FOR BHF USE

LL1

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

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0051706

Facility Name: Frankfort Terrace Nursing Ctr

Address: 40 North Smith Street (Number) Frankfort (City) 60423 (Zip Code)

County: Will

Telephone Number: (815) 469-3156 **Fax #** (815) 469-8991

HFS ID Number:

Date of Initial License for Current Owners: 6/27/2012

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2017 to 12/31/2017 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)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	37,795			37,795	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,795			37,795	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.29%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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] Non-allowable costs have been eliminated in Schedule V, Column 7

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 6/27/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/27/2012 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 N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	184,831	36,778	7,818	229,427		229,427		229,427			1
2	Food Purchase		201,712		201,712		201,712	(5,148)	196,564			2
3	Housekeeping	161,458	25,049		186,507		186,507		186,507			3
4	Laundry	68,232	9,322		77,554		77,554		77,554			4
5	Heat and Other Utilities			70,595	70,595		70,595		70,595			5
6	Maintenance	67,206	893	23,591	91,690		91,690		91,690			6
7	Other (specify):* Waste Removal			10,680	10,680		10,680		10,680			7
8	TOTAL General Services	481,727	273,754	112,684	868,165		868,165	(5,148)	863,017			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,182,712	43,366	21,812	1,247,890		1,247,890	(80)	1,247,810			10
10a	Therapy											10a
11	Activities	71,728		7,575	79,303		79,303		79,303			11
12	Social Services	331,296		509	331,805		331,805		331,805			12
13	CNA Training											13
14	Program Transportation			1,064	1,064		1,064		1,064			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,585,736	43,366	40,560	1,669,662		1,669,662	(80)	1,669,582			16
	C. General Administration											
17	Administrative	133,144		213,791	346,935		346,935		346,935			17
18	Directors Fees											18
19	Professional Services			75,354	75,354		75,354	(1,500)	73,854			19
20	Dues, Fees, Subscriptions & Promotions			32,136	32,136		32,136	(8,803)	23,333			20
21	Clerical & General Office Expenses	97,861	8,963	47,005	153,829		153,829		153,829			21
22	Employee Benefits & Payroll Taxes			520,846	520,846		520,846		520,846			22
23	Inservice Training & Education											23
24	Travel and Seminar			331	331		331		331			24
25	Other Admin. Staff Transportation			2,108	2,108		2,108		2,108			25
26	Insurance-Prop.Liab.Malpractice			58,911	58,911		58,911	7,725	66,636			26
27	Other (specify):*											27
28	TOTAL General Administration	231,005	8,963	950,482	1,190,450		1,190,450	(2,578)	1,187,872			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,298,468	326,083	1,103,726	3,728,277		3,728,277	(7,806)	3,720,471			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 Number Frankfort Terrace Nursing Ctr #0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							131,149	131,149			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			96,322	96,322		96,322	168,308	264,630			32
33	Real Estate Taxes							68,285	68,285			33
34	Rent-Facility & Grounds			583,743	583,743		583,743	(580,037)	3,706			34
35	Rent-Equipment & Vehicles			18,513	18,513		18,513		18,513			35
36	Other (specify):*											36
37	**TOTAL Ownership**			698,578	698,578		698,578	(212,295)	486,283			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			295,116	295,116		295,116		295,116			42
43	Other (specify):* **Disallowed Costs**			81,922	81,922		81,922	(81,922)				43
44	**TOTAL Special Cost Centers**			377,038	377,038		377,038	(81,922)	295,116			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,298,468	326,083	2,179,342	4,803,893		4,803,893	(302,023)	4,501,870			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	(8,410)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	131,149	30		9
10	Interest and Other Investment Income	(3,031)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,500)	19		17
18	Fines and Penalties	(8,023)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(64,936)	43		24
25	Fund Raising, Advertising and Promotional	(108)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(151,415)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (106,274)		$	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)	(195,749)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (195,749)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (302,023)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Frankfort Terrace Nursing Ctr

ID# 0051706

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (5,148)	2	1
2	Medical Records Income	(80)	10	2
3	Resident Needs/Charity	(445)	43	3
4	PAC Dues	(8,803)	20	4
5	Building Co. - Admin Expenses	(781)	21	5
6	Building Co. - Amortization of Goodwill	(126,000)	36	6
7	Building Co. - Other Financing Costs	(9,908)	36	7
8	Building Co. - Licenses & Fees	(250)	20	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**	(151,415)		49

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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	20	Licenses & Fees	$	FT Frankfort LLC	100.00%	$ 250	$ 250	1
2	V	21	Bank Charges		FT Frankfort LLC	100.00%	781	781	2
3	V	26	Property Insurance		FT Frankfort LLC	100.00%	7,725	7,725	3
4	V	32	Interest		FT Frankfort LLC	100.00%	171,339	171,339	4
5	V	33	Real Estate Taxes		FT Frankfort LLC	100.00%	68,285	68,285	5
6	V	34	Rent	580,037	FT Frankfort LLC	100.00%		(580,037)	6
7	V	36	Amortization Exp-Goodwill		FT Frankfort LLC	100.00%	126,000	126,000	7
8	V	36	Finance Costs		FT Frankfort LLC	100.00%	9,908	9,908	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 580,037			$ 384,288	$ * (195,749)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jimmy Nassour	50	Bourbonnais Terrace NH	Bourbonnais	FT Frankfort, LLC	Frankfort	Lessor	1
2	Carl Meyer	50	Community Care Center	Chicago				2
3			Crestwood Terrace Nursing Ctr	Crestwood				3
4			Joliet Terrace Nursing Ctr	Joliet				4
5			Kankakee Terrace Nursing Ctr	Bourbonnais				5
6			Southview Manor Nursing Ctr	Chicago				6
7			Sycamore Healthcare Center	Quincy				7
8			Terrace Nursing Home, The	Waukegan				8
9			West Chicago Terrace NH	West Chicago				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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	First Mortgage		X	Mortgage Payable			$	$ 6,429,043			$ 170,559	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap		X	Line of Credit				1,623			89,530	6
7												7
8												8
9	TOTAL Facility Related						$	$ 6,430,666			$ 260,089	9
	B. Non-Facility Related*											
10								Amortization Expense			7,572	10
11								Interest Income Offset			(3,031)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 4,541	14
15	TOTALS (line 9+line14)						$	$ 6,430,666			$ 264,630	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

SEE ACCOUNTANTS' PREPARATION REPORT

** 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 Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 157,998	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.)	2016	$ 68,285	2
3. Under or (over) accrual (line 2 minus line 1).		$ (89,713)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 157,998	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.		$ 68,285	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	76,411	8
	2013	76,680	9
	2014	78,807	10
	2015	79,046	11
	2016	68,285	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Frankfort Terrace Nursing Ctr COUNTY Will

FACILITY IDPH LICENSE NUMBER 0051706

CONTACT PERSON REGARDING THIS REPORT Jerry Harris

TELEPHONE (630) 501-0996 FAX #: (630) 501-0987

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-09-21-410-021-0000	Long Term Care Property	$ 31,994.12	$ 31,994.12
2.	19-09-21-410-007-0000	Long Term Care Property	$ 36,290.84	$ 36,290.84
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 68,284.96	$ 68,284.96

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 [X] (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? [X] (a) Own the Equipment [X] (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).

None

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

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

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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	Facility		2012	$ 1,200,000	1
2					2
3	TOTALS			$ 1,200,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		2012	1972	$ 2,140,346	$	35	$ 61,153	$ 61,153	$ 366,917	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

*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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Leasehold Improvements (Real Estate Entity):						$	$	37
38	Rooftop A/C Unit & Ductwork	2012	5,218		20	261	261	1,566	38
39	Signs	2013	4,800		20	240	240	1,200	39
40	New Gas Line from Building to Generator	2013	6,200		20	310	310	1,550	40
41	Install New Underground Gas Piping	2013	4,439		20	222	222	1,110	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)		$ 2,161,003	$		$ 62,186	$ 62,186	$ 372,343	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 682,449	$	$ 68,245	$ 68,245	10 Yrs	$ 402,490	71
72	Current Year Purchases	7,180		718	718	10 Yrs	718	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 689,629	$	$ 68,963	$ 68,963		$ 403,208	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	N/A									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)	$ 4,050,632	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 131,149	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 131,149	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 775,551	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	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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:				$			3
4	Additions							4
5	Storage				3,706			5
6								6
7	TOTAL				$ 3,706 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 5,645 Description: See Attached Schedule 14A
(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	Facility - Res. Transport	2013 Ford XL	$ 690.00	$ 6,805	17
18	Facility - Maintenance	2013 Ford E150	546.60	6,063	18
19					19
20					20
21	TOTAL		$ 1,237	$ 12,868	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Frankfort Terrace Nursing Ctr**
IDPH License ID Number: **0051706**
Fiscal Year End: **12/31/2017**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	2,895
Postage Machine	560
Computer Equipment	
Dishwasher	2,190
Total - Line 16	**5,645**

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 ____

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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Terrace Nursing Ctr **#** 0051706 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 137,976	$ 138,040	1
2	Cash-Patient Deposits	(6,226)	(6,226)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 286,945)	824,321	824,321	3
4	Supply Inventory (priced at Cost)	2,500	2,500	4
5	Short-Term Investments			5
6	Prepaid Insurance	23,557	43,762	6
7	Other Prepaid Expenses	16,387	16,387	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule 17A	1,810,972	2,011,936	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,809,487	$ 3,030,720	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,200,000	13
14	Buildings, at Historical Cost		2,155,326	14
15	Leasehold Improvements, at Historical Cost	1,238	5,677	15
16	Equipment, at Historical Cost	25,363	689,629	16
17	Accumulated Depreciation (book methods)	(3,345)	(775,551)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Goodwill	293,977	921,721	22
23	Other(specify): Loan Costs, Net		20,466	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 317,233	$ 4,217,268	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,126,720	$ 7,247,988	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 886,249	$ 1,416,927	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,623	1,623	29
30	Accrued Salaries Payable	301,418	301,418	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,597	1,597	31
32	Accrued Real Estate Taxes(Sch.IX-B)		157,998	32
33	Accrued Interest Payable		238,607	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	205,185	205,185	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,396,072	$ 2,323,355	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,429,043	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule 17A	1,822,260	146,725	43
44	Mortgage Premium		269,380	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,822,260	$ 6,845,148	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,218,332	$ 9,168,503	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (91,612)	$ (1,920,515)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,126,720	$ 7,247,988	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Frankfort Terrace Nursing Ctr**
IDPH License ID Number: **0051706**
Fiscal Year End: **12/31/2017**

Schedule 17A

XV. Balance Sheet
Line 9 Other Assets (specify):

Description	Operating	After Consolidation
DUE FROM EKS	2,166	2,166
IMPOUND RESERVE	138,808	138,808
DUE TO MID CAP LINE OF CREI	1,669,998	1,669,998
MORTGAGE ESCROWS		200,964
Total - Line 9	**1,810,972**	**2,011,936**

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
ACCRUED EXPENSES	55,582	55,582
ALLIED ACCRUAL	170,202	170,202
PAYROLL WITHHOLDINGS	(2,164)	(2,164)
DUE TO/FROM ALIEN RECIPIEN	(4,262)	(4,262)
DUE TO PA (AUDIT ADJ)	(14,173)	(14,173)
Total - Line 36	**205,185**	**205,185**

XV. Balance Sheet
Line 43 Long-Term Liabilities (specify):

Description	Operating	After Consolidation
ACCRUED RENT	279,896	9,212
DUE TO/FROM FACILITIES	134,213	137,513
DUE TO/FROM PROPERTY	1,408,151	
Total - Line 43	**1,822,260**	**146,725**

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 295,459	1
2	Restatements (describe):		2
3	**Prior Period Adj-Cash Reconciliation**	(1,207)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 294,252	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(463,134)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	77,270	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)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (385,864)	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)**	$ (91,612)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,329,065	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,329,065	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***	3,031	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,031	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	585	27
28	Miscellaneous Income	80	28
28a	Vend Inc (5,148)/Parking Lease Rev (2,850)	7,998	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,663	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,340,759	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	868,165	31
32	Health Care	1,669,662	32
33	General Administration	1,190,450	33
	B. Capital Expense		
34	Ownership	698,578	34
	C. Ancillary Expense		
35	Special Cost Centers	81,922	35
36	Provider Participation Fee	295,116	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,803,893	40
41	**Income before Income Taxes (line 30 minus line 40)****	(463,134)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (463,134)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,329,065	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,329,065	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **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.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,976	2,032	$ 85,508	$ 42.08	1
2	Assistant Director of Nursing	2,008	2,080	70,173	33.74	2
3	Registered Nurses	5,526	5,768	160,147	27.76	3
4	Licensed Practical Nurses	11,028	12,424	317,565	25.56	4
5	CNAs & Orderlies	37,918	42,902	466,600	10.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,912	2,080	26,008	12.50	9
10	Activity Assistants	4,050	4,770	45,720	9.58	10
11	Social Service Workers	24,244	25,407	331,296	13.04	11
12	Dietician					12
13	Food Service Supervisor	1,848	2,080	32,196	15.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,515	14,557	152,635	10.49	15
16	Dishwashers					16
17	Maintenance Workers	3,679	4,047	67,206	16.61	17
18	Housekeepers	12,853	14,019	161,458	11.52	18
19	Laundry	6,466	7,117	68,232	9.59	19
20	Administrator	1,928	2,080	133,144	64.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,466	6,686	97,861	14.64	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					31
32	Other Health C: Ward Clerk	2,528	2,576	30,697	11.92	32
33	Other(specify) MDS Coordinator	1,911	2,071	52,022	25.12	33
34	TOTAL (lines 1 - 33)	139,856	152,696	$ 2,298,468 *	$ 15.05	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	151	$ 7,818	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	213	10,214	L10, C3	38
39	Pharmacist Consultant	Monthly	9,312	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychosocial				46
47	Psychiatric Medical Director	Monthly	3,600	L9,C3	47
48	Administrative	136	7,094	L21,C3	48
49	TOTAL (lines 35 - 48)	500	$ 44,038		49

C. CONTRACT NURSES

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

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Judith Majchrowicz	Administrator	0	$ 133,144
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 133,144

B. Administrative - Other

Description	Amount
TM Healthcare Management - Management Fees	$ 213,791
TOTAL (agree to Schedule V, line 17, col. 3)	$ 213,791
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached Schedule	Legal	$ 947
Marcum LLP	Accounting	24,000
Templin Healthcare Accounting Svc	Accounting	2,107
PointClickCare	Data Processing	23,531
Relias & Tsonas	RE Tax Appeal	2,288
Information Controls	Data Processing	5,719
Change Healthcare	Data Processing	849
Charles E. Butzow, Architect	Safety Code Survey	1,249
Personnel Planners	Unemployment Consulting	1,169
Howard Simon & Associates	Payroll Processing	7,120
US Trustee Payment Center	Trustee Fees	4,875
S4 Group	Lobbying	1,500
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 75,354

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,351
Unemployment Compensation Insurance	14,599
FICA Taxes	173,860
Employee Health Insurance	251,868
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	594
Severance & Retirement	10,981
Employee Drug Screening	593
TOTAL (agree to Schedule V, line 22, col.8)	$ 520,846

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,988
Advertising: Employee Recruitment	10,200
Health Care Worker Background Check	
(Indicate # of checks performed 35)	
Patient Background Checks	825
Illinois Council on LTC	17,606
Licenses & Fees	1,517
Less PAC Dues	(8,803)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,333

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	331
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 331

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Frankfort Terrace Nursing Ctr # 0051706 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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. **17,606 IL Council on LTC**

(3) Did the nursing home make political contributions or payments to a politica
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? **N/A**

(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 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **4,925** Line **10**

(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. **N/A**

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

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **295,116**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% of Lin**
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: **N/A**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees