FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0048397

Facility Name: THE TERRACE NH OPERATOR, LLC

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

County: LAKE

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 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) CEO

Paid Preparer

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

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,535	79	4,714	6,328	8
9	SNF/PED					9
10	ICF	28,973	5,426	73	34,472	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,508	5,505	4,787	40,800	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.20%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

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

NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES [ ] NO [X]

I. On what date did you start providing long term care at this location?

Date started 11/01/06

J. Was the facility purchased or leased after January 1, 1978?

YES [x] Date 11/01/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?

YES [x] NO [ ] If YES, enter number of beds certified 22 and days of care provided 4,684

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 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	258,846	16,359	7,519	282,724		282,724		282,724			1
2	Food Purchase		230,034		230,034		230,034		230,034			2
3	Housekeeping	184,811	18,171		202,982		202,982		202,982			3
4	Laundry	71,278	15,104	7,993	94,375		94,375		94,375			4
5	Heat and Other Utilities			88,901	88,901		88,901	251	89,152			5
6	Maintenance	34,259	29,525	30,757	94,541		94,541	4,465	99,006			6
7	Other (specify):*			19,277	19,277		19,277	47	19,324			7
8	TOTAL General Services	549,194	309,193	154,447	1,012,834		1,012,834	4,763	1,017,597			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,330,435	129,591	14,567	2,474,593		2,474,593		2,474,593			10
10a	Therapy	134,325			134,325		134,325		134,325			10a
11	Activities	84,397	7,365		91,762		91,762		91,762			11
12	Social Services			2,174	2,174		2,174		2,174			12
13	CNA Training											13
14	Program Transportation			1,304	1,304		1,304		1,304			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,549,157	136,956	36,045	2,722,158		2,722,158		2,722,158			16
	C. General Administration											
17	Administrative	75,003		72,000	147,003		147,003	6,749	153,752			17
18	Directors Fees											18
19	Professional Services			99,286	99,286		99,286	(22,619)	76,667			19
20	Dues, Fees, Subscriptions & Promotions			41,331	41,331		41,331	(24,057)	17,274			20
21	Clerical & General Office Expenses	93,277	23,023	64,863	181,163		181,163	(16,432)	164,731			21
22	Employee Benefits & Payroll Taxes			632,604	632,604		632,604		632,604			22
23	Inservice Training & Education			1,550	1,550		1,550	6	1,556			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			14,252	14,252		14,252	754	15,006			25
26	Insurance-Prop.Liab.Malpractice			63,188	63,188		63,188	799	63,987			26
27	Other (specify):*			124,377	124,377		124,377	(116,946)	7,431			27
28	TOTAL General Administration	168,280	23,023	1,113,451	1,304,754		1,304,754	(171,746)	1,133,008			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,266,631	469,172	1,303,943	5,039,746		5,039,746	(166,983)	4,872,763			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: THE TERRACE NH OPERATOR, LLC #0048397 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		1,579	
			0	7,519
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		7,993	
			0	7,993
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		28,627	
	ELECTRICITY		40,192	
	WATER		19,338	
	CABLE TV - LOBBY		744	
			0	88,901
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,190	
	PAINTING & DECORATING		1,015	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		14,526	
	ELEVATOR MAINTENANCE & REPAIR		3,331	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,119	
	FIRE SERVICE		3,576	
			0	
			0	
			0	
			0	30,757
7	**OTHER**			
	SCAVENGER		18,890	
	SECURITY SERVICE		387	
			0	
			0	19,277
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	18,000	18,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		3,275	
	PURCHASED SERVICES			
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,512	
	PHARMACY CONSULTANT	XVIII B 39-2	5,980	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	800	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	14,567
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	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,174	
				2,174
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC **#0048397** **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		1,304	1,304
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	72,000	72,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	13,874	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	85,412	
			0	99,286
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	8,223	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	9,771	
	LICENSES & PERMITS	XIX F	5,307	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	13,889	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3,156	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	485	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				41,331
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,094	
	EQUIPMENT REPAIR & MAINTENANCE		5,556	
	OUTSIDE CLERICAL SERVICES		30,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	8,800	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		19,413	
	MESSENGER SERVICE		0	
			0	64,863

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	244,989	
	UNEMPLOYMENT COMPENSATION	XIX D	27,208	
	WORKERS COMPENSATION INSURANC	XIX D	92,090	
	HOSPITALIZATION INSURANCE	XIX D	222,199	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,857	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	43,261	
	CHICAGO HEAD TAX	XIX D	0	
			0	632,604
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,550	
				1,550
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		14,252	
				14,252
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		63,188	
				63,188
27	**OTHER**			
	BAD DEBTS	VI 24	124,377	
				124,377

GRAND TOTAL COLUMN 3 OTHER **1,303,943**

THE TERRACE NH OPERATOR, LLC
SCHEDULES
12/31/2011

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

TOTAL FOOD PURCHASE	230,034	
LESS SALES TAX	0	**HAVE YOU FORGOTTEN TO EN**
NET FOOD	230,034	
TOTAL PATIENT CENSUS	40,800	
TIME 3 MEALS PER DAY	3	
TOTAL PATIENT MEALS	122,400	
ADD # EMPLOYEE MEALS/DAY	0	
TIME # DAYS	365	
TOTAL EMPLOYEE MEALS	0	
PATIENT MEALS	122,400	
ADD EMPLOYEE MEALS	0	
TOTAL MEALS/YEAR	122,400	
NET FOOD	230,034	
DIVIDE TOTAL MEALS/YEAR	122,400	
COST PER MEAL	1.88	
TIME EMPLOYEE MEALS	0	
EMPLOYEE MEAL RECLASSIFICATION	**0**	
	========	

NTER SALES TAX ON PAGE 5??

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC #0048397 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			18,904	18,904		18,904	(11,183)	7,721			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,296	3,296		3,296	1,271	4,567			32
33	Real Estate Taxes			110,203	110,203		110,203	1,356	111,559			33
34	Rent-Facility & Grounds			537,950	537,950		537,950		537,950			34
35	Rent-Equipment & Vehicles			88,485	88,485		88,485	1,284	89,769			35
36	Other (specify):* IME			9,570	9,570		9,570	(9,570)				36
37	TOTAL Ownership			768,408	768,408		768,408	(16,842)	751,566			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		112,450	673,931	786,381		786,381		786,381			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,963	62,963		62,963		62,963			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		112,450	736,894	849,344		849,344		849,344			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,266,631	581,622	2,809,245	6,657,498		6,657,498	(183,825)	6,473,673			45

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

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 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	(12,086)	30		9
10	Interest and Other Investment Income	(132)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(8,800)	21		18
19	Entertainment		20		19
20	Contributions	(3,656)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(124,377)	27		24
25	Fund Raising, Advertising and Promotional	(8,223)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(13,889)	20		28
29	Other-Attach Schedule	(28,439)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (199,602)		$	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)	15,777		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 15,777		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (183,825)		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

THE TERRACE NH OPERATOR, LLC

ID# 0048397

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2	MARKETING AUTO LEASING	(1,165)	35	2
3	OTHER PROFESSIONAL FEES	(27,274)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
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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**	(28,439)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 **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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	251	0	0	0	0	0	0	251	5
6	Maintenance	0	0	1,874	1,947	644	0	0	0	0	0	0	4,465	6
7	Other (specify):*	0	0	47	0	0	0	0	0	0	0	0	47	7
8	**TOTAL General Services**	0	0	1,921	1,947	895	0	0	0	0	0	0	4,763	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	(593)	5,534	1,808	0	0	0	0	0	0	0	6,749	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(27,274)	60	4,235	312	48	0	0	0	0	0	0	(22,619)	19
20	Fees, Subscriptions & Promotions	(25,768)	0	1,685	0	26	0	0	0	0	0	0	(24,057)	20
21	Clerical & General Office Expenses	(8,800)	0	(11,826)	4,194	0	0	0	0	0	0	0	(16,432)	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	641	113	0	0	0	0	0	0	0	754	25
26	Insurance-Prop.Liab.Malpractice	0	0	120	618	61	0	0	0	0	0	0	799	26
27	Other (specify):*	(124,377)	0	2,896	4,535	0	0	0	0	0	0	0	(116,946)	27
28	**TOTAL General Administration**	(186,219)	(533)	3,291	11,580	135	0	0	0	0	0	0	(171,746)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(186,219)	(533)	5,212	13,527	1,030	0	0	0	0	0	0	(166,983)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 **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 D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(12,086)	0	74	0	829	0	0	0	0	0	0	(11,183)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(132)	0	0	0	1,403	0	0	0	0	0	0	1,271	32
33	Real Estate Taxes	0	0	0	0	1,356	0	0	0	0	0	0	1,356	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	1,774	261	414	0	0	0	0	0	0	1,284	35
36	Other (specify):*	0	0	0	0	(9,570)	0	0	0	0	0	0	(9,570)	36
37	**TOTAL Ownership**	(13,383)	0	1,848	261	(5,568)	0	0	0	0	0	0	(16,842)	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)**	(199,602)	(533)	7,060	13,788	(4,538)	0	0	0	0	0	0	(183,825)	45

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 72,000	6865 FINANCIAL INC		$	$ (72,000)	1
2	V	17	EMI ENTERPRISES		6865 FINANCIAL INC		17,253	17,253	2
3	V	17	PHILIP ESFORMES INC		6865 FINANCIAL INC		34,505	34,505	3
4	V	17	M. ROSEN		6865 FINANCIAL INC		17,253	17,253	4
5	V	17	D. WEISS		6865 FINANCIAL INC		2,396	2,396	5
6	V	19	ACCOUNTING FEES		6865 FINANCIAL INC		60	60	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 72,000			$ 71,467	$ * (533)	14

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

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 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	OUTSIDE CLERICAL	$ 30,000	EKS MANAGEMENT		$	$ (30,000)	15
16	V	6	PAINTERS SALARY		EKS MANAGEMENT		1,874	1,874	16
17	V	7	SACVENGER		EKS MANAGEMENT		47	47	17
18	V	17	CFO - SALARY		EKS MANAGEMENT		5,534	5,534	18
19	V	19	PROFESSIONAL FEES		EKS MANAGEMENT		4,235	4,235	19
20	V	20	WANT ADS/ BACK GRD CKS		EKS MANAGEMENT		1,685	1,685	20
21	V	21	OFFICE / CLERICAL		EKS MANAGEMENT		18,174	18,174	21
22	V	23	SEMINARS		EKS MANAGEMENT		6	6	22
23	V	25	TRANSPORTATION		EKS MANAGEMENT		641	641	23
24	V	26	INSURANCE		EKS MANAGEMENT		120	120	24
25	V	27	EMPLOYEE BENEFITS		EKS MANAGEMENT		2,896	2,896	25
26	V	30	SL DEPRECIATION		EKS MANAGEMENT		74	74	26
27	V	35	EQUIPMENT RENTAL		EKS MANAGEMENT		1,774	1,774	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			$ 30,000			$ 37,060	$ * 7,060	39

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

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 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 FEE	$ 17,253	EMI MANAGEMENT		$	$ (17,253)	15
16	V	6	DRIVERS SALARY		EMI MANAGEMENT		1,947	1,947	16
17	V	17	OFFICER SALARY		EMI MANAGEMENT		9,386	9,386	17
18	V	17	REGIONAL DIRECTOR		EMI MANAGEMENT		289	289	18
19	V	17	MGT CONSULTANT		EMI MANAGEMENT		9,386	9,386	19
20	V	19	ACCOUNTING FEES		EMI MANAGEMENT		312	312	20
21	V	21	OFFICE		EMI MANAGEMENT		4,194	4,194	21
22	V	25	TRANSPORTATION		EMI MANAGEMENT		113	113	22
23	V	26	INSURANCE		EMI MANAGEMENT		618	618	23
24	V	27	EMPLOYEE BENEFITS		EMI MANAGEMENT		4,535	4,535	24
25	V	35	AUTO LEASE		EMI MANAGEMENT		261	261	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			$ 17,253			$ 31,041	$ * 13,788	39

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

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 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	$ 9,570	IME REALTY		$	$ (9,570)	15
16	V	5	UTILITIES		IME REALTY		251	251	16
17	V	6	REPAIRS / MAINTENCE		IME REALTY		644	644	17
18	V	19	ACCOUNTING FEES		IME REALTY		48	48	18
19	V	20	LICENSE & PERMITS		IME REALTY		26	26	19
20	V	26	INSURANCE		IME REALTY		61	61	20
21	V	30	SL DEPRECIATION		IME REALTY		829	829	21
22	V	32	INTEREST		IME REALTY		1,403	1,403	22
23	V	33	REAL ESTATE TAX		IME REALTY		1,356	1,356	23
24	V	35	STORAGE FEES		IME REALTY		414	414	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,570			$ 5,032	$ * (4,538)	39

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

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 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	Alloc from Emi Entertprises:								$		1
2	MORRIS ESFORMES	PRESIDENT	MGMT	48.00		4	0.05	Salary	9,386	17-7	2
3	PHILIP ESFORMES	Admin Consultant	Administrative	48.00	SEE	1.5	2.27	Consult Fee	8,386	17-7	3
4											4
5	Alloc from Eks Management:										5
6	AVRUM WEINFELD	CFO	CFO	2.00	ATTACHED	3	4.60	Salary	5,534	17-7	6
7	FLORA WEISS	o/s consulting	Bookkeeping	0.00		0.5	0.89	Consult Fee	806	21-7	7
8											8
9	Alloc from 6865 Management										9
10	PHILIP ESFORMES	Admin Consultant	Admin Consult		SCHEDULE	1.5	2.27	Consult Fee	34,505	17-7	10
11	DANIEL WEISS	Admin Consultant	Admin Consult			0		Consult Fee	2,396	17-7	11
12											12
13								TOTAL	$ 61,013		13

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	EMI ENTERPRISES	PATIENT DAYS	510,807	10	$ 216,000	$	40,800	$ 17,253	1
2	17	PHILIP ESFORMES INC	PATIENT DAYS	510,807	10	432,000		40,800	34,505	2
3	17	MICHAEL ROSEN	PATIENT DAYS	510,807	10	216,000		40,800	17,253	3
4	17	DANIEL WEISS	PATIENT DAYS	510,807	10	30,000		40,800	2,396	4
5	19	ACCOUNTING FEES	PATIENT DAYS	510,807	10	750		40,800	60	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	$		$ 71,467	25

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTERS SALARY	PATIENT DAYS	847,662	14	$ 38,929	$ 38,929	40,800	$ 1,874	1
2	7	SCAVENGER	PATIENT DAYS	847,662	14	971		40,800	47	2
3	17	CFO - SALARY	PATIENT DAYS	847,662	14	114,971	114,971	40,800	5,534	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	847,662	14	87,982	76,534	40,800	4,235	4
5	20	WANT ADS/ BACK GRD CKS	PATIENT DAYS	847,662	14	35,000		40,800	1,685	5
6	21	OFFICE / CLERICAL	PATIENT DAYS	847,662	14	377,586	282,348	40,800	18,174	6
7	23	SEMINARS	PATIENT DAYS	847,662	14	115		40,800	6	7
8	25	TRANSPORTATION	PATIENT DAYS	847,662	14	13,315		40,800	641	8
9	26	INSURANCE	PATIENT DAYS	847,662	14	2,501		40,800	120	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,662	14	60,163		40,800	2,896	10
11	30	SL DEPRECIATION	PATIENT DAYS	847,662	14	1,536		40,800	74	11
12	35	EQUIPMENT RENTAL	PATIENT DAYS	847,662	14	36,848		40,800	1,774	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		$ 37,060	25

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	DRIVERS SALARY	PATIENT DAYS	847,662	14	$ 40,460	$ 40,460	40,800	$ 1,947	1
2	17	OFFICER SALARY	PATIENT DAYS	847,662	14	195,000	195,000	40,800	9,386	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	847,662	14	6,000	6,000	40,800	289	3
4	17	MGT CONSULTANT	PATIENT DAYS	847,662	14	195,000		40,800	9,386	4
5	19	ACCOUNTING FEES	PATIENT DAYS	847,662	14	6,480		40,800	312	5
6	21	OFFICE	PATIENT DAYS	847,662	14	87,144	58,016	40,800	4,194	6
7	25	TRANSPORTATION	PATIENT DAYS	847,662	14	2,349		40,800	113	7
8	26	INSURANCE	PATIENT DAYS	847,662	14	12,837		40,800	618	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,662	14	94,218		40,800	4,535	9
10	35	AUTO LEASE	PATIENT DAYS	847,662	14	5,453		40,800	261	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					$ 644,941	$ 299,476		$ 31,041	25

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	195,459	14	$ 5,131	$	9,570	$ 251	1
2	6	REPAIRS / MAINTENCE	RENTAL INCOME	195,459	14	13,157		9,570	644	2
3	19	ACCOUNTING FEES	RENTAL INCOME	195,459	14	973		9,570	48	3
4	20	LICENSE & PERMITS	RENTAL INCOME	195,459	14	526		9,570	26	4
5	26	INSURANCE	RENTAL INCOME	195,459	14	1,254		9,570	61	5
6	30	SL DEPRECIATION	RENTAL INCOME	195,459	14	16,930		9,570	829	6
7	32	INTEREST	RENTAL INCOME	195,459	14	28,650		9,570	1,403	7
8	33	REAL ESTATE TAX	RENTAL INCOME	195,459	14	27,693		9,570	1,356	8
9	35	STORAGE FEES	RENTAL INCOME	195,459	14	8,451		9,570	414	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	$		$ 5,032	25

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7	THE PRIVATE BANK		X	WORKING CAPITAL	INTEREST	REVOLV		794,000		prime +	3,296	7
8	RELATED PARTY ALLOC										1,403	8
9	TOTAL Facility Related						$	$ 794,000			$ 4,699	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 794,000			$ 4,699	15

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

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

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

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC **#** 0048397 **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.**	$ 83,973	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.)		$ 97,088	2
3. Under or (over) accrual (line 2 minus line 1).		$ 13,115	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 97,088	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.		$ 110,203	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	76,451	8
	2007	76,756	9
	2008	81,014	10
	2009	83,973	11
	2010	97,088	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 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 THE TERRACE NH OPERATOR, LLC COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0048397

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 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.	08-08-403-011	NURSING HOME	$ 97,088.19	$ 97,088.19
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 97,088.19	$ 97,088.19

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 THE TERRACE NH OPERATOR, LLC # 0048397 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 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				26,461	796	39	796			7
8	HOME OFFICE										8
	Improvement Type**										
9	DOORS			2007	16,876	614	27.5	614		2,737	9
10	RAIL GUARDS & KICK PLATES			2007	11,890	432	27.5	432		1,746	10
11	DRYWALL STAIRWELLS & 2ND FL CORRIDOR			2009	21,652	787	27.5	787		1,869	11
12	INSTALL 5 TON CONDENSER			2009	3,732	136	27.5	136		323	12
13	ANNUNCIATOR & CONYTOL PANEL			2009	9,457	344	27.5	344		817	13
14	COMPRESSOR & 275 AMP CONTRACTOR			2009	9,893	360	27.5	360		855	14
15	SIDEWALK & EMERGENCY EXIT LIGHTING			2009	3,600	240	15	240		600	15
16	FLOOR TILE			2010	8,121	295	27.5	295		455	16
17	4 TO CHILLER WITH VALVES & FREEZE PIPING			2010	5,839	212	27.5	212		256	17
18	REBUILDING WALLS WITH FIRE RATED MATERIALS			2011	17,800	458	27.5	458		458	18
19	INSTALL 2 DAMPER MOTORS			2011	3,618	6	27.5	6		6	19
20											20
21											21
22											22
23											23
24											24
25	ROOF- LANDLORD			2009	84,700						25
26	WINDOWS- LANDLORD			2010	32,864						26
27	PARKING LOT- LANDLORD			2010	33,630						27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 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)		$ 290,133	$ 4,680		$ 4,680	$	$ 10,122	70

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

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 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	$ 22,697	$ 1,750	$ 2,270	$ 520	10 YRS	$ 8,863	71
72	Current Year Purchases	13,270	13,270	664	(12,606)	10 YRS	664	72
73	Fully Depreciated Assets							73
74	RELATED PARTY ALLOC		107	107				74
75	TOTALS	$ 35,967	$ 15,127	$ 3,041	$ (12,086)		$ 9,527	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)	$ 326,100	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 19,807	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 7,721	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (12,086)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 19,649	85	

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

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

G. Construction-in-Progress

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

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

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

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

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		115	11/01/06	$ 537,950	5.5	5	3
4	Additions							4
5								5
6								6
7	TOTAL		115		$ 537,950 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/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: $ 64,839 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			$	$	17
18		SEE SCHEDULE ATTACHED		23,646	18
19					19
20					20
21	TOTAL		$	$ 23,646	21

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

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

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 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.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$		$ 325,746	$		$ 325,746	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			21,903			21,903	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			320,271			320,271	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				112,450		112,450	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					6,011			6,011	13
14	TOTAL			$		$ 673,931	$ 112,450		$ 786,381	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 THE TERRACE NH OPERATOR, LLC # 0048397 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	$ 168,733	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (320,000))	1,426,076		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	94,264		6
7	Other Prepaid Expenses	6,000		7
8	Accounts Receivable (owners or related parties)	68,106		8
9	Other(specify): real estate & ins. Escrow	25,438		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,788,617	$	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	112,478		15
16	Equipment, at Historical Cost	35,967		16
17	Accumulated Depreciation (book methods)	(44,426)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	166,948		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 270,967	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,059,584	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 256,399	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	794,000		29
30	Accrued Salaries Payable	109,628		30
31	Accrued Taxes Payable (excluding real estate taxes)	48,901		31
32	Accrued Real Estate Taxes(Sch.IX-B)	97,088		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)**	$ 1,306,016	$	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)**	$ 1,306,016	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 753,568	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,059,584	$	48

***(See instructions.)**

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC **#** 0048397 **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**	$ 648,928	1
2	Restatements (describe):		2
3	ROUNDING	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 648,930	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	630,726	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	(526,088)	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)**	$ 104,638	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)**	$ 753,568	24 *

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

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 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	$ 6,900,797	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,900,797	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	393,889	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 393,889	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***	132	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 132	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)**	$ 7,294,818	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,012,834	31
32	Health Care	2,722,158	32
33	General Administration	1,304,754	33
	B. Capital Expense		
34	Ownership	768,408	34
	C. Ancillary Expense		
35	Special Cost Centers	786,381	35
36	Provider Participation Fee	62,963	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	(1,231)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,656,267	40
41	**Income before Income Taxes (line 30 minus line 40)****	638,551	41
42	**Income Taxes**	(7,825)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 630,726	43

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

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

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

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

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 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	2,006	2,168	$ 61,923	$ 28.56	1
2	Assistant Director of Nursing	1,784	1,993	55,777	27.99	2
3	Registered Nurses	29,263	31,012	882,614	28.46	3
4	Licensed Practical Nurses	8,812	9,208	207,585	22.54	4
5	CNAs & Orderlies	80,469	85,900	976,416	11.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,975	9,819	134,325	13.68	8
9	Activity Director					9
10	Activity Assistants	8,497	9,168	84,397	9.21	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,431	26,667	258,846	9.71	15
16	Dishwashers					16
17	Maintenance Workers	2,032	2,345	34,259	14.61	17
18	Housekeepers	18,301	19,874	184,811	9.30	18
19	Laundry	6,524	7,254	71,278	9.83	19
20	Administrator	1,888	2,080	75,003	36.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,566	8,347	93,277	11.17	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	1,728	1,905	17,619	9.25	31
32	Other Health C: see schedule	4,036	4,307	77,624	18.02	32
33	Other(specify) admitting,ward cle	3,803	3,970	50,877	12.82	33
34	TOTAL (lines 1 - 33)	210,115	226,017	$ 3,266,631 *	$ 14.45	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 5,940	1-3	35
36	Medical Director	O	18,000	9-3	36
37	Medical Records Consultant	N	4,512	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,980	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	0	11-3	44
45	Social Service Consultant	E	2,174	12-3	45
46	Other(specify) Physicians	S	800	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 37,406		49

C. CONTRACT NURSES

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

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ROSE SHULZ	ADMINISTRATOR		$ 75,003
	ASST ADMIN		0
	OTHER ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,003

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		99,286
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 99,286

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,090
Unemployment Compensation Insurance	27,208
FICA Taxes	244,989
Employee Health Insurance	222,199
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,857
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	43,261
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 632,604

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	$
Advertising: Employee Recruitment	0
Health Care Worker Background Check	485
(Indicate # of checks performed 12)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	3,656
MARKETING/ADV/PROMO	22,112
LICENSES/DUES/SUBSCRIPTIONS	15,078
MGMT CO ALLOC	1,711
TRUST/FRANCHISE/CONTRIB/ETC	(3,656)
Less: Public Relations Expense	(0)
Non-allowable advertising	(8,223)
Yellow page advertising	(13,889)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,274

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 THE TERRACE NH OPERATOR, LLC # 0048397 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	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5						N/A							
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number THE TERRACE NH OPERATOR, LLC # 0048397 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 LONG TERM CARE $8,448**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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