		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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

I. IDPH License ID Number: 0048371

Facility Name: FRANKFORT TERRACE

Address: 40 NORTH SMITH (Number) FRANKFORT (City) 60423 (Zip Code)

County: WILL

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

HFS ID Number: 611510021-001

Date of Initial License for Current Owners: 11/1/06

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		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2008 to 12/31/2008 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

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

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 FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	43,920	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	41,803	1,165		42,968	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,803	1,165		42,968	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.83%

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 11/1/06

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	145,805	14,233	5,940	165,978		165,978		165,978			1
2	Food Purchase		186,623		186,623		186,623	(503)	186,120			2
3	Housekeeping	158,763	15,126		173,889		173,889		173,889			3
4	Laundry	65,858	21,917	3,410	91,185		91,185	975	92,160			4
5	Heat and Other Utilities			97,865	97,865		97,865	280	98,145			5
6	Maintenance	67,206	14,405	32,638	114,249		114,249	4,419	118,668			6
7	Other (specify):*			9,414	9,414		9,414	58	9,472			7
8	**TOTAL General Services**	437,632	252,304	149,267	839,203		839,203	5,229	844,432			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,045,815	31,292	7,440	1,084,547		1,084,547		1,084,547			10
10a	Therapy	25,458		1,504	26,962		26,962		26,962			10a
11	Activities	106,276	8,486	560	115,322		115,322		115,322			11
12	Social Services	82,886		2,604	85,490		85,490		85,490			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,260,435	39,778	15,108	1,315,321		1,315,321		1,315,321			16
	C. General Administration											
17	Administrative	111,694		74,979	186,673		186,673	(8,316)	178,357			17
18	Directors Fees											18
19	Professional Services			58,339	58,339		58,339	(10,225)	48,114			19
20	Dues, Fees, Subscriptions & Promotions			63,139	63,139		63,139	(53,507)	9,632			20
21	Clerical & General Office Expenses	98,854	12,724	85,199	196,777		196,777	(66,477)	130,300			21
22	Employee Benefits & Payroll Taxes			246,022	246,022		246,022		246,022			22
23	Inservice Training & Education			1,433	1,433		1,433	5	1,438			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			10,461	10,461		10,461	698	11,159			25
26	Insurance-Prop.Liab.Malpractice			46,064	46,064		46,064	753	46,817			26
27	Other (specify):*			83,005	83,005		83,005	(73,777)	9,228			27
28	**TOTAL General Administration**	210,548	12,724	668,641	891,913		891,913	(210,846)	681,067			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,908,615	304,806	833,016	3,046,437		3,046,437	(205,617)	2,840,820			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#: FRANKFORT TERRACE **#0048371** **Report Period Beginning: 01/01/2008** **Ending: 12/31/2008**

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		3,410	
			0	3,410
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		46,636	
	ELECTRICITY		14,033	
	WATER		35,290	
	CABLE TV - LOBBY		1,906	
			0	97,865
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		10,095	
	PAINTING & DECORATING		1,790	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		13,342	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,863	
	FIRE SERVICE		5,548	
			0	
			0	
			0	
			0	32,638
7	**OTHER**			
	SCAVENGER		7,340	
	SECURITY SERVICE		2,074	
			0	9,414
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	2,400	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	1,440	
	DENTAL CONSULTANT		3,600	
			0	7,440
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	1,504	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				1,504
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	560	
			0	560
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,604	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	2,604
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number FRANKFORT TERRACE **#0048371** **Report Period Beginning: 01/01/2008** **Ending: 12/31/2008**

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	74,979	74,979
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	16,463	
	ADMINISTRATIVE CONSULTANTS	XIX C	9,429	
	PROFESSIONAL FEES	XIX C	32,447	
			0	58,339
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	3,334	
	EMPLOYEE WANT ADS	XIX F	1,203	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	3,937	
	LICENSES & PERMITS	XIX F	1,925	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,535	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,000	
	PATIENT BACKGROUND CHECKS	XIX F	0	
	STAFF DEVELOPMENT		46705	63,139
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		997	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		78,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		6,202	
	MESSENGER SERVICE		0	
			0	85,199

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	144,002	
	UNEMPLOYMENT COMPENSATION	XIX D	16,621	
	WORKERS COMPENSATION INSURANC	XIX D	66,751	
	HOSPITALIZATION INSURANCE	XIX D	11,064	
	EMPLOYEE BENEFITS - OTHER	XIX D	914	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	6,670	
	CHICAGO HEAD TAX	XIX D	0	
			0	246,022
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,433	
				1,433
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		10,461	
				10,461
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		46,064	
				46,064
27	**OTHER**			
	BAD DEBTS	VI 24	83,005	
				83,005

GRAND TOTAL COLUMN 3 OTHER **833,016**

FRANKFORT TERRACE
SCHEDULES
12/31/2008

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

TOTAL FOOD PURCHASE	186,623
LESS SALES TAX	(503)
NET FOOD	186,120
TOTAL PATIENT CENSUS	42,968
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	128,904
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	366
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	128,904
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	128,904
NET FOOD	186,120
DIVIDE TOTAL MEALS/YEAR	128,904
COST PER MEAL	1.44
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number FRANKFORT TERRACE #0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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			10,199	10,199		10,199	(5,148)	5,051			30
31	Amortization of Pre-Op. & Org.			500	500		500		500			31
32	Interest			25,289	25,289		25,289	(7,840)	17,449			32
33	Real Estate Taxes			51,094	51,094		51,094	1,209	52,303			33
34	Rent-Facility & Grounds			701,645	701,645		701,645		701,645			34
35	Rent-Equipment & Vehicles			27,630	27,630		27,630	2,259	29,889			35
36	Other (specify):*			9,360	9,360		9,360	(9,360)				36
37	TOTAL Ownership			825,717	825,717		825,717	(18,880)	806,837			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,880	65,880		65,880		65,880			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			65,880	65,880		65,880		65,880			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,908,615	304,806	1,724,613	3,938,034		3,938,034	(224,497)	3,713,537			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 # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	(6,229)	30		9
10	Interest and Other Investment Income	(9,433)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(503)	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		21		18
19	Entertainment		20		19
20	Contributions	(5,035)	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	(83,005)	27		24
25	Fund Raising, Advertising and Promotional	(3,334)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(75,212)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (182,751)		$	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)	(41,746)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (41,746)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (224,497)		37

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

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

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

STATE OF ILLINOIS

FRANKFORT TERRACE

ID# 0048371

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	STAFF DEVELOPMENT	$ (46,705)	20	1
2	NON ALLOWABLE PROFESSIONAL FEES	(16,507)	19	2
3	MARKETING SALARIES	(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	(75,212)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	(503)	0	0	0	0	0	0	0	0	0	0	(503)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	975	0	0	0	0	0	0	0	0	975	4
5	Heat and Other Utilities	0	0	0	280	0	0	0	0	0	0	0	280	5
6	Maintenance	0	0	1,297	1,250	1,872	0	0	0	0	0	0	4,419	6
7	Other (specify):*	0	0	43	15	0	0	0	0	0	0	0	58	7
8	**TOTAL General Services**	(503)	0	2,315	1,545	1,872	0	0	0	0	0	0	5,229	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	7,472	6,177	0	(21,965)	0	0	0	0	0	0	(8,316)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(16,507)	58	5,923	107	194	0	0	0	0	0	0	(10,225)	19
20	Fees, Subscriptions & Promotions	(55,074)	0	1,567	0	0	0	0	0	0	0	0	(53,507)	20
21	Clerical & General Office Expenses	(12,000)	0	(59,505)	24	5,004	0	0	0	0	0	0	(66,477)	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	5	0	0	0	0	0	0	0	0	5	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	405	0	293	0	0	0	0	0	0	698	25
26	Insurance-Prop.Liab.Malpractice	0	0	304	64	385	0	0	0	0	0	0	753	26
27	Other (specify):*	(83,005)	0	3,840	0	5,388	0	0	0	0	0	0	(73,777)	27
28	**TOTAL General Administration**	(166,586)	7,530	(41,284)	195	(10,701)	0	0	0	0	0	0	(210,846)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(167,089)	7,530	(38,969)	1,740	(8,829)	0	0	0	0	0	0	(205,617)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	(6,229)	0	147	867	67	0	0	0	0	0	0	(5,148)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,433)	0	0	1,593	0	0	0	0	0	0	0	(7,840)	32
33	Real Estate Taxes	0	0	0	1,209	0	0	0	0	0	0	0	1,209	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	1,617	294	348	0	0	0	0	0	0	2,259	35
36	Other (specify):*	0	0	0	(9,360)	0	0	0	0	0	0	0	(9,360)	36
37	TOTAL Ownership	(15,662)	0	1,764	(5,397)	415	0	0	0	0	0	0	(18,880)	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)	(182,751)	7,530	(37,205)	(3,657)	(8,414)	0	0	0	0	0	0	(224,497)	45

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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
				6865 FINANCIAL INC	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. [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	$ 74,979	6865 FINANCIAL INC	100.00%	$	$ (74,979)	1
2	V								2
3	V	17	SHELDON NEIDICH						3
4	V	17	EMI ENTERPRISES				36,088	36,088	4
5	V	17	PHILIP ESFORMES INC				36,088	36,088	5
6	V	17	DANIEL WEISS				2,506	2,506	6
7	V	17	AVRUM WEINFELD				7,769	7,769	7
8	V	19	ACCOUNTING				58	58	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 74,979			$ 82,509	$ * 7,530	14

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

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	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	$ 78,000	EKS MANAGEMENT	100.00%	$	$ (78,000)	15
16	V								16
17	V	4	HOUSEKEEPING SALARIES				975	975	17
18	V	6	PAINTERS SALARIES				1,297	1,297	18
19	V	7	SCAVENGER				43	43	19
20	V	17	CFO SALARY				6,177	6,177	20
21	V	19	PROFESSIONAL FEES				5,923	5,923	21
22	V	20	WANT ADS/BACKGR CKS				1,567	1,567	22
23	V	21	OFFICE EXPENSE				18,495	18,495	23
24	V	23	SEMINARS				5	5	24
25	V	25	TRANSPORTATION				405	405	25
26	V	26	INSURANCE				304	304	26
27	V	27	EMPLOYEE BENEFITS				3,840	3,840	27
28	V	30	DEPRECIATION				147	147	28
29	V	35	EQUIPMENT RENT				1,617	1,617	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 78,000			$ 40,795	$ * (37,205)	39

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

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	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 RENT	100.00%	$	$ (9,360)	15
16	V								16
17	V	5	UTILITIES				280	280	17
18	V	6	PAINTERS FEES				616	616	18
19	V	6	REPAIR & MAINTENANCE				634	634	19
20	V	7	ALARM SERVICE				15	15	20
21	V	19	PROFESSIONAL FEES				107	107	21
22	V	21	OFFICE EXPENSE				24	24	22
23	V	26	INSURANCE				64	64	23
24	V	30	DEPRECIATION				867	867	24
25	V	32	INTEREST				1,593	1,593	25
26	V	33	RE TAX				1,209	1,209	26
27	V	35	STORAGE FEES				294	294	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			$ 9,360			$ 5,703	$ * (3,657)	39

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

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 36,088	EMI ENTERPRISES	100.00%	$	$ (36,088)	15
16	V								16
17	V	6	DRIVERS SALARIES				1,872	1,872	17
18	V	17	M ESFORMES, OFFICER				9,749	9,749	18
19	V	17	REGIONAL DIRECTOR				4,374	4,374	19
20	V	19	ACCOUNTING FEES				194	194	20
21	V	21	OFFICE				5,004	5,004	21
22	V	25	TRANSPORTATION				293	293	22
23	V	26	INSURANCE				385	385	23
24	V	27	EMPLOYEE BENEFITS				5,388	5,388	24
25	V	30	DEPRECIATION				67	67	25
26	V	35	AUTO LEASE				348	348	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			$ 36,088			$ 27,674	$ * (8,414)	39

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

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	MORRIS ESFORMES				SCHEDULE ATTACHED			SALARY	$ 9,749	17-7	1
2	AVFUM WEINFELD	CFO						SALARY	7,769	17-7	2
3	AVFUM WEINFELD	CFO						SALARY	6,177	17-7	3
4	PHILIP ESFORMES							SALARY	36,088	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 59,783		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 # 0048371 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: 6865 FINANCIAL INC
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847)674-1946
Fax Number: (847)674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SHELDON NEIDICH	PATIENT DAYS	514,353	10	$ 90,000	$ 90,000		$ 0	1
2	17	EMI ENTERPRISES	PATIENT DAYS	514,353	10	432,000	432,000	42,968	36,088	2
3	17	PHILIP ESFORMES INC	PATIENT DAYS	514,353	10	432,000	432,000	42,968	36,088	3
4	17	DANIEL WEISS	PATIENT DAYS	514,353	10	30,000	30,000	42,968	2,506	4
5	17	AVRUM WEINFELD	PATIENT DAYS	514,353	10	93,005	97,505	42,968	7,769	5
6	19	ACCOUNTING FEES	PATIENT DAYS	514,353	10	700		42,968	58	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,077,705	$ 1,081,505		$ 82,509	25

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847)674-1946
Fax Number: (847)674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	HOUSEKEEPING SALARIES	PATIENT DAYS	859,462	14	$ 19,500	$ 19,500	42,968	$ 975	1
2	6	PAINTERS SALARIES	PATIENT DAYS	859,462	14	25,953	25,953	42,968	1,297	2
3	7	SCAVENGER	PATIENT DAYS	859,462	14	866		42,968	43	3
4	17	CFO SALARY	PATIENT DAYS	859,462	14	123,563	123,563	42,968	6,177	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	859,462	14	118,475	96,329	42,968	5,923	5
6	20	WANT ADS/BACKGR CKS	PATIENT DAYS	859,462	14	31,349		42,968	1,567	6
7	21	OFFICE EXPENSE	PATIENT DAYS	859,462	14	369,953	256,233	42,968	18,495	7
8	24	IN STATE TRAVEL	PATIENT DAYS	859,462	14	95		42,968	5	8
9	25	TRANSPORTATION	PATIENT DAYS	859,462	14	8,106		42,968	405	9
10	26	INSURANCE	PATIENT DAYS	859,462	14	6,085		42,968	304	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	859,462	14	76,819		42,968	3,840	11
12	30	DEPRECIATION	PATIENT DAYS	859,462	14	2,943		42,968	147	12
13	35	EQUIPMENT RENT	PATIENT DAYS	859,462	14	32,345		42,968	1,617	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					$ 816,052	$ 521,578		$ 40,795	25

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP.
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847)674-1946
Fax Number: (847)674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	187,059	15	$ 5,588	$	9,360	$ 280	1
2	6	PAINTERS FEE	RENTAL INCOME	187,059	15	12,303		9,360	616	2
3	6	REPAIR & MAINTENANCE	RENTAL INCOME	187,059	15	12,671		9,360	634	3
4	7	ALARM SERVICE	RENTAL INCOME	187,059	15	301		9,360	15	4
5	19	PROFESSIONAL FEES	RENTAL INCOME	187,059	15	2,135		9,360	107	5
6	21	OFFICE EXPENSE	RENTAL INCOME	187,059	15	489		9,360	24	6
7	26	INSURANCE	RENTAL INCOME	187,059	15	1,275		9,360	64	7
8	30	DEPRECIATION	RENTAL INCOME	187,059	15	17,336		9,360	867	8
9	32	INTEREST	RENTAL INCOME	187,059	15	31,829		9,360	1,593	9
10	33	RE TAX	RENTAL INCOME	187,059	15	24,171		9,360	1,209	10
11	35	STORAGE FEES	RENTAL INCOME	187,059	15	5,882		9,360	294	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					$ 113,980	$		$ 5,703	25

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847)674-1946
Fax Number: (847)674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	DRIVERS SALARIES	PATIENT DAYS	859,462	14	$ 37,451	$ 37,451	42,968	$ 1,872	1
2	17	M ESFORMES, OFFICER	PATIENT DAYS	859,462	14	195,000	195,000	42,968	9,749	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	859,462	14	87,500	87,500	42,968	4,374	3
4	19	ACCOUNTING FEES	PATIENT DAYS	859,462	14	3,885		42,968	194	4
5	21	OFFICE	PATIENT DAYS	859,462	14	100,089	57,703	42,968	5,004	5
6	25	TRANSPORTATION	PATIENT DAYS	859,462	14	5,861		42,968	293	6
7	26	INSURANCE	PATIENT DAYS	859,462	14	7,710		42,968	385	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	859,462	14	107,763		42,968	5,388	8
9	30	DEPRECIATION	PATIENT DAYS	859,462	14	1,340		42,968	67	9
10	35	AUTO LEASE	PATIENT DAYS	859,462	14	6,960		42,968	348	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					$ 553,559	$ 377,654		$ 27,674	25

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	PRIVATE BANK		X	LINE OF CREDIT				930,000			25,289	6
7												7
8	RELATED PARTY										1,593	8
9	TOTAL Facility Related						$	$ 930,000			$ 26,882	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 930,000			$ 26,882	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.)

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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 2007 report.	$ 53,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 50,894	2
3. Under or (over) accrual (line 2 minus line 1).	$ (2,106)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 53,200	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.	$ 51,094	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2003		8
2004		9
2005		10
2006	51,736	11
2007	50,894	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 2007 TAX BILL

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2007	$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FRANKFORT TERRACE COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0048371

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2007 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 2007.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-09-21-410-021-0000	NURSING HOME	$ 47,640.08	$ 47,640.08
2.	19-09-21-410-007-0000	NURSING HOME	$ 3,253.52	$ 3,253.52
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 50,893.60	$ 50,893.60

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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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 # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

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

3. Current Period Amortization: 500 4. Dates Incurred: 11/06

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8	RELATED PARTY					833		833			8
	Improvement Type**										
9	SIDEWALK			2007	35,500	2,367	15	2,367		3,551	9
10	FLOOR TILE/LIGHT FIXTURES			2008	7,634	127	27.5	127		127	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

*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 FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 43,134	$ 3,327		$ 3,327	$	$ 3,678	70

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

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	$ 4,124	$ 1,320	$ 412	$ (908)	10 YRS	$ 1,596	71
72	Current Year Purchases	10,642	6,385	1,064	(5,321)	10 YRS	1,064	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		248	248				74
75	TOTALS	$ 14,766	$ 7,953	$ 1,724	$ (6,229)		$ 2,660	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 57,900	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 11,280	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 5,051	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (6,229)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,338	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 FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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. [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:	1976	120	11/06	$ 701,645	5.5	5	3
4	Additions							4
5								5
6								6
7	TOTAL		120		$ 701,645 **			7

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

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

10. Effective dates of current rental agreement:
Beginning 11/01/2006
Ending 01/01/2012

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

	Fiscal Year Ending	Annual Rent
12.	12/2009	$ 680,020
13.	12/2010	$ 680,020
14.	12/2011	$ 680,020

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: $ 17,528 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		06 FORD ECONOLINE	$ 690.00	$ 8,280	17
18	MARKETING	06 MERCEDES BENZ	#######	1,177	18
19	PAINTERS	06 CHRYSLER TOWN	645.00	645	19
20					20
21	TOTAL		$ #######	$ 10,102	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 FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

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

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

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

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

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2008 (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	$ 44,666	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 93,005)	1,254,530		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	67,575		7
8	Accounts Receivable (owners or related parties)	258,030		8
9	Other(specify): ESCROWS	61,110		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,685,911	$	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	43,134		15
16	Equipment, at Historical Cost	14,766		16
17	Accumulated Depreciation (book methods)	(12,208)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,500		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,084)		20
21	Restricted Funds	174,993		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	93,421		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 315,522	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,001,433	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 163,218	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	930,000		29
30	Accrued Salaries Payable	60,243		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,013		31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,200		32
33	Accrued Interest Payable	2,888		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)**	$ 1,234,562	$	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)**	$ 1,234,562	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 766,871	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,001,433	$	48

*(See instructions.)

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 595,152	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 595,152	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	260,191	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	(88,472)	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)**	$ 171,719	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)**	$ 766,871	24 *

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

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	$ 4,188,792	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,188,792	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,433	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,433	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,198,225	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	839,203	31
32	Health Care	1,315,321	32
33	General Administration	891,913	33
	B. Capital Expense		
34	Ownership	825,717	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	65,880	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,938,034	40
41	**Income before Income Taxes (line 30 minus line 40)****	260,191	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 260,191	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 # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	2,122	2,242	$ 61,787	$ 27.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,431	4,631	99,971	21.59	3
4	Licensed Practical Nurses	10,186	10,664	193,904	18.18	4
5	CNAs & Orderlies	55,084	58,898	580,248	9.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,146	2,454	25,458	10.37	8
9	Activity Director					9
10	Activity Assistants	9,357	10,237	106,276	10.38	10
11	Social Service Workers	6,540	6,659	82,886	12.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,795	17,303	145,805	8.43	15
16	Dishwashers					16
17	Maintenance Workers	5,924	6,020	67,206	11.16	17
18	Housekeepers	15,547	17,113	158,763	9.28	18
19	Laundry	6,819	7,469	65,858	8.82	19
20	Administrator	2,080	2,200	111,694	50.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,716	11,191	98,854	8.83	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	1,806	2,069	22,454	10.85	31
32	Other Health Care(specify)					32
33	Other(specify)	4,160	4,424	87,451	19.77	33
34	TOTAL (lines 1 - 33)	152,713	163,574	$ 1,908,615 *	$ 11.67	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	1,440	10-3	38
39	Pharmacist Consultant	H	2,400	10-3	39
40	Physical Therapy Consultant	L	1,504	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	560	11-3	44
45	Social Service Consultant	E	2,604	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 17,448		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

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDITH MAJCHROWICZ	ADMINISTRATOR		$ 111,694
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 111,694

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 74,979
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 74,979

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		58,339
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 58,339

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,751
Unemployment Compensation Insurance	16,621
FICA Taxes	144,002
Employee Health Insurance	11,064
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	914
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	6,670
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 246,022

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,203
Health Care Worker Background Check	1,000
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	5,035
MARKETING/ADV/PROMO	3,334
LICENSES/DUES/SUBSCRIPTIONS	5,862
MGMT CO ALLOC	1,567
TRUST/FRANCHISE/CONTRIB/ETC	(5,035)
Less: Public Relations Expense	(0)
Non-allowable advertising	(3,334)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,632

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number FRANKFORT TERRACE # 0048371 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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 $3,937**

(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 ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **65,880**
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 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