

Facility Name & ID Number FRANKFORT TERRACE

0022889 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	41,622	1,176		42,798
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	41,622	1,176		42,798

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.71%

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 11/01/06

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/01/06 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 _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **FRANKFORT TERRACE** # **0022889** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	134,297	15,424	5,940	155,661		155,661	0	155,661		1
2	Food Purchase		156,297		156,297	0	156,297	(220)	156,077		2
3	Housekeeping	152,093	15,930	0	168,023		168,023	0	168,023		3
4	Laundry	66,657	25,284	1,451	93,392	0	93,392	966	94,358		4
5	Heat and Other Utilities			70,412	70,412		70,412	283	70,695		5
6	Maintenance	65,826	16,095	26,201	108,122		108,122	732	108,854		6
7	Other (specify):*			8,772	8,772		8,772	70	8,842		7
8	TOTAL General Services	418,873	229,030	112,776	760,679	0	760,679	1,831	762,510		8
	B. Health Care and Programs										
9	Medical Director	0		3,000	3,000		3,000	0	3,000		9
10	Nursing and Medical Records	1,050,549	43,137	6,720	1,100,406		1,100,406	0	1,100,406		10
10a	Therapy	23,666		2,339	26,005		26,005	0	26,005		10a
11	Activities	98,159	7,435	2,457	108,051		108,051	0	108,051		11
12	Social Services	76,228		3,169	79,397		79,397	0	79,397		12
13	CNA Training			600	600		600	0	600		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	1,248,602	50,572	18,285	1,317,459	0	1,317,459	0	1,317,459		16
	C. General Administration										
17	Administrative	103,000		264,497	367,497		367,497	(242,983)	124,514		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			97,079	97,079		97,079	(13,199)	83,880		19
20	Dues, Fees, Subscriptions & Promotions			17,822	17,822		17,822	39	17,861		20
21	Clerical & General Office Expenses	106,541	13,610	122,794	242,945		242,945	(100,079)	142,866		21
22	Employee Benefits & Payroll Taxes			254,705	254,705	0	254,705	0	254,705		22
23	Inservice Training & Education			2,672	2,672		2,672	0	2,672		23
24	Travel and Seminar			0	0		0	6	6		24
25	Other Admin. Staff Transportation			8,511	8,511		8,511	525	9,036		25
26	Insurance-Prop.Liab.Malpractice			47,962	47,962		47,962	436	48,398		26
27	Other (specify):*			13,200	13,200		13,200	(4,923)	8,277		27
28	TOTAL General Administration	209,541	13,610	829,242	1,052,393	0	1,052,393	(360,178)	692,215		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,877,016	293,212	960,303	3,130,531	0	3,130,531	(358,347)	2,772,184		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	1,451
		0
		1,451
5	HEAT & OTHER UTILITIES	
	GAS HEAT	33,318
	ELECTRICITY	11,662
	WATER	23,544
	CABLE TV - LOBBY	1,888
		0
		70,412
6	MAINTENANCE	
	GROUNDS MAINTENANCE	6,370
	PAINTING & DECORATING	4,326
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	10,426
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,348
	FIRE SERVICE	3,731
		0
		0
		0
		0
		26,201
7	OTHER	
	SCAVENGER	6,246
	SECURITY SERVICE	2,526
		0
		0
		8,772
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	4,320
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	1,200
	DENTAL	1,200
		0
		6,720
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	2,339
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		2,339
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,457
		0
		2,457
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	3,169
	SOCIAL WORKER XVIII B 45-2	0
		0
		3,169
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	600
		600

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	264,497
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	17,615
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	79,464
		0
		97,079
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	225
	EMPLOYEE WANT ADS XIX F	2,970
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	5,696
	LICENSES & PERMITS XIX F	4,700
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	631
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	1,000
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,000
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,600
	PATIENT BACKGROUND CHECKS XIX F	0
		17,822
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,126
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	77,500
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	9,768
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	34,400
		122,794

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	142,696
	UNEMPLOYMENT COMPENSATION XIX D	21,795
	WORKERS COMPENSATION INSURANC XIX D	69,784
	HOSPITALIZATION INSURANCE XIX D	12,332
	EMPLOYEE BENEFITS - OTHER XIX D	806
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	7,292
	CHICAGO HEAD TAX XIX D	0
		0
		254,705
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	2,672
		2,672
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	8,511
		8,511
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	47,962
		47,962
27	OTHER	
	BAD DEBTS VI 24	13,200
		13,200

GRAND TOTAL COLUMN 3 OTHER

960,303

FRANKFORT TERRACE
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	156,297	PATIENT MEALS	128394
LESS SALES TAX	(220)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	156,077	TOTAL MEALS/YEAR	128394
TOTAL PATIENT CENSUS	42,798	NET FOOD	156077
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	128394

TOTAL PATIENT MEALS	128394	COST PER MEAL	1.22
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number

FRANKFORT TERRACE

#0022889

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			25,450	25,450		25,450	11,225	36,675			30
31	Amortization of Pre-Op. & Org.			14,372	14,372		14,372	0	14,372			31
32	Interest			151,149	151,149		151,149	(65,949)	85,200			32
33	Real Estate Taxes			53,229	53,229		53,229	1,193	54,422			33
34	Rent-Facility & Grounds			116,662	116,662		116,662	0	116,662			34
35	Rent-Equipment & Vehicles			31,759	31,759		31,759	2,850	34,609			35
36	Other (specify):* IME RENT			9,360	9,360		9,360	(9,360)	0			36
37	TOTAL Ownership			401,981	401,981	0	401,981	(60,041)	341,940			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			65,700	65,700		65,700	0	65,700			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	65,700	65,700	0	65,700	0	65,700			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,877,016	293,212	1,427,984	3,598,212	0	3,598,212	(418,388)	3,179,824			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 **FRANKFORT TERRACE**

0022889

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	OHF 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	10,048	30		9
10	Interest and Other Investment Income	(67,613)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(220)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,000)	20		17
18	Fines and Penalties	0	21		18
19	Entertainment	0	20		19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(20,409)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,200)	27		24
25	Fund Raising, Advertising and Promotional	(225)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(631)	20		28
29	Other-Attach Schedule	(48,796)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (143,046)		\$ 0	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	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)	(275,342)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (275,342)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (418,388)		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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

FRANKFORT TERRACE

ID# 0022889

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (2,396)	6	1
2	STAFF DEVELOPMENT	(34,400)	21	2
3	MARKETING SALARY	(12,000)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(48,796)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FRANKFORT TERRACE# 0022889

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(220)	0	0	0	0	0	0	0	0	0	0	(220)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	966	0	0	0	0	0	0	0	0	966	4
5	Heat and Other Utilities	0	0	0	283	0	0	0	0	0	0	0	283	5
6	Maintenance	(2,396)	1,327	1,286	515	0	0	0	0	0	0	0	732	6
7	Other (specify):*	0	0	41	29	0	0	0	0	0	0	0	70	7
8	TOTAL General Services	(2,616)	1,327	2,293	827	0	1,831	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	(249,020)	6,037	0	0	0	0	0	0	0	0	(242,983)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(20,409)	758	6,409	43	0	0	0	0	0	0	0	(13,199)	19
20	Fees, Subscriptions & Promotions	(2,856)	0	2,895	0	0	0	0	0	0	0	0	39	20
21	Clerical & General Office Expenses	(46,400)	7,689	(61,421)	53	0	0	0	0	0	0	0	(100,079)	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	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	6	0	0	0	0	0	0	0	0	6	24
25	Other Admin. Staff Transportation	0	209	316	0	0	0	0	0	0	0	0	525	25
26	Insurance-Prop.Liab.Malpractice	0	121	196	119	0	0	0	0	0	0	0	436	26
27	Other (specify):*	(13,200)	3,696	4,581	0	0	0	0	0	0	0	0	(4,923)	27
28	TOTAL General Administration	(82,865)	(236,547)	(40,981)	215	0	(360,178)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(85,481)	(235,220)	(38,688)	1,042	0	(358,347)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FRANKFORT TERRACE

0022889

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	10,048	158	192	827	0	0	0	0	0	0	0	11,225	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(67,613)	0	0	1,664	0	0	0	0	0	0	0	(65,949)	32
33	Real Estate Taxes	0	0	0	1,193	0	0	0	0	0	0	0	1,193	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	300	2,276	274	0	0	0	0	0	0	0	2,850	35
36	Other (specify):*	0	0	0	(9,360)	0	0	0	0	0	0	0	(9,360)	36
37	TOTAL Ownership	(57,565)	458	2,468	(5,402)	0	(60,041)	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)	(143,046)	(234,762)	(36,220)	(4,360)	0	(418,388)	45						

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE

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

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

1	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)		
1	V	17	MANAGEMENT FEES	\$ 257,497	EMI ENTERPRISES	100.00%	\$	\$ (257,497)	1
2	V								2
3	V	6	DRIVERS SALARY			1,327		1,327	3
4	V	17	OFFICERS SALARY			8,477		8,477	4
5	V	19	ACCOUNTING FEES			758		758	5
6	V	21	OFFICE EXPENSE			7,689		7,689	6
7	V	25	TRANSPORTATION			209		209	7
8	V	26	INSURANCE			121		121	8
9	V	27	EMPLOYEE BENEFITS			3,696		3,696	9
10	V	35	AUTO LEASE			300		300	10
11	V	30	DEPRECIATION			158		158	11
12	V								12
13	V								13
14	Total		\$ 257,497			\$ 22,735	\$ *	(234,762)	14

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

Facility Name & ID Number FRANKFORT TERRACE# 0022889Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	\$ 77,500	EKS MANAGEMENT	100.00%	\$	\$ (77,500)
16	V						
17	V	4 HOUSEKEEPING SALARIES				966	966
18	V	6 PAINTERS SALARIES				1,286	1,286
19	V	7 SCAVENGER				41	41
20	V	17 CFO SALARY				6,037	6,037
21	V	19 PROFESSIONAL FEES				6,409	6,409
22	V	20 WANT ADS/BACKGR CKS				2,895	2,895
23	V	21 OFFICE EXPENSE				16,079	16,079
24	V	24 IN STATE TRAVEL				6	6
25	V	25 TRANSPORTATION				316	316
26	V	26 INSURANCE				196	196
27	V	27 EMPLOYEE BENEFITS				4,581	4,581
28	V	30 DEPRECIATION				192	192
29	V	35 EQUIPMENT RENT				2,276	2,276
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 77,500			\$ 41,280	\$ * (36,220)

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

Facility Name & ID Number FRANKFORT TERRACE# 0022889Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	\$ 9,360	IME REALTY	100.00%	\$	\$ (9,360)
16	V						
17	V						
18	V	5 UTILITIES				283	283
19	V	6 REPAIR & MAINTENANCE				515	515
20	V	7 ALARM SERVICE				29	29
21	V	19 PROFESSIONAL FEES				43	43
22	V	21 OFFICE EXPENSE				53	53
23	V	26 INSURANCE				119	119
24	V	30 DEPRECIATION				827	827
25	V	32 INTEREST				1,664	1,664
26	V	33 RE TAX				1,193	1,193
27	V	35 STORAGE FEES				274	274
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 9,360			\$ 5,000	\$ * (4,360)

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

Facility Name & ID Number

FRANKFORT TERRACE

#

0022889

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	MORRIS ESFORMES							SALARY	\$ 8,477	17-7	1
2	AVFUM WEINFELD	CEO						SALARY	6,037	17-7	2
3	PHILIP ESFORMES							MGMT FEE	7,000	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 21,514		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**

0022889 Report Period Beginning: **01/01/2006**

Ending: **2/31/2006**

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, 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	6	DRIVERS SALARY	PATIENT DAYS	778,042	14	\$ 28,965	\$ 35,651	\$ 1,327	1
2	17	OFFICERS SALARY	PATIENT DAYS	778,042	14	185,000	35,651	8,477	2
3	19	ACCOUNTING FEES	PATIENT DAYS	778,042	14	16,537	35,651	758	3
4	21	OFFICE EXPENSE	PATIENT DAYS	778,042	14	167,811	35,651	7,689	4
5	25	TRANSPORTATION	PATIENT DAYS	778,042	14	4,565	35,651	209	5
6	26	INSURANCE	PATIENT DAYS	778,042	14	2,648	35,651	121	6
7	27	EMPLOYEE BENEFITS	PATIENT DAYS	778,042	14	80,669	35,651	3,696	7
8	35	AUTO LEASE	PATIENT DAYS	778,042	14	6,544	35,651	300	8
9	30	DEPRECIATION	PATIENT DAYS	778,042	14	3,451	35,651	158	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					\$ 496,190	\$ 345,993	\$ 22,735	25

Facility Name & ID Number **FRANKFORT TERRACE**

0022889 Report Period Beginning: **01/01/2006** Ending: **2/31/2006**

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	4	HOUSEKEEPING SALARIES	PATIENT DAYS	863,827	14	\$ 19,500	\$ 42,798	\$ 966	1
2	6	PAINTERS SALARIES	PATIENT DAYS	863,827	14	25,953	42,798	1,286	2
3	7	SCAVENGER	PATIENT DAYS	863,827	14	825	42,798	41	3
4	17	CFO SALARY	PATIENT DAYS	863,827	14	121,844	42,798	6,037	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	863,827	14	129,352	42,798	6,409	5
6	20	WANT ADS/BACKGR CKS	PATIENT DAYS	863,827	14	58,423	42,798	2,895	6
7	21	OFFICE EXPENSE	PATIENT DAYS	863,827	14	324,544	42,798	16,079	7
8	24	IN STATE TRAVEL	PATIENT DAYS	863,827	14	112	42,798	6	8
9	25	TRANSPORTATION	PATIENT DAYS	863,827	14	6,388	42,798	316	9
10	26	INSURANCE	PATIENT DAYS	863,827	14	3,958	42,798	196	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	863,827	14	92,462	42,798	4,581	11
12	30	DEPRECIATION	PATIENT DAYS	863,827	14	3,880	42,798	192	12
13	35	EQUIPMENT RENT	PATIENT DAYS	863,827	14	45,937	42,798	2,276	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					\$ 833,178	\$ 496,665	\$ 41,280	25

Facility Name & ID Number **FRANKFORT TERRACE**

0022889 Report Period Beginning: **01/01/2006** Ending: **2/31/2006**

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 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	344,402	15	\$ 10,404	\$ 9,360	\$ 283	1
2	6	REPAIR & MAINTENANCE	RENTAL INCOME	344,402	15	18,957	9,360	515	2
3	7	ALARM SERVICE	RENTAL INCOME	344,402	15	1,056	9,360	29	3
4	19	PROFESSIONAL FEES	RENTAL INCOME	344,402	15	1,575	9,360	43	4
5	21	OFFICE EXPENSE	RENTAL INCOME	344,402	15	1,942	9,360	53	5
6	26	INSURANCE	RENTAL INCOME	344,402	15	4,387	9,360	119	6
7	30	DEPRECIATION	RENTAL INCOME	344,402	15	30,446	9,360	827	7
8	32	INTEREST	RENTAL INCOME	344,402	15	61,229	9,360	1,664	8
9	33	RE TAX	RENTAL INCOME	344,402	15	43,904	9,360	1,193	9
10	35	STORAGE FEES	RENTAL INCOME	344,402	15	10,073	9,360	274	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					\$ 183,973	\$	\$ 5,000	25

Facility Name & ID Number

FRANKFORT TERRACE

0022889

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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		7	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	LASALLE BANK		X	MORTGAGE		11/01/01	\$ 2,218,297	\$ 0			\$ 116,361	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	LASALLE BANK		X	WORKING CAPITAL				123,000			34,788	6						
7												7						
8	RELATED PARTY										1,664	8						
9	TOTAL Facility Related						\$ 2,218,297	\$ 123,000			\$ 152,813	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14						
15	TOTALS (line 9+line14)						\$ 2,218,297	\$ 123,000			\$ 152,813	15						

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

* 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 2005 report.		\$	54,100	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.)		\$	53,586	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(514)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	9,260	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.)	ADJ FOR OLD FACILITY	\$	44,483	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	53,229	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	49,637	8
	2002	49,584	9
	2003	50,939	10
	2004	54,421	11
	2005	53,586	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 2005 TAX BILL.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FRANKFORT TERRACE COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0022889

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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>19-09-21-410-007-0000</u>	<u>NURSING HOME</u>	\$ <u>3,425.62</u>	\$ <u>3,425.62</u>
2. <u>19-09-21-410-021-0000</u>	<u>NURSING HOME</u>	\$ <u>50,159.96</u>	\$ <u>50,159.96</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>53,585.58</u>	\$ <u>53,585.58</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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 FRANKFORT TERRACE

0022889

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (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. 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$ 0	3

Facility Name & ID Number FRANKFORT TERRACE

0022889

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	120	1976	1972	\$ 1,233,000	\$	25	\$	\$	\$ 1,233,000	4
5										5
6										6
7										7
8	RELATED PARTY				795		795			8
	Improvement Type**									
9	BUILDING IMPROVEMENTS		1980	7,438	0	5	0		7,438	9
10	BUILDING IMPROVEMENTS		1981	3,000	0	15	0		3,000	10
11	BUILDING IMPROVEMENTS		1983	3,138	0	5	0		3,138	11
12	BUILDING IMPROVEMENTS		1987	8,474	224	31.5	224		5,189	12
13	BUILDING IMPROVEMENTS		1988	51,503	1,363	31.5	1,363		30,725	13
14	BUILDING IMPROVEMENTS		1988	13,056	345	31.5	345		7,561	14
15	BUILDING IMPROVEMENTS		1990	6,944	183	31.5	183		3,609	15
16	BUILDING IMPROVEMENTS		1992	21,890	580	31.5	580		9,919	16
17	BUILDING IMPROVEMENTS		1993	4,065	107	31.5	107		1,746	17
18	BUILDING IMPROVEMENTS		1993	24,826	530	39	530		8,314	18
19	BUILDING IMPROVEMENTS		1994	7,630	164	39	164		2,395	19
20	FLOORING		1995	4,350	93	39	93		1,292	20
21	ROOFING		1995	10,000	213	39	213		2,912	21
22	FLOORING		1995	1,712	37	39	37		493	22
23	ROOFING		1995	5,200	111	39	111		1,480	23
24	FLOORING		1995	14,193	303	39	303		3,958	24
25	PARKING LOT LIGHT		1996	5,700	317	15	317		3,927	25
26	ROOFING		1996	10,330	221	39	221		2,850	26
27	LANDSCAPE		1997	6,700	373	15	373		4,172	27
28	DOOR ALARM		1997	1,980	42	39	42		465	28
29	SHOWER		1997	1,660	36	39	36		382	29
30	TILE		1998	6,250	133	39	133		1,407	30
31	FLOORING		1998	2,650	57	39	57		593	31
32	AWNING		1999	3,530	196	15	196		1,724	32
33	FLOORING		1999	4,700	101	39	101		923	33
34	CARPET/COVE BASE		2000	11,042	822	20	822		3,621	34
35	ROOFTOP AC		2000	2,490	76	27.5	76		535	35
36	VERTICAL BLINDS		2001	974	72	20	72		317	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.

Facility Name & ID Number FRANKFORT TERRACE

0022889

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	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	CUBICLE CURTAINS	2001	\$ 19,810	\$ 1,473	20	\$ 1,473	\$	\$ 6,428	37
38	ROOF REPAIR	2001	4,450	135	27.5	135		938	38
39	FLOOR TILE	2001	18,654	566	27.5	566		3,567	39
40	ROOFTOP HEAT COOL	2001	1,734	52	27.5	52		333	40
41	CARPET	2002	2,485	75	27.5	75		390	41
42	ROOF VENTILATOR	2002	1,155	35	27.5	35		182	42
43	WINDOW	2002	1,055	32	27.5	32		165	43
44	FENCE	2002	8,986	272	27.5	272		1,394	44
45	STEEL DOORS	2003	2,109	64	27.5	64		254	45
46	ROOFTOP AIR CONDITIONER	2003	2,068	63	27.5	63		247	46
47	FURNACES	2003	34,636	1,049	27.5	1,049		4,144	47
48	FLOOR VINYL TILES	2004	17,480	530	27.5	530		1,458	48
49	UPGRADE ELECTRIC	2005	42,500	1,288	27.5	1,288		1,996	49
50	FLOORING	2005	30,000	910	27.5	910		1,410	50
51	ROOFING	2005	41,255	1,250	27.5	1,250		1,938	51
52	PAVING	2005	19,955	1,108	15	1,108		2,438	52
53	CARPET	2006	3,473	48	27.5	48		48	53
54	DOORS/FRAMES	2006	20,965	291	27.5	291		291	54
55	FIRE SPRINKLER	2006	32,976	458	27.5	458		458	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)		\$ 1,784,171	\$ 17,193		\$ 17,193	\$ 0	\$ 1,375,164	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 200,415	\$ 6,878	\$ 18,830	\$ 11,952		\$ 518,473-130,37-3744	71
72	Current Year Purchases	13,037	2,174	652	(1,522)		13,037	72
73	Fully Depreciated Assets	374,404			0		374,404	73
74	RELATED PARTY		382		(382)			74
75	TOTALS	\$ 587,856	\$ 9,434	\$ 19,482	\$ 10,048		\$ 387,441	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$ 0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 2,372,027	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 26,627	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 36,675	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,048	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,762,605	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 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: 1972	120	11/01/06	\$ 116,662	66 MOS		3
4	Additions						4
5							5
6							6
7	TOTAL	120		\$ 116,662			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: \$ **20,175** 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		03 FORD WAGON	\$ 683.65	\$ 4,786	17
18		06 FORD WAGON	690.00	3,450	18
19	PAINTERS	06 CHRYSLER	645.00	1,290	19
20				2,058	20
21	TOTAL		\$ #####	\$ 11,584	21

10. Effective dates of current rental agreement:

Beginning **11/01/06**

Ending **04/01/12**

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

Fiscal Year Ending Annual Rent

12. **11/01/2007** \$ **669,970**

13. **11/01/2008** \$ **669,970**

14. **11/01/2009** \$ **680,020**

* 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? <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>2. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

0022889

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>13,200</u>)	497,170		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	79,481		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>RE TAX & INS ESCROW</u>	10,223		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 586,874	\$ 0	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			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,500		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(84)		20
21	Restricted Funds	174,993		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>ADV RENT,REPL RESV</u>	13,545		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 190,954	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 777,828	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 161,577	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	123,000		29
30	Accrued Salaries Payable	67,500		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,787		31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,260		32
33	Accrued Interest Payable	276		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)	\$ 388,400	\$ 0	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)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 388,400	\$ 0	46
47	TOTAL EQUITY (page 18, line 24)	\$ 389,428	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 777,828	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3	ADJ PRIOR FACILITY NET INCOME	(431,804)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (431,804)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	451,232	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	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) MEMBERS EQUITY	370,000	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 821,232	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 389,428	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	\$ 3,988,813	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,988,813	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)	\$ 0	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)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	67,613	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 67,613	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)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,056,426	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	760,679	31
32	Health Care	1,317,459	32
33	General Administration	1,052,393	33
	B. Capital Expense		
34	Ownership	401,981	34
	C. Ancillary Expense		
35	Special Cost Centers	0	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)*	\$ 3,598,212	40
41	Income before Income Taxes (line 30 minus line 40)**	458,214	41
42	Income Taxes	(6,982)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 451,232	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**

0022889

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	2,080	2,080	\$ 57,000	\$ 27.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,528	5,791	121,026	20.90	3
4	Licensed Practical Nurses	9,567	10,119	188,228	18.60	4
5	CNAs & Orderlies	56,439	61,064	580,446	9.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,188	2,526	23,666	9.37	8
9	Activity Director					9
10	Activity Assistants	8,381	9,446	98,159	10.39	10
11	Social Service Workers	6,067	6,154	76,228	12.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,326	17,477	134,297	7.68	15
16	Dishwashers					16
17	Maintenance Workers	5,874	5,934	65,826	11.09	17
18	Housekeepers	15,774	17,412	152,093	8.73	18
19	Laundry	7,584	8,290	66,657	8.04	19
20	Administrator	2,123	2,293	103,000	44.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,299	12,039	106,541	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	3,137	2,956	51,440	17.40	31
32	Other Health Care(specify)	4,073	4,073	52,409	12.87	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	156,440	167,654	\$ 1,877,016 *	\$ 11.20	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	1,200	10-3	38
39	Pharmacist Consultant	H	4,320	10-3	39
40	Physical Therapy Consultant	L	2,339	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	2,457	11-3	44
45	Social Service Consultant	E	3,169	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 22,425		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			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
JUDITH MAJCHROWICZ	ADMINISTRATOR	0.00%	\$ 103,000	Workers' Compensation Insurance	\$ 69,784	IDPH License Fee	\$	
			0	Unemployment Compensation Insurance	21,795	Advertising: Employee Recruitment	2,970	
				FICA Taxes	142,696	Health Care Worker Background Check	1,600	
				Employee Health Insurance	12,332	(Indicate # of checks performed)		
				Employee Meals	0	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	2,000	
				EMPLOYEE BENEFITS - OTHER	806	MARKETING/ADV/PROMO	856	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	10,396	
				PENSION/PROFIT SHARING PLANS	7,292	MGMT CO ALLOC	2,895	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(2,000)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense (0	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(225)	
						Yellow page advertising	(631)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 103,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 254,705	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,861	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
MANAGEMENT FEES			\$ 257,497			\$	Out-of-State Travel	\$
PHILIP ESFORMES			7,000					
							In-State Travel	0
							MGMT CO ALLOC	6
							Seminar Expense	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 264,497	TOTAL		\$	Entertainment Expense (
							(agree to Sch. V, line 24, col. 8)	
C. Professional Services							TOTAL	\$ 6
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			97,079					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 97,079					

* Attach copy of IMRF notifications

**See instructions.

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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	2003	\$ 7,249	3	\$ 1,208	\$ 2,416	\$ 2,416	\$ 1,209												
2	PAINT/DECORATING	2006	4,326	3				721	1,442	1,442	721									
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$ 11,575		\$ 1,208	\$ 2,416	\$ 2,416	\$ 1,930	\$ 1,442	\$ 1,442	\$ 721	\$								

Facility Name & ID Number **FRANKFORT TERRACE**# **0022889**Report Period Beginning: **01/01/2006**Ending: **12/31/2006****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. ICLTC \$ 5,346
- (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. \$ 991 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.
FRANKFORT TERRACE #0022889 11/01/06
- (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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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 \$2500, 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