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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0051714

Facility Name: Crestwood Terrace Nrsing Ctr

Address: 13301 S Central Ave (Number) Crestwood (City) 60445 (Zip Code)

County: Cook

Telephone Number: (708) 597-5251 **Fax #** (708) 597-4998

HFS ID Number:

Date of Initial License for Current Owners: 41087

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 1/1/16 to 12/31/16 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 Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	126	Intermediate (ICF)	126	46,116	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	126	TOTALS	126	46,116	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			8	8
9	SNF/PED					9
10	ICF	41,112	366		41,478	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,120	366		41,486	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.96%

D. How many bed-hold days during this year were paid by the Department?
None (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] 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 06/27/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/27/2012 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 _____

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: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	181,241	24,557	9,668	215,466		215,466		215,466			1
2	Food Purchase		215,590		215,590		215,590	(6,252)	209,338			2
3	Housekeeping	164,706	24,598		189,304		189,304		189,304			3
4	Laundry	18,608	8,931		27,539		27,539		27,539			4
5	Heat and Other Utilities			94,109	94,109		94,109		94,109			5
6	Maintenance	150,288	3,153	45,833	199,274		199,274	(6,529)	192,745			6
7	Other (specify):* Waste Removal			16,782	16,782		16,782		16,782			7
8	TOTAL General Services	514,843	276,829	166,392	958,064		958,064	(12,781)	945,283			8
	B. Health Care and Programs											
9	Medical Director			13,800	13,800		13,800		13,800			9
10	Nursing and Medical Records	1,052,202	47,452	23,213	1,122,867		1,122,867	1,727	1,124,594			10
10a	Therapy	18,666			18,666		18,666		18,666			10a
11	Activities	88,902		11,566	100,468		100,468		100,468			11
12	Social Services	270,619		1,235	271,854		271,854		271,854			12
13	CNA Training											13
14	Program Transportation			1,395	1,395		1,395		1,395			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,430,389	47,452	51,209	1,529,050		1,529,050	1,727	1,530,777			16
	C. General Administration											
17	Administrative	113,276		216,861	330,137		330,137		330,137			17
18	Directors Fees											18
19	Professional Services			73,871	73,871		73,871		73,871			19
20	Dues, Fees, Subscriptions & Promotions			38,387	38,387		38,387	(4,354)	34,033			20
21	Clerical & General Office Expenses	170,240	15,950	41,299	227,489		227,489		227,489			21
22	Employee Benefits & Payroll Taxes			389,013	389,013		389,013		389,013			22
23	Inservice Training & Education											23
24	Travel and Seminar			885	885		885		885			24
25	Other Admin. Staff Transportation			1,707	1,707		1,707		1,707			25
26	Insurance-Prop.Liab.Malpractice			90,811	90,811		90,811	8,082	98,893			26
27	Other (specify):*											27
28	TOTAL General Administration	283,516	15,950	852,834	1,152,300		1,152,300	3,728	1,156,028			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,228,748	340,231	1,070,435	3,639,414		3,639,414	(7,326)	3,632,088			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 Crestwood Terrace Nrsing Ctr #0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

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							140,516	140,516			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			77,569	77,569		77,569	377,174	454,743			32
33	Real Estate Taxes							368,190	368,190			33
34	Rent-Facility & Grounds			933,660	933,660		933,660	(931,968)	1,692			34
35	Rent-Equipment & Vehicles			21,549	21,549		21,549		21,549			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,032,778	1,032,778		1,032,778	(46,088)	986,690			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			320,994	320,994		320,994		320,994			42
43	Other (specify):* Non-Allow. Costs			80,354	80,354		80,354	(80,354)				43
44	**TOTAL Special Cost Centers**			401,348	401,348		401,348	(80,354)	320,994			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,228,748	340,231	2,504,561	5,073,540		5,073,540	(133,768)	4,939,772			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 Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	(5,559)	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	140,516	30		9
10	Interest and Other Investment Income	(699)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(25)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,506)	43		18
19	Entertainment	(106)	43		19
20	Contributions	(200)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(65,941)	43		24
25	Fund Raising, Advertising and Promotional	(1,790)	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	(328,726)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (268,036)		$	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)	134,268		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 134,268		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (133,768)		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

Crestwood Terrace Nrsing Ctr

ID# 0051714

Report Period Beginning: 1/1/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Resident Needs/Charity	$ (1,227)	43	1
2	Vending Income	(6,252)	2	2
3	Medical Records Income	(141)	21	3
4	PAC Dues	(4,354)	20	4
5	Building Co. - Admin Expenses	(208)	21	5
6	Building Co. - Amortization of Goodwill	(277,315)	36	6
7	Building Co. - Other Financing Costs	(33,949)	36	7
8	Building Co. - Licenses & Fees	(619)	20	8
9	Additional Repairs and Maintenance	1,308	6	9
10	Additional Nursing Equipment	1,868	10	10
11	Capitalized Repairs and Maintenance	(7,837)	6	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**	(328,726)		49

Facility Name & ID Number Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$	CT Crestwood, LLC	100.00%	$ 619	$ 619	1
2	V	21	Bank Charges		CT Crestwood, LLC	100.00%	208	208	2
3	V	26	Property Insurance		CT Crestwood, LLC	100.00%	8,082	8,082	3
4	V	32	Interest		CT Crestwood, LLC	100.00%	377,873	377,873	4
5	V	33	Real Estate Taxes		CT Crestwood, LLC	100.00%	368,190	368,190	5
6	V	34	Rent	931,968	CT Crestwood, LLC	100.00%		(931,968)	6
7	V	36	Amortization Exp-Goodwill		CT Crestwood, LLC	100.00%	277,315	277,315	7
8	V	36	Finance Costs		CT Crestwood, LLC	100.00%	33,949	33,949	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 931,968			$ 1,066,236	$ * 134,268	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	CT Crestwood, LLC	Crestwood	Lessor	1
2	Carl Meyer	50	Community Care Center	Chicago				2
3			Frankfort Terrace Nursing Ctr	Frankfort				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 Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

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			$	$ 6,586,339			$ 377,093	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap		X	Line of Credit				1,704,128			63,937	6
7												7
8												8
9	TOTAL Facility Related						$	$ 8,290,467			$ 441,030	9
	B. Non-Facility Related*											
10								Amortization Expense			14,412	10
11								Interest Income Offset			(699)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 13,713	14
15	TOTALS (line 9+line14)						$	$ 8,290,467			$ 454,743	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 Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 327,405	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.)	2015	$	2
3. Under or (over) accrual (line 2 minus line 1).		$ (327,405)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 695,595	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.		$ 368,190	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	339,851	8
	2012	360,222	9
	2013	317,869	10
	2014	360,173	11
	2015	368,190	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Crestwood Terrace Nrsing Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051714

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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-33-307-001-0000	Long Term Care Property	$ 368,190.39	$ 368,190.39
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 368,190.39	$ 368,190.39

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,623 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: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2012	$ 600,000	1
2					2
3	TOTALS			$ 600,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	126		2012	1976	$ 2,252,370	$	35	$ 64,353	$ 64,353	$ 321,766	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fireline			2014	5,513		20	276	276	575	9
10	Replace Compressor On Walk In Cooler			2015	3,330		20	167	167	333	10
11	Wood Fence - 300ft			2016	7,837		20	392	392	392	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 Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	1,305	38
39	Stationary Awning in West Face Entrance	2012	3,785		20	189	189	946	39
40	Rooftop Heating System	2012	3,144		20	157	157	786	40
41	Internal Signage	2013	9,382		20	469	469	1,876	41
42	Roto Rooter	2015	4,050		20	203	203	406	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)		$ 2,294,629	$		$ 66,467	$ 66,467	$ 328,385	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$ 740,487	$	$ 74,049	$ 74,049	10	$ 358,702	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 740,487	$	$ 74,049	$ 74,049		$ 358,702	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,635,116	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)	$ 140,516	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 140,516	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 687,087	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 Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

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								5
6	Storage				1,692			6
7	TOTAL				$ 1,692 **			7

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

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

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 5,426 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	Maintenance	2013 Ford E150	$ 547	$ 6,559	17
18	Facility	2012 Ford E350	797	9,564	18
19					19
20					20
21	TOTAL		$ 1,344	$ 16,123	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: **Crestwood Terrace Nrsing Ctr**
IDPH License ID Number: **0051714**
Fiscal Year End: **12/31/16**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Postage Machine	510
Copier	2,815
Computer	304
Dishwasher	1,797
Total - Line 16	**5,426**

Facility Name & ID Number Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

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		hrs							2
3	Licensed Recreational Therapist	N/A	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

STATE OF ILLINOIS

Facility Name & ID Number Crestwood Terrace Nrsing Ctr **#** 0051714 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 106,221	$ 106,490	1
2	Cash-Patient Deposits	642	642	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 323,034)	2,520,336	2,520,336	3
4	Supply Inventory (priced at Cost)	2,300	2,300	4
5	Short-Term Investments			5
6	Prepaid Insurance	38,389	49,925	6
7	Other Prepaid Expenses	10,154	10,154	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule 17A	53,601	315,573	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,731,643	$ 3,005,420	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		600,000	13
14	Buildings, at Historical Cost	5,991	2,276,555	14
15	Leasehold Improvements, at Historical Cost		18,074	15
16	Equipment, at Historical Cost	37,039	740,487	16
17	Accumulated Depreciation (book methods)	(11,739)	(687,087)	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	712,066	2,375,955	22
23	Other(specify): Loan Costs		21,246	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 743,357	$ 5,345,230	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,475,000	$ 8,350,650	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 595,166	$ 629,323	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,704,128	1,704,128	29
30	Accrued Salaries Payable	230,914	230,914	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,772	9,772	31
32	Accrued Real Estate Taxes(Sch.IX-B)		695,595	32
33	Accrued Interest Payable		444,729	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	119,843	119,843	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,659,823	$ 3,834,304	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,586,339	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule 17A	1,554,772	29,130	43
44	Mortgage Premium		289,166	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,554,772	$ 6,904,635	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,214,595	$ 10,738,939	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (739,595)	$ (2,388,289)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,475,000	$ 8,350,650	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Crestwood Terrace Nrsing Ctr**
IDPH License ID Number: **0051714**
Fiscal Year End: **12/31/16**

Schedule 17A

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

Description	Operating	After Consolidation
DUE FROM EKS	7,891	7,891
IMPOUND RESERVE	45,710	45,710
MORTGAGE ESCROWS		261,972
Total - Line 9	**53,601**	**315,573**

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

Description	Operating	After Consolidation
ACCRUED EXPENSES	33,394	33,394
ALLIED ACCRUAL	80,684	80,684
PAYROLL WITHHOLDINGS	(71)	(71)
DUE TO/FROM ALIEN RECIPIEN	5,836	5,836
Total - Line 36	**119,843**	**119,843**

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

Description	Operating	After Consolidation
ACCRUED RENT	388,642	-
DUE TO/FROM FACILITIES	81,389	29,130
DUE TO/FROM PROPERTY	1,084,741	-
Total - Line 43	**1,554,772**	**29,130**

Facility Name & ID Number Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (150,606)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (150,606)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(670,371)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	81,382	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)**	$ (588,989)	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)**	$ (739,595)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$ 4,396,077	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,396,077	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***	687	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 687	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous Income**	153	28
28a	**Vending Income**	6,252	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,405	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,403,169	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	958,064	31
32	Health Care	1,529,050	32
33	General Administration	1,152,300	33
	B. Capital Expense		
34	Ownership	1,032,778	34
	C. Ancillary Expense		
35	Special Cost Centers	80,354	35
36	Provider Participation Fee	320,994	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,073,540	40
41	**Income before Income Taxes (line 30 minus line 40)****	(670,371)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (670,371)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,396,077	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)	$ 4,396,077	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 Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	1,904	2,080	$ 88,686	$ 42.64	1
2	Assistant Director of Nursing	1,940	2,088	62,725	30.04	2
3	Registered Nurses	4,945	5,268	91,857	17.44	3
4	Licensed Practical Nurses	12,392	12,924	382,222	29.57	4
5	CNAs & Orderlies	32,677	34,558	365,521	10.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	720	832	18,666	22.44	8
9	Activity Director	2,006	2,160	35,295	16.34	9
10	Activity Assistants	5,959	6,161	53,607	8.70	10
11	Social Service Workers	14,461	15,353	270,619	17.63	11
12	Dietician					12
13	Food Service Supervisor	2,016	2,152	32,852	15.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,498	13,725	148,389	10.81	15
16	Dishwashers					16
17	Maintenance Workers	12,968	13,673	150,288	10.99	17
18	Housekeepers	18,698	19,603	164,706	8.40	18
19	Laundry	1,954	2,179	18,608	8.54	19
20	Administrator	2,096	2,267	113,276	49.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,315	12,394	170,240	13.74	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	1,835	2,091	22,219	10.63	31
32	Other Health Care(specify)					32
33	Other(specify) MDS Coordinator	1,743	1,983	38,972	19.65	33
34	TOTAL (lines 1 - 33)	142,127	151,491	$ 2,228,748 *	$ 14.71	34

SEE ACCOUNTANTS' PREPARATION REPORT

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	186	$ 9,668	L1, C3	35
36	Medical Director	Monthly	6,600	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	257	12,755	L10, C3	38
39	Pharmacist Consultant	Monthly	9,839	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	30	1,829	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Medical Director	Monthly	7,200	L9,C3	47
48	Administrative	72	4,366	L21,C3	48
49	TOTAL (lines 35 - 48)	545	$ 52,257		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

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

** See instructions.

Facility Name & ID Number Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Margaret Olson	Administrator	0	$ 72,065
Yomi Adebogun	Administrator	0	8,654
Mary Ellen McDevitt	Administrator	0	32,557
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 113,276

B. Administrative - Other

Description	Amount
TM Healthcare Management - Management Fees	$ 216,861
TOTAL (agree to Schedule V, line 17, col. 3)	$ 216,861
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached Schedule	Legal	$ 12,055
FR&R/Marcum LLP	Accounting	24,000
First Advantage	Accounting	2,271
PointClickCare	Data Processing	21,308
Information Controls	Data Processing	4,411
E-Health Data Solutions	Data Processing	2,450
Change Healthcare	Data Processing	786
Personnel Planners	Unemployment Tax Consult	1,293
Howard Simon & Associates	Payroll Processing	5,297
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 73,871

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,755
Unemployment Compensation Insurance	69,788
FICA Taxes	169,954
Employee Health Insurance	75,702
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	3,493
Severance & Retirement	6,616
Employee Drug Screening	705
TOTAL (agree to Schedule V, line 22, col.8)	$ 389,013

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	$ 1,902
Advertising: Employee Recruitment	19,980
Health Care Worker Background Check	
(Indicate # of checks performed 1)	150
Patient Background Checks 80	1,861
IL Council on LTC	13,074
Dues & Subscriptions	45
Licenses & Fees	1,375
Less PAC Dues	(4,354)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,033

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	885
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 885

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Crestwood Terrace Nrsing Ctr # 0051714 Report Period Beginning: 1/1/16 Ending: 12/31/16

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. **13,074 IL Council on LTC**

(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? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **None**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,066** 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 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **320,994**
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 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? **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 for 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% Ln 14**
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 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