

		FOR BHF USE					

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

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.

<p>I. IDPH License ID Number: <u>0051631</u></p> <p>Facility Name: <u>Bourbonnais Terrace NH</u></p> <p>Address: <u>133 Mohawk Drive</u> <u>Bourbonnais</u> <u>60914</u> Number City Zip Code</p> <p>County: <u>Kankakee</u></p> <p>Telephone Number: <u>(815) 937-4790</u> Fax # <u>(815) 937-0432</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>6/27/2012</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Larry Templin</u> Telephone Number: <u>(630) 361-2868</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2017</u> to <u>12/31/2017</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%;"> <tr> <td rowspan="2" style="width: 20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4" style="vertical-align: top;">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Larry Templin Partner</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(630) 361-2868</u> Fax # () _____</td> </tr> <tr> <td colspan="2" style="text-align: center;">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</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____ (Date) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____	(Print Name and Title) <u>Larry Templin Partner</u>	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u>		(Telephone) <u>(630) 361-2868</u> 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	
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Bourbonnais Terrace NH

0051631 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3	97	Intermediate (ICF)	97	35,405	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	71,905	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	45,950	1,414		47,364	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,950	1,414		47,364	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.87%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO 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

I. On what date did you start providing long term care at this location?
Date started 6/27/2012

J. Was the facility purchased or leased after January 1, 1978?
YES Date 6/27/2012 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Bourbonnais Terrace NH # 0051631 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	271,587	31,757	10,085	313,429		313,429		313,429		1
2	Food Purchase		258,175		258,175		258,175	(11,016)	247,159		2
3	Housekeeping	280,119	47,223		327,342		327,342		327,342		3
4	Laundry	65,041	6,314		71,355		71,355		71,355		4
5	Heat and Other Utilities			104,494	104,494		104,494		104,494		5
6	Maintenance	77,605	2,290	25,848	105,743		105,743		105,743		6
7	Other (specify):* Waste Disposal			11,701	11,701		11,701		11,701		7
8	TOTAL General Services	694,352	345,759	152,128	1,192,239		1,192,239	(11,016)	1,181,223		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,703,706	42,097	29,636	1,775,439		1,775,439	(446)	1,774,993		10
10a	Therapy										10a
11	Activities	103,910		12,820	116,730		116,730		116,730		11
12	Social Services	269,679		1,384	271,063		271,063		271,063		12
13	CNA Training										13
14	Program Transportation			3,930	3,930		3,930		3,930		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,077,295	42,097	53,770	2,173,162		2,173,162	(446)	2,172,716		16
	C. General Administration										
17	Administrative	101,176		239,030	340,206		340,206		340,206		17
18	Directors Fees										18
19	Professional Services			114,522	114,522		114,522	(1,500)	113,022		19
20	Dues, Fees, Subscriptions & Promotions			11,831	11,831		11,831		11,831		20
21	Clerical & General Office Expenses	154,139	10,268	61,311	225,718		225,718		225,718		21
22	Employee Benefits & Payroll Taxes			531,631	531,631		531,631		531,631		22
23	Inservice Training & Education			3,605	3,605		3,605		3,605		23
24	Travel and Seminar			2,656	2,656		2,656		2,656		24
25	Other Admin. Staff Transportation			2,334	2,334		2,334		2,334		25
26	Insurance-Prop.Liab.Malpractice			35,745	35,745		35,745	10,493	46,238		26
27	Other (specify):*										27
28	TOTAL General Administration	255,315	10,268	1,002,665	1,268,248		1,268,248	8,993	1,277,241		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,026,962	398,124	1,208,563	4,633,649		4,633,649	(2,469)	4,631,180		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

Bourbonnais Terrace NH

#0051631

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							248,019	248,019			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			153,849	153,849		153,849	354,606	508,455			32
33	Real Estate Taxes							111,959	111,959			33
34	Rent-Facility & Grounds			1,100,626	1,100,626		1,100,626	(1,100,626)				34
35	Rent-Equipment & Vehicles			22,762	22,762		22,762		22,762			35
36	Other (specify):*											36
37	TOTAL Ownership			1,277,237	1,277,237		1,277,237	(386,042)	891,195			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											42
43	Other (specify):* Disallowed Costs			93,630	93,630		93,630	(93,630)				43
44	TOTAL Special Cost Centers			93,630	93,630		93,630	(93,630)				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,026,962	398,124	2,579,430	6,004,516		6,004,516	(482,141)	5,522,375			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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(14,113)	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	248,019	30		9
10	Interest and Other Investment Income	(4,051)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(47)	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	(1,500)	19		17
18	Fines and Penalties	(5,186)	43		18
19	Entertainment	(747)	43		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	(72,556)	43		24
25	Fund Raising, Advertising and Promotional				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	(494,864)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (345,045)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(137,096)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (137,096)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (482,141)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' PREPARATION REPORT

Bourbonnais Terrace NH

ID# 0051631

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (11,016)	2	1
2	Resident Needs/Charity	(981)	43	2
3	Building Co. - Admin Expenses	(781)	21	3
4	Building Co. - Amortization of Goodwill	(461,021)	36	4
5	Building Co. - Other Financing Costs	(20,369)	36	5
6	Building Co. - Licenses & Fees	(250)	20	6
7	Medical Records Income/Rebate Income	(446)	10	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
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22				22
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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	(494,864)		49

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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	20 Licenses & Fees	\$	BT Bourbonnais, LLC	100.00%	\$ 250	\$	250	1
2	V	21 Bank Charges		BT Bourbonnais, LLC	100.00%	781		781	2
3	V	26 Property Insurance		BT Bourbonnais, LLC	100.00%	10,493		10,493	3
4	V	32 Interest		BT Bourbonnais, LLC	100.00%	358,657		358,657	4
5	V	33 Real Estate Taxes		BT Bourbonnais, LLC	100.00%	111,959		111,959	5
6	V	34 Rent	1,100,626	BT Bourbonnais, LLC	100.00%			(1,100,626)	6
7	V	36 Amortization Exp-Goodwill		BT Bourbonnais, LLC	100.00%	461,021		461,021	7
8	V	36 Finance Costs		BT Bourbonnais, LLC	100.00%	20,369		20,369	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 1,100,626			\$ 963,530	\$ *	(137,096)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Bourbonnais Terrace NH

0051631

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jimmy Nassour	50	Community Care Center	Chicago	BT Bourbonnais, LLC	Bourbonnais	Lessor	1
2	Carl Meyer	50	Crestwood Terrace Nursing Ctr	Crestwood				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 Bourbonnais Terrace NH # 0051631 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	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 Bourbonnais Terrace NH

0051631

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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

Bourbonnais Terrace NH

0051631

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	First Mortgage		X	Mortgage Payable			\$	\$ 13,442,544		\$ 357,623	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	MidCap		X	Line of Credit				2,664		142,699	6									
7											7									
8											8									
9	TOTAL Facility Related					\$	\$ 13,445,208			\$ 500,322	9									
B. Non-Facility Related*																				
10								Amortization Expense		12,184	10									
11								Interest Income Offset		(4,051)	11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$ 8,133	14									
15	TOTALS (line 9+line14)					\$	\$ 13,445,208			\$ 508,455	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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2016 report.		\$	237,073	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2016	\$	111,959	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(125,114)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	237,073	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.		\$	111,959	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	76,838	8
	2013	83,392	9
	2014	85,043	10
	2015	151,180	11
	2016	111,959	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' PREPARATION REPORT

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bourbonnais Terrace NH COUNTY Kankakee

FACILITY IDPH LICENSE NUMBER 0051631

CONTACT PERSON REGARDING THIS REPORT Jerry Harris

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>17-09-17-300-020</u>	<u>Long Term Care Property</u>	\$ <u>111,959.00</u>	\$ <u>111,959.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>111,959.00</u></u>	\$ <u><u>111,959.00</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

PLEASE NOTE: Payment information from the Internet or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Bourbonnais Terrace NH

0051631

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,232 B. General Construction Type: Exterior Brick Frame Number of Stories

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Row 1: Facility, 2012, \$600,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, (blank), \$600,000, 3.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Bourbonnais Terrace NH**

0051631

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	197	2012	1975	\$ 3,438,746	\$	35	\$ 98,250	\$ 98,250	\$ 589,500	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Annunciator Panel		2013	2,530		20	127	127	518	9
10	Masonry Tuckpointing		2014	2,774		20	139	139	787	10
11	Sidewalk Pavement Outside of D Wing		2014	10,000		20	500	500	2,222	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	<u>Leasehold Improvements (Real Estate Entity):</u>		\$	\$		\$	\$	\$	37
38	<u>Rooftop A/C Unit & Ductwork</u>	2012	5,219		20	261	261	1,566	38
39	<u>Sewer Pipe</u>	2013	7,500		20	375	375	1,875	39
40	<u>Roof AC Unit</u>	2013	2,652		20	133	133	665	40
41	<u>Cooling w/Heat</u>	2012	2,922		20	146	146	1,022	41
42	<u>Kitchen Hood</u>	2013	3,751		20	188	188	940	42
43	<u>B & D Wing Kitchen, Dining Room, Storage Room,</u>	2014	50,000		20	2,500	2,500	10,000	43
44	<u>Hallway Debris Hauling, Doors, Tiling</u>	2014			20				44
45	<u>Mold Remediation in B & D Wing Kitchen, Dining Room,</u>	2014	17,081		20	854	854	3,416	45
46	<u>Storage Room, Hallway</u>	2014			20				46
47	<u>D-Wing Electrical Wiring, Insulation, Tiling, Roof</u>	2014	8,682		20	434	434	1,736	47
48	<u>Drainage Repair</u>	2014	3,250		20	163	163	651	48
49	<u>Roof Repair - Ridges, pipes, valley</u>	2014	12,325		20	616	616	2,465	49
50	<u>Drainage Repair</u>	2014	7,374		20	369	369	1,475	50
51	<u>Excavation - Tree Removal, pipe protection,asphalt, pavement, fer</u>	2014	398,778		20	19,939	19,939	79,756	51
52	<u>Engineering Fees - Drainage Improvements/Excavation</u>	2015	22,820		20	1,141	1,141	3,423	52
53	<u>Plumbing & Heating</u>	2015	14,605		20	730	730	2,190	53
54	<u>Roofing</u>	2015	6,209		20	310	310	930	54
55	<u>Windows</u>	2015	2,559		20	128	128	384	55
56	<u>Compressor/Roof Curb</u>	2015	4,565		20	228	228	684	56
57	<u>Excavation - Tree Removal, pipe protection,asphalt, pavement, fer</u>	2016	48,646		20	2,432	2,432	4,864	57
58	<u>Roof Repairs above Unit C4</u>	2016	2,742		20	137	137	274	58
59	<u>81 Gallon Water Heater</u>	2016	4,034		20	202	202	404	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)		\$ 4,079,764	\$		\$ 130,302	\$ 130,302	\$ 711,747	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

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	\$ 1,175,283	\$	\$ 117,528	\$ 117,528	10	\$ 676,369	71
72	Current Year Purchases	3,789		189	189	10	189	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,179,072	\$	\$ 117,717	\$ 117,717		\$ 676,558	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,858,836	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)	\$ 248,019	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 248,019	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,388,305	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 Bourbonnais Terrace NH

0051631

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

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

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 7,762

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			\$	\$	17
18	<u>Resident Transport</u>	<u>Ford E350 2013</u>	<u>1,250</u>	<u>15,000</u>	18
19					19
20					20
21	TOTAL		\$ <u>1,250</u>	\$ <u>15,000</u>	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: Bourbonnais Terrace NH
IDPH License ID Number: 0051631
Fiscal Year End: 12/31/2017

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	2,864
Postage Machine	840
Dishwasher	2,243
Freezer Trailer	1,740
Floor Tile Stripper	75
Total - Line 16	<u>7,762</u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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 **Bourbonnais Terrace NH**

0051631

Report Period Beginning: **1/1/2017**

Ending: **12/31/2017**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2017**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 71,580	\$ 71,641	1
2	Cash-Patient Deposits	16,671	16,671	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>317,034</u>)	1,355,939	1,355,939	3
4	Supply Inventory (priced at <u>Cost</u>)	2,100	2,100	4
5	Short-Term Investments			5
6	Prepaid Insurance	21,920	66,435	6
7	Other Prepaid Expenses	21,419	21,419	7
8	Accounts Receivable (owners or related parties)	121,004	121,004	8
9	Other(specify): <u>See Attached Schedule 17A</u>	3,536,813	3,966,847	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,147,446	\$ 5,622,056	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		4,064,460	14
15	Leasehold Improvements, at Historical Cost	16,362	15,304	15
16	Equipment, at Historical Cost	22,503	1,179,072	16
17	Accumulated Depreciation (book methods)	(3,291)	(1,388,305)	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 <u>Goodwill</u>)	540,030	2,845,138	22
23	Other(specify): <u>Loan Costs, Net</u>		27,133	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 575,604	\$ 7,342,802	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,723,050	\$ 12,964,858	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,177,504	\$ 2,254,403	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,664	2,664	29
30	Accrued Salaries Payable	405,049	405,049	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		237,073	32
33	Accrued Interest Payable		499,134	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule 17A</u>	2,636,311	2,656,311	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,221,528	\$ 6,054,634	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,442,544	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule 17A</u>	2,640,691	40,423	43
44	<u>Mortgage Premium</u>		549,650	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,640,691	\$ 14,032,617	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,862,219	\$ 20,087,251	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,139,169)	\$ (7,122,393)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,723,050	\$ 12,964,858	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name: Bourbonnais Terrace NH
 IDPH License ID Number: 0051631
 Fiscal Year End: 12/31/2017

Schedule 17A

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

Description	Operating	After Consolidation
DUE FROM EKS	49,148	49,148
IMPOUND RESERVE	12,122	12,122
DUE TO MID CAP LINE OF CRED	3,475,543	3,475,543
DEPOSITS		100,000
MORTGAGE ESCROWS		330,034
Total - Line 9	3,536,813	3,966,847

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

Description	Operating	After Consolidation
ACCRUED EXPENSES	79,510	99,510
ALLIED ACCRUAL	32,581	32,581
PAYROLL WITHHOLDINGS	(8,543)	(8,543)
DUE TO/FROM INSURANCE	191,328	191,328
DUE TO PA (AUDIT ADJ)	15,658	15,658
DUE TO BLUE CROSS	2,325,777	2,325,777
Total - Line 36	2,636,311	2,656,311

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

Description	Operating	After Consolidation
ACCRUED RENT	510,524	(45,605)
DUE TO/FROM FACILITIES	(9,925)	5,182
DUE TO/FROM PROPERTY	2,140,092	-
Total - Line 43	2,640,691	(40,423)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (120,633)	1
2	Restatements (describe):		2
3	Prior Period Adj-Cash Reconciliation	5,971	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (114,662)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,151,357)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	126,850	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)	\$ (1,024,507)	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)	\$ (1,139,169)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Bourbonnais Terrace NH

0051631

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,837,046	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,837,046	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***	4,051	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,051	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	600	27
28	Miscellaneous Income	446	28
28a	Vending Income	11,016	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,062	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,853,159	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,192,239	31
32	Health Care	2,173,162	32
33	General Administration	1,268,248	33
B. Capital Expense			
34	Ownership	1,277,237	34
C. Ancillary Expense			
35	Special Cost Centers	93,630	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,004,516	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,151,357)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,151,357)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,649,376	44
45	Private Pay - Net Inpatient Revenue	187,670	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)	\$ 4,837,046	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 Bourbonnais Terrace NH

0051631

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,904	2,080	\$ 82,927	\$ 39.87	1
2	Assistant Director of Nursing	1,832	2,080	62,130	29.87	2
3	Registered Nurses	4,519	4,615	157,036	34.03	3
4	Licensed Practical Nurses	14,367	15,910	378,362	23.78	4
5	CNAs & Orderlies	50,920	57,620	889,922	15.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,832	2,080	27,755	13.34	9
10	Activity Assistants	7,156	7,765	76,155	9.81	10
11	Social Service Workers	15,306	16,690	269,679	16.16	11
12	Dietician					12
13	Food Service Supervisor	1,944	2,080	28,678	13.79	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,776	18,477	242,909	13.15	15
16	Dishwashers					16
17	Maintenance Workers	1,978	2,106	77,605	36.85	17
18	Housekeepers	23,358	25,350	280,119	11.05	18
19	Laundry	3,364	3,874	65,041	16.79	19
20	Administrator	1,872	2,080	101,176	48.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,528	10,291	154,139	14.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>MDS Coordinator</u>	4,332	4,838	133,329	27.56	33
34	TOTAL (lines 1 - 33)	160,988	177,936	\$ 3,026,962 *	\$ 17.01	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	192	\$ 10,085	L1,C3	35
36	Medical Director	Monthly	6,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	265	12,797	L10,C3	38
39	Pharmacist Consultant	Monthly	15,287	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)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	457	\$ 44,169		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

SEE ACCOUNTANTS' PREPARATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Debra Wood	Administrator	0	\$ 101,176	Workers' Compensation Insurance	\$ 56,943	IDPH License Fee	\$ 1,992	
				Unemployment Compensation Insurance	40,098	Advertising: Employee Recruitment	380	
				FICA Taxes	230,442	Health Care Worker Background Check	480	
				Employee Health Insurance	172,327	(Indicate # of checks performed 16)		
				Employee Meals		Patient Background Checks	2,009	
				Illinois Municipal Retirement Fund (IMRF)*		SMRF License/App Fee	5,000	
				Union Pension Fund	29,993	Dues & Subscriptions	244	
				Other Employee Benefits	1,828	Licenses & Fees	1,726	
						Advertising	747	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 101,176			Less: Public Relations Expense	(747)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,831	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 531,631	
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
TM Healthcare Management - Management Fees			\$ 239,030	Description	Line #	Amount		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 239,030					
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description				Amount
See Attached Schedule	Legal		\$ 1,010	Out-of-State Travel				\$
Marcum LLP	Accounting		24,000	In-State Travel				
Templin Healthcare Accounting Svc	Accounting		2,107	Seminar Expense				2,656
PointClickCare	Data Processing		38,846	Entertainment Expense				()
Change Healthcare	Data Processing		730	TOTAL (agree to Sch. V, line 24, col. 8)				\$ 2,656
Information Controls	Data Processing		5,719					
Personnel Planners	Unemployment Consulting		1,378					
HSA Payroll Billing	Payroll Processing		8,923					
S4 Group	Lobbying		1,500					
Relias & Tsonas	RE Tax Appeal		23,773					
US Trustee Payment Center	Trustee Fee		6,536					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 114,522	TOTAL				\$

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number Bourbonnais Terrace NH# 0051631Report Period Beginning: 1/1/2017Ending: 12/31/2017**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (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. \$ 1,571 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. \$
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? 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% of Line
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

SEE ACCOUNTANTS' PREPARATION REPORT