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: 0051672

Facility Name: West Chicago Terrace NH

Address: 928 Joliet Road (Number) West Chicago (City) 60185 (Zip Code)

County: Dupage

Telephone Number: (630) 231-9292 **Fax #** (630) 2316797

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 West Chicago Terrace NH # 0051672 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)		0	1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,920	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 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	37,834	1,380		39,214	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,834	1,380		39,214	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.29%

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 West Chicago Terrace NH # 0051672 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	184,800	15,701	9,686	210,187		210,187		210,187			1
2	Food Purchase		192,352		192,352		192,352	(4,632)	187,720			2
3	Housekeeping	158,036	28,090		186,126		186,126		186,126			3
4	Laundry	89,240	8,057		97,297		97,297		97,297			4
5	Heat and Other Utilities			123,235	123,235		123,235		123,235			5
6	Maintenance	82,297	3,934	48,754	134,985		134,985		134,985			6
7	Other (specify):* Waste Removal			10,694	10,694		10,694		10,694			7
8	TOTAL General Services	514,373	248,134	192,369	954,876		954,876	(4,632)	950,244			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	1,492,202	60,787	22,201	1,575,190		1,575,190	(9,275)	1,565,915			10
10a	Therapy	68,230			68,230		68,230		68,230			10a
11	Activities	108,026		9,972	117,998		117,998		117,998			11
12	Social Services	300,021		2,790	302,811		302,811		302,811			12
13	CNA Training											13
14	Program Transportation			4,368	4,368		4,368		4,368			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,968,479	60,787	63,331	2,092,597		2,092,597	(9,275)	2,083,322			16
	C. General Administration											
17	Administrative	86,809		220,879	307,688		307,688		307,688			17
18	Directors Fees											18
19	Professional Services			76,923	76,923		76,923		76,923			19
20	Dues, Fees, Subscriptions & Promotions			28,943	28,943		28,943	(4,148)	24,795			20
21	Clerical & General Office Expenses	128,421	16,193	56,041	200,655		200,655		200,655			21
22	Employee Benefits & Payroll Taxes			434,815	434,815		434,815		434,815			22
23	Inservice Training & Education											23
24	Travel and Seminar			80	80		80		80			24
25	Other Admin. Staff Transportation			1,707	1,707		1,707		1,707			25
26	Insurance-Prop.Liab.Malpractice			48,658	48,658		48,658	7,342	56,000			26
27	Other (specify):*											27
28	TOTAL General Administration	215,230	16,193	868,046	1,099,469		1,099,469	3,194	1,102,663			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,698,082	325,114	1,123,746	4,146,942		4,146,942	(10,713)	4,136,229			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 West Chicago Terrace NH #0051672 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							128,695	128,695			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,879	73,879		73,879	126,404	200,283			32
33	Real Estate Taxes							69,820	69,820			33
34	Rent-Facility & Grounds			496,378	496,378		496,378	(485,930)	10,448			34
35	Rent-Equipment & Vehicles			29,631	29,631		29,631		29,631			35
36	Other (specify):*											36
37	**TOTAL Ownership**			599,888	599,888		599,888	(161,011)	438,877			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			304,668	304,668		304,668		304,668			42
43	Other (specify):* See Att Sch 4A			128,907	128,907		128,907	(128,807)	100			43
44	**TOTAL Special Cost Centers**			433,575	433,575		433,575	(128,807)	304,768			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,698,082	325,114	2,157,209	5,180,405		5,180,405	(300,531)	4,879,874			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

West Chicago Terrace NH

Period Beginning **1/1/16**
Period End **12/31/16**

Schedule 4A

V. Cost Center Expenses

		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	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory Expense			100	100		100		100			
	Radiology Expenses				0		0		0			
	Non-Allowable Expenses			128,807	128,807		128,807	(128,807)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	0	0	128,907	128,907	0	128,907	(128,807)	100			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Chicago Terrace NH # 0051672 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	(4,119)	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	128,695	30		9
10	Interest and Other Investment Income	(2,576)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(50)	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	(53,268)	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	(67,022)	43		24
25	Fund Raising, Advertising and Promotional	(25)	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	(180,656)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (179,021)		$	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)	(121,510)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (121,510)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (300,531)		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

West Chicago Terrace NH

ID# 0051672

Report Period Beginning: 1/1/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (4,632)	2	1
2	Medical Records Income	(140)	10	2
3	Purchase Rebate	(9,135)	10	3
4	Theft and Damage Loss	(1,089)	43	4
5	PAC Dues	(4,148)	20	5
6	Building Co. - Admin Expenses	(291)	21	6
7	Building Co. - Amortization of Goodwill	(145,229)	36	7
8	Building Co. - Other Financing Costs	(12,139)	36	8
9	Building Co. - Licenses & Fees	(619)	20	9
10	Resident Needs/Charity	(3,234)	43	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**	(180,656)		49

Facility Name & ID Number West Chicago Terrace NH # 0051672 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	$	WCT West Chicago LLC	100.00%	$ 619	$ 619	1
2	V	21	Bank Charges		WCT West Chicago LLC	100.00%	291	291	2
3	V	26	Property Insurance		WCT West Chicago LLC	100.00%	7,342	7,342	3
4	V	32	Interest		WCT West Chicago LLC	100.00%	128,980	128,980	4
5	V	33	Real Estate Taxes		WCT West Chicago LLC	100.00%	69,820	69,820	5
6	V	34	Rent	485,930	WCT West Chicago LLC	100.00%		(485,930)	6
7	V	36	Amortization Exp-Goodwill		WCT West Chicago LLC	100.00%	145,229	145,229	7
8	V	36	Finance Costs		WCT West Chicago LLC	100.00%	12,139	12,139	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 485,930			$ 364,420	$ * (121,510)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number West Chicago Terrace NH # 0051672 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	WCT West Chicago LL	West Chicago	Lessor	1
2	Carl Meyer	50	Community Care Center	Chicago				2
3			Crestwood Terrace Nursing Ctr	Crestwood				3
4			Frankfort Terrace Nursing Center	Frankfort				4
5			Joliet Terrace Nursing Center	Joliet				5
6			Kankakee Terrace Nursing Center	Bourbonnais				6
7			Southview Manor Nursing Center	Chicago				7
8			The Terrace Nursing Home	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 West Chicago Terrace NH # 0051672 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 West Chicago Terrace NH # 0051672 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 West Chicago Terrace NH # 0051672 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			$	$ 4,949,733			$ 128,264	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap		X	Line of Credit				1,670,437			60,895	6
7												7
8												8
9	TOTAL Facility Related						$	$ 6,620,170			$ 189,159	9
	B. Non-Facility Related*											
10								Amortization Expense			13,700	10
11								Interest Income Offset			(2,576)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 11,124	14
15	TOTALS (line 9+line14)						$	$ 6,620,170			$ 200,283	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 West Chicago Terrace NH # 0051672 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.**	$ 87,852	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).		$ (87,852)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 157,672	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.		$ 69,820	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	79,892	8
	2012	82,070	9
	2013	85,293	10
	2014	84,496	11
	2015	69,820	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 West Chicago Terrace NH COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0051672

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.	04-16-202-008	Long Term Care Property	$ 69,819.60	$ 69,819.60
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 69,819.60	$ 69,819.60

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 West Chicago Terrace NH # 0051672 Report Period Beginning: 1/1/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,898 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 West Chicago Terrace NH # 0051672 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	120		2012	1976	$ 2,158,459	$	35	$ 61,670	$ 61,670	$ 308,351	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Commericial Heater			2015	2,666		20	133	133	152	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 West Chicago Terrace NH # 0051672 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	Door Replacement	2012	6,740		20	337	337	1,685	38
39	Mounted Security System	2013	4,771		20	239	239	956	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,172,636	$		$ 62,379	$ 62,379	$ 311,144	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number West Chicago Terrace NH # 0051672 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	$ 659,133	$	$ 65,913	$ 65,913	10	$ 263,653	71
72	Current Year Purchases	4,032		403	403	10	403	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 663,165	$	$ 66,316	$ 66,316		$ 264,056	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)	$ 3,435,801	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)	$ 128,695	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 128,695	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 575,200	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 West Chicago Terrace NH # 0051672 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	Storage				10,448			5
6								6
7	TOTAL				$ 10,448 **			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: $ 6,308 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	Residents	2012 Ford Ecoline	$ 797.00	$ 9,564	17
18	Maintenance	2013 Ford E150	547.00	6,559	18
19	Maintenance	2013 Ford E150	600.00	7,200	19
20					20
21	TOTAL		$ 1,944.00	$ 23,323	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: **West Chicago Terrace NH**
IDPH License ID Number: **0051672**
Fiscal Year End: **12/31/16**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Postage Machine	428
Copier	3,353
Computer Equip	304
Water Cooler	479
Dishwasher	1,635
Miscellaneous	109
Total - Line 16	**6,308**

Facility Name & ID Number West Chicago Terrace NH # 0051672 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

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		hrs							3
4	Licensed Physical Therapist	N/A	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 West Chicago Terrace NH # 0051672 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	$ 86,671	$ 86,767	1
2	Cash-Patient Deposits	(2,367)	(2,367)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 229,290)	1,930,745	1,930,745	3
4	Supply Inventory (priced at Cost)	4,250	4,250	4
5	Short-Term Investments			5
6	Prepaid Insurance	31,816	48,289	6
7	Other Prepaid Expenses	9,723	9,723	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule 17A	65,731	195,570	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,126,569	$ 2,272,977	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		2,171,886	14
15	Leasehold Improvements, at Historical Cost		750	15
16	Equipment, at Historical Cost	18,162	663,165	16
17	Accumulated Depreciation (book methods)	(1,702)	(575,200)	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	546,225	1,417,598	22
23	Other(specify): Loan Costs		19,518	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 562,685	$ 4,297,717	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,689,254	$ 6,570,694	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 613,064	$ 625,416	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,670,437	1,670,437	29
30	Accrued Salaries Payable	392,281	392,281	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,898	10,898	31
32	Accrued Real Estate Taxes(Sch.IX-B)		157,672	32
33	Accrued Interest Payable		179,313	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	203,651	203,651	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,890,331	$ 3,239,668	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,949,733	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule 17A	1,130,664	172,244	43
44	Mortgage Premium		220,498	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,130,664	$ 5,342,475	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,020,995	$ 8,582,143	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,331,741)	$ (2,011,449)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,689,254	$ 6,570,694	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **West Chicago Terrace NH**
IDPH License ID Number: **0051672**
Fiscal Year End: **12/31/16**

Schedule 17A

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

Description	Operating	After Consolidation
DUE FROM EKS	9,431	9,431
IMPOUND RESERVE	56,300	56,300
MORTGAGE ESCROWS		129,839
Total - Line 9	**65,731**	**195,570**

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

Description	Operating	After Consolidation
ACCRUED EXPENSES	63,822	63,822
ALLIED ACCRUAL	101,625	101,625
PAYROLL WITHHOLDINGS	1,457	1,457
DUE TO PA (AUDIT ADJ)	(18)	(18)
DUE TO/FROM PRIOR PERIOD	1,184	1,184
DUE TO/FROM ALIEN RECIPIEN	35,581	35,581
Total - Line 36	**203,651**	**203,651**

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

Description	Operating	After Consolidation
ACCRUED RENT	232,438	-
DUE TO/FROM FACILITIES	172,244	172,244
DUE TO/FROM PROPERTY	725,982	-
Total - Line 43	**1,130,664**	**172,244**

Facility Name & ID Number West Chicago Terrace NH # 0051672 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**	$ (713,455)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (713,455)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(695,796)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	77,510	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)**	$ (618,286)	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)**	$ (1,331,741)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number West Chicago Terrace NH # 0051672 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	$ 4,468,126	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,468,126	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***	2,576	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,576	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	140	28
28a	Vending Income/Purchase Discounts	13,767	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,907	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,484,609	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	954,876	31
32	Health Care	2,092,597	32
33	General Administration	1,099,469	33
	B. Capital Expense		
34	Ownership	599,888	34
	C. Ancillary Expense		
35	Special Cost Centers	128,907	35
36	Provider Participation Fee	304,668	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,180,405	40
41	**Income before Income Taxes (line 30 minus line 40)****	(695,796)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (695,796)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,281,324	44
45	Private Pay - Net Inpatient Revenue	181,602	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Hospice	5,200	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,468,126	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 West Chicago Terrace NH # 0051672 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	1,784	1,960	$ 70,489	$ 35.96	1
2	Assistant Director of Nursing	1,968	2,080	65,773	31.62	2
3	Registered Nurses	6,943	7,143	189,617	26.55	3
4	Licensed Practical Nurses	18,425	19,413	432,588	22.28	4
5	CNAs & Orderlies	41,820	43,751	642,603	14.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,889	3,026	68,230	22.55	8
9	Activity Director	1,839	2,039	27,395	13.44	9
10	Activity Assistants	7,475	7,780	80,631	10.36	10
11	Social Service Workers	21,156	22,677	300,021	13.23	11
12	Dietician					12
13	Food Service Supervisor	1,768	1,960	31,186	15.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,558	12,456	153,614	12.33	15
16	Dishwashers					16
17	Maintenance Workers	1,974	2,094	82,297	39.30	17
18	Housekeepers	12,404	13,266	158,036	11.91	18
19	Laundry	9,028	9,637	89,240	9.26	19
20	Administrator	1,896	2,080	86,809	41.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,258	7,634	128,421	16.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,160	3,520	29,041	8.25	31
32	Other Health Care(specify)					32
33	Other(specify) MDS Coordinator	1,939	2,099	62,091	29.58	33
34	TOTAL (lines 1 - 33)	155,284	164,615	$ 2,698,082 *	$ 16.39	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	196	$ 9,686	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	191	9,487	L10, C3	38
39	Pharmacist Consultant	Monthly	9,360	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	45	2,790	L12, C3	46
47	Psychiatric Medical Director	Monthly	12,000	L9,C3	47
48	Administrative	80	4,450	L21,C3	48
49	TOTAL (lines 35 - 48)	512	$ 59,773		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	48	2,230	L10,C3	51
52	Certified Nurse Assistants/Aides	15	404	L10,C3	52
53	TOTAL (lines 50 - 52)	63	$ 2,634		53

Facility Name & ID Number West Chicago Terrace NH # 0051672 Report Period Beginning: 1/1/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Amy Wallace	Administrator	0.00%	$ 86,809
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 86,809

B. Administrative - Other

Description	Amount
TM Healthcare Management - Management Fees	$ 220,879
TOTAL (agree to Schedule V, line 17, col. 3)	$ 220,879
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached Schedule	Legal	$ 16,483
Frost/Marcum	Accounting	24,000
Point Click Care	Data Processing	19,429
Information Controls	Data Processing	4,411
E-Health Data Solutions	Data Processing	2,450
Change Healthcare	Data Processing	786
Personnel Planners	Unemployement Consulting	1,123
Howard Simon & Associates	Payroll Processing	6,104
First Advantage Tax Consulting	Accounting	2,137
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 76,923

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,558
Unemployment Compensation Insurance	27,317
FICA Taxes	202,620
Employee Health Insurance	72,146
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Fund	62,374
Other Employee Benefits	2,800
TOTAL (agree to Schedule V, line 22, col.8)	$ 434,815

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	$ 1,868
Advertising: Employee Recruitment	9,936
Health Care Worker Background Check	
(Indicate # of checks performed 20)	700
Patient Background Checks 84	2,026
IL Council on LTC	12,456
Licenses & Fees	1,957
Less PAC Dues	(4,148)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,795

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	80
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 80

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number West Chicago Terrace NH # 0051672 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. **12,456 IL Council on LTC**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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. $ **8,928** 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. $ **304,668**
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