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39-3	hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39-2	# of prescripts							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 **FRANKFORT TERRACE OPERATOR LLC**# **0048371**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	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 500	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 4,425)	1,553,147		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,814		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	217,762		8
9	Other(specify): R/E/TAX / INS ESCROW	46,452		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,875,675	\$	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	61,329		15
16	Equipment, at Historical Cost	68,589		16
17	Accumulated Depreciation (book methods)	(73,217)		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 (specify):			22
23	Other(specify): REPL RESV/ADVANCE RENT	199,921		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 256,622	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,132,297	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 115,488	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30		28
29	Short-Term Notes Payable	1,047,025		29
30	Accrued Salaries Payable	72,385		30
31	Accrued Taxes Payable (excluding real estate taxes)	28,613		31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,000		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)	\$ 1,323,541	\$	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)	\$ 1,323,541	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 808,756	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,132,297	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 965,005	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 965,005	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	258,100	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	(414,349)	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)	\$ (156,249)	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)	\$ 808,756	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,483,582	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,483,582	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***	2,712	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,712	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,486,294	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	948,491	31
32	Health Care	1,554,924	32
33	General Administration	810,353	33
B. Capital Expense			
34	Ownership	835,167	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	65,700	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,214,635	40
41	Income before Income Taxes (line 30 minus line 40)**	271,659	41
42	Income Taxes	(13,559)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 258,100	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 FRANKFORT TERRACE OPERATOR LLC

0048371

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,000	2,080	\$ 85,355	\$ 41.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,234	3,498	83,005	23.73	3
4	Licensed Practical Nurses	7,683	8,425	276,999	32.88	4
5	CNAs & Orderlies	58,410	63,304	648,189	10.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,790	2,052	23,897	11.65	8
9	Activity Director	1,960	2,080	22,704	10.92	9
10	Activity Assistants	7,370	8,222	97,511	11.86	10
11	Social Service Workers	7,663	7,943	120,499	15.17	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	29,214	14.05	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,510	14,437	130,100	9.01	15
16	Dishwashers					16
17	Maintenance Workers	7,994	8,021	132,983	16.58	17
18	Housekeepers	15,120	16,383	165,147	10.08	18
19	Laundry	6,854	7,408	66,466	8.97	19
20	Administrator	2,080	2,160	117,089	54.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,968	9,114	80,641	8.85	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	1,802	1,877	16,736	8.92	31
32	Other Health C: SEE ATTACHED	5,827	6,027	108,495	18.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	154,225	165,111	\$ 2,205,030 *	\$ 13.35	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 5,940	1-3	35
36	Medical Director	O	3,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	1,846	10-3	38
39	Pharmacist Consultant	H	5,760	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	5,858	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) DENTAL	S	3,600	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 26,004		49

C. CONTRACT NURSES

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

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7						N/A						
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number FRANKFORT TERRACE OPERATOR LLC

0048371

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. IL COUNCIL ON LONG TERM CARE \$8,461
- (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. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees