

Facility Name & ID Number Community Care Center

0051722 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	145	Skilled (SNF)	145	52,925	1
2		Skilled Pediatric (SNF/PED)			2
3	59	Intermediate (ICF)	59	21,535	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,460	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	6,980		1,216	8,196	8
9	SNF/PED					9
10	ICF	51,885	365		52,250	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,865	365	1,216	60,446	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.18%

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 52 and days of care provided 1,146

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL 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 Community Care Center # 0051722 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	331,031	62,261	20,591	413,883		413,883		413,883		1
2	Food Purchase		331,475		331,475		331,475	(8,088)	323,387		2
3	Housekeeping	352,736	33,867		386,603		386,603		386,603		3
4	Laundry	46,489	13,780		60,269		60,269		60,269		4
5	Heat and Other Utilities			188,657	188,657		188,657		188,657		5
6	Maintenance	272,971	1,621	38,421	313,013		313,013		313,013		6
7	Other (specify):* Waste Disposal			43,502	43,502		43,502		43,502		7
8	TOTAL General Services	1,003,227	443,004	291,171	1,737,402		1,737,402	(8,088)	1,729,314		8
	B. Health Care and Programs										
9	Medical Director			36,000	36,000		36,000		36,000		9
10	Nursing and Medical Records	2,687,312	99,709	118,169	2,905,190		2,905,190	(922)	2,904,268		10
10a	Therapy	124,879			124,879		124,879		124,879		10a
11	Activities	126,276		13,751	140,027		140,027		140,027		11
12	Social Services	320,824		989	321,813		321,813		321,813		12
13	CNA Training										13
14	Program Transportation			2,851	2,851		2,851		2,851		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,259,291	99,709	171,760	3,530,760		3,530,760	(922)	3,529,838		16
	C. General Administration										
17	Administrative	158,744		440,392	599,136		599,136		599,136		17
18	Directors Fees										18
19	Professional Services			140,572	140,572		140,572	(6,162)	134,410		19
20	Dues, Fees, Subscriptions & Promotions			32,095	32,095		32,095	(13,785)	18,310		20
21	Clerical & General Office Expenses	120,333	14,216	64,482	199,031		199,031		199,031		21
22	Employee Benefits & Payroll Taxes			702,093	702,093		702,093		702,093		22
23	Inservice Training & Education										23
24	Travel and Seminar			501	501		501		501		24
25	Other Admin. Staff Transportation			1,724	1,724		1,724		1,724		25
26	Insurance-Prop.Liab.Malpractice			177,718	177,718		177,718	16,520	194,238		26
27	Other (specify):*										27
28	TOTAL General Administration	279,077	14,216	1,559,577	1,852,870		1,852,870	(3,427)	1,849,443		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,541,595	556,929	2,022,508	7,121,032		7,121,032	(12,437)	7,108,595		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

Community Care Center

#0051722

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							285,845	285,845			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			159,309	159,309		159,309	337,841	497,150			32
33	Real Estate Taxes							350,843	350,843			33
34	Rent-Facility & Grounds			1,447,968	1,447,968		1,447,968	(1,447,968)				34
35	Rent-Equipment & Vehicles			18,700	18,700		18,700		18,700			35
36	Other (specify):*											36
37	TOTAL Ownership			1,625,977	1,625,977		1,625,977	(473,439)	1,152,538			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		86,636	414,557	501,193		501,193		501,193			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			454,954	454,954		454,954		454,954			42
43	Other (specify):* Disallowed Costs			263,651	263,651		263,651	(260,877)	2,774			43
44	TOTAL Special Cost Centers		86,636	1,133,162	1,219,798		1,219,798	(260,877)	958,921			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,541,595	643,565	4,781,647	9,966,807		9,966,807	(746,753)	9,220,054			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

Community Care Center

Period Beginning
Period End

1/1/2017
12/31/2017

Schedule 4A

V. Cost Center Expenses

		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
	Ancillary Expense										
	E. Special Cost Centers										
43	Other (specify):*				0		0		0		
	Laboratory Expense				0		0		0		
	Radiology Expenses			2,774	2,774		2,774		2,774		
	Non-Allowable Expenses			263,651	263,651		263,651	(263,651)	0		
					0		0		0		
					0		0		0		
	TOTAL Other Special Cost Centers	0	0	266,425	266,425	0	266,425	(263,651)	2,774		

SEE ACCOUNTANTS' COMPILATION 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	(1,170)	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	285,845	30		9
10	Interest and Other Investment Income	(22,253)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(29,185)	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	(94,625)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,662)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(133,878)	43		24
25	Fund Raising, Advertising and Promotional	(439)	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	(347,783)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (349,650)		\$	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)	(397,103)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (397,103)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (746,753)		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

SEE ACCOUNTANTS' PREPARATION REPORT

BHF USE ONLY							
48		49		50		51	

Community Care Center

ID# 0051722

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Vending Income	\$ (8,088)	2	1
2	Medical Records Income	(922)	10	2
3	Resident Needs/Charity	(1,580)	43	3
4	PAC Dues	(13,785)	20	4
5	Building Co. - Admin Expenses	(781)	21	5
6	Building Co. - Amortization of Goodwill	(291,408)	36	6
7	Building Co. - Other Financing Costs	(30,969)	36	7
8	Building Co. - Licenses & Fees	(250)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(347,783)		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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	20 Licenses & Fees	\$	CC Chicago, LLC	100.00%	\$ 250	\$ 250	1
2	V	21 Bank Charges		CC Chicago, LLC	100.00%	781	781	2
3	V	26 Property Insurance		CC Chicago, LLC	100.00%	16,520	16,520	3
4	V	32 Interest		CC Chicago, LLC	100.00%	360,094	360,094	4
5	V	33 Real Estate Taxes		CC Chicago, LLC	100.00%	350,843	350,843	5
6	V	34 Rent	1,447,968	CC Chicago, LLC	100.00%		(1,447,968)	6
7	V	36 Amortization Exp-Goodwill		CC Chicago, LLC	100.00%	291,408	291,408	7
8	V	36 Finance Costs		CC Chicago, LLC	100.00%	30,969	30,969	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,447,968			\$ 1,050,865	\$ * (397,103)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Community Care Center

0051722

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jimmy Nassour	50	Bourbonnais Terrace NH	Bourbonnais	CC Chicago LLC	Chicago	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 Community Care Center # 0051722 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 Community Care Center

0051722

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

Community Care Center

0051722

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			\$	\$ 13,240,759			\$	359,060						
2																		
3																		
4																		
5																		
Working Capital																		
6	MidCap		X	Line of Credit				6,141,695				147,546						
7																		
8																		
9	TOTAL Facility Related						\$	\$ 19,382,454			\$	506,606						
B. Non-Facility Related*																		
10								Amortization Expense				12,797						
11								Interest Income Offset				(22,253)						
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$			\$	(9,456)						
15	TOTALS (line 9+line14)						\$	\$ 19,382,454			\$	497,150						

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.				\$	653,295	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		\$	350,843	2	
3. Under or (over) accrual (line 2 minus line 1).				\$	(302,452)	3	
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	653,295	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.				\$	350,843	7	
Real Estate Tax History:							
Real Estate Tax Bill for Calendar Year:	2012	318,318	8	FOR BHF USE ONLY			
	2013	322,626	9	13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
	2014	329,125	10	14	PLUS APPEAL COST FROM LINE 5	\$	14
	2015	320,990	11	15	LESS REFUND FROM LINE 6	\$	15
	2016	350,843	12	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
Accrual based on prior year tax bill.							

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Community Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051722

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>20-03-300-021-0000</u>	<u>Long Term Care Property</u>	\$ <u>8,250.12</u>	\$ <u>8,250.12</u>
2. <u>20-03-300-022-0000</u>	<u>Long Term Care Property</u>	\$ <u>83,279.19</u>	\$ <u>83,279.19</u>
3. <u>20-03-300-023-0000</u>	<u>Long Term Care Property</u>	\$ <u>85,455.99</u>	\$ <u>85,455.99</u>
4. <u>20-03-300-024-0000</u>	<u>Long Term Care Property</u>	\$ <u>83,860.65</u>	\$ <u>83,860.65</u>
5. <u>20-03-300-025-0000</u>	<u>Long Term Care Property</u>	\$ <u>81,697.50</u>	\$ <u>81,697.50</u>
6. <u>20-03-300-026-0000</u>	<u>Long Term Care Property</u>	\$ <u>8,299.99</u>	\$ <u>8,299.99</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>350,843.44</u></u>	\$ <u><u>350,843.44</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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ 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, \$900,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, (blank), \$900,000, 3.

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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	204	2012	1971	\$ 4,581,347	\$	35	\$ 130,896	\$ 130,896	\$ 785,376	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Lobby Walls & Ceiling & Reception Room Desk	2012		24,217		20	1,211	1,211	6,559	9
10	Security Door & System	2012		3,326		20	166	166	859	10
11	Security Door & System	2012		3,326		20	166	166	859	11
12	Additional 1St Floor Painting	2012		6,691		20	335	335	1,841	12
13	Pump, Igniter, Elevator	2013		10,012		20	501	501	5,174	13
14	Sprinkler System	2013		6,449		20	322	322	2,579	14
15	Heat/Smoke Detectors	2013		2,648		20	132	132	1,014	15
16	Sump Pump	2013		8,829		20	441	441	3,016	16
17	A/C Compressor Repair	2013		2,546		20	127	127	572	17
18	Reclass & Upgrade Coil	2014		7,636		20	382	382	1,200	18
19	Elevator Vic Seal	2014		2,948		20	147	147	446	19
20	Watertight Roof	2014		109,321		20	5,466	5,466	15,570	20
21	Boiler Piping	2014		2,558		20	128	128	491	21
22	Asbestos Removal - Basement, Elevator, Lobby	2014		5,900		20	295	295	1,180	22
23	Grease Trap	2014		4,051		20	203	203	625	23
24	Fire Alarm Sprinkler	2015		5,750		20	288	288	713	24
25	Rear Door Repair	2017		3,330		20	167	167	167	25
26	Elevator Pump Motor Repair	2017		5,550		20	278	278	278	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 Community Care Center

0051722

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Building Improvements (Real Estate Entity):		\$	\$		\$	\$	\$	37
38	Repaving of Parking Lot	2012	6,350		20	318	318	1,906	38
39	2nd Fl Nurses Station Exterior Custom Wood Railing & Base Molding	2012	21,750		20	1,088	1,088	6,526	39
40	Interior Signs - Main Fl, 2nd Fl, 3rd Fl, Basement Area	2012	10,905		20	545	545	3,271	40
41	1st Fl - Floor Molding & Cove Base	2012	3,308		20	165	165	992	41
42	Paint Exterior Facility	2012	25,000		20	1,250	1,250	7,500	42
43	Painting of Entire 1st Fl Patient Area Including Patient Rooms	2012	3,420		20	171	171	1,026	43
44	Toilets	2012	5,705		20	285	285	1,711	44
45	Security Cameras	2013	3,449		20	172	172	861	45
46	Door	2013	2,524		20	126	126	631	46
47	Roof Ventilators	2012	5,226		20	261	261	1,567	47
48	Floor & Ceiling Tiles Replaced, Light Fixtures, Crown Molding Replaced	2014	8,294		20	415	415	1,659	48
49	in Front Lobby Area, 1st Fl Hallway, Basement Dining Area, PT Rm				20				49
50	Fire System	2014	49,295		20	2,465	2,465	9,860	50
51	Water Heater	2014	23,801		20	1,190	1,190	4,760	51
52	Installation of 6 Daikin Fan Coils	2015	22,027		20	1,101	1,101	3,303	52
53	Northside Concrete Patio & Install Drain on East Side	2015	10,380		20	519	519	1,557	53
54	Chiller Area Pipe Insulation	2015	2,695		20	135	135	405	54
55	Northside Concrete Patio & Install Drain on East Side	2015	11,879		20	594	594	1,782	55
56	Repair Carrier Water Cooled Reciprocating Chiller	2015	14,297		20	715	715	2,145	56
57	Install 2 Door Restrictors for Elevator	2015	6,497		20	325	325	975	57
58	Repair Carrier Water Cooled Reciprocating Chiller	2015	26,297		20	1,315	1,315	3,945	58
59	Installation of Variable Speed Draft Controlled System	2015	2,461		20	123	123	369	59
60	Fire Alarm System	2015	29,894		20	1,495	1,495	4,475	60
61	Replace Leaking Gas Valve/Chiller Compressor Repairs	2015	2,648		20	132	132	396	61
62	Emergency Elevator Door Repairs	2016	8,890		20	445	445	890	62
63	Repair Exhaust Ventilator and Air Handles Motor	2016	7,877		20	394	394	788	63
64	Replace Elevator	2017	74,375		20	3,719	3,719	3,719	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,185,679	\$		\$ 161,114	\$ 161,114	\$ 895,538	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Community Care Center

0051722

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,247,305	\$	\$ 124,731	\$ 124,731	10	\$ 729,059	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	6,347					6,347	73
74								74
75	TOTALS	\$ 1,253,652	\$	\$ 124,731	\$ 124,731		\$ 735,406	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)	\$ 7,339,331	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)	\$ 285,845	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 285,845	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,630,944	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 Community Care Center

0051722

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: \$ 8,890 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	<u>Resident Transport</u>	<u>2014 Ford, XLT 15</u>	\$ <u>810.00</u>	\$ <u>9,810</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 810	\$ 9,810	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: Community Care Center
IDPH License ID Number: 0051722
Fiscal Year End: 12/31/2017

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	2,573
Postage Machine	656
Ice Machine	238
Dishwasher	3,004
Water Cooler	2,419
Total - Line 16	<u>8,890</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	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)		
			Staff		Outside Practitioner (other than consultant)								
			Units of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	39(3)	hrs	\$			\$	155,992	\$		\$	155,992	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs					100,531				100,531	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	39(3)	hrs					158,034				158,034	4
5	Physician Care		visits										5
6	Dental Care		visits										6
7	Work Related Program		hrs										7
8	Habilitation		hrs										8
9	Pharmacy	39(2)	# of prescripts						74,404			74,404	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Other (specify): <u>See Attached Schedule 16A</u>								12,232			12,232	12
13	Other (specify):												13
14	TOTAL			\$			\$	414,557	\$	86,636	\$	501,193	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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Urological Supplies	39(2)	hrs	\$		\$	\$	1,011		\$	1,011	1
2	Oxygen Rental/Cost	39(2)	hrs					9,017			9,017	2
3	Respiratory Rental/Cost	39(2)	hrs					2,204			2,204	3
4			hrs									4
5			visits									5
6			visits									6
7			hrs									7
8			hrs									8
9			# of prescripts									9
10			hrs									10
11			hrs									11
12												12
13												13
14	TOTAL			\$		\$	\$	12,232		\$	12,232	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 Community Care Center

0051722

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	\$ 601,361	\$ 601,424	1
2	Cash-Patient Deposits	(5,607)	(5,607)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 788,123)	7,316,427	7,316,427	3
4	Supply Inventory (priced at Cost)	4,850	4,850	4
5	Short-Term Investments			5
6	Prepaid Insurance	52,852	91,901	6
7	Other Prepaid Expenses	106,255	106,255	7
8	Accounts Receivable (owners or related parties)	285,358	285,358	8
9	Other(specify): See Attached Schedule 17A	64,366	472,587	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,425,862	\$ 8,873,195	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		900,000	13
14	Buildings, at Historical Cost	187,710	5,025,692	14
15	Leasehold Improvements, at Historical Cost		159,987	15
16	Equipment, at Historical Cost	101,303	1,253,652	16
17	Accumulated Depreciation (book methods)	(29,260)	(1,630,944)	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)	682,404	2,139,441	22
23	Other(specify): Loan Costs, Net		27,133	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 942,157	\$ 7,874,961	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,368,019	\$ 16,748,156	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 3,984,811	\$ 4,043,417	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	6,141,695	6,141,695	29
30	Accrued Salaries Payable	646,939	646,939	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		653,295	32
33	Accrued Interest Payable		496,365	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule 17A	262,275	282,275	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 11,035,720	\$ 12,263,986	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,240,759	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule 17A	3,674,307	81,489	43
44	Mortgage Premium		376,810	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,674,307	\$ 13,699,058	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,710,027	\$ 25,963,044	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,342,008)	\$ (9,214,888)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,368,019	\$ 16,748,156	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name: Community Care Center
 IDPH License ID Number: 0051722
 Fiscal Year End: 12/31/2017

Schedule 17A

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

Description	Operating	After Consolidation
DUE FROM EKS	36,517	36,517
IMPOUND RESERVE	27,849	27,849
DUE TO MID CAP LINE OF CREDIT		
DEPOSITS		25,000
MORTGAGE ESCROWS		383,221
Total - Line 9	64,366	472,587

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

Description	Operating	After Consolidation
ACCRUED EXPENSES	160,205	180,205
ALLIED ACCRUAL	105,397	105,397
PAYROLL WITHHOLDINGS	(1,766)	(1,766)
DUE TO/FROM ALIEN RECIPIEN'	(1,561)	(1,561)
DUE TO PA (AUDIT ADJ)		
DUE TO BLUE CROSS		
Total - Line 36	262,275	282,275

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

Description	Operating	After Consolidation
ACCRUED RENT	491,159	80,919
DUE TO/FROM FACILITIES	(20,477)	570
DUE TO/FROM PROPERTY	3,203,625	
Total - Line 43	3,674,307	81,489

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,449,192)	1
2	Restatements (describe):		2
3	Prior Period Adj-Cash Reconciliation	907	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,448,285)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,025,093)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	131,370	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)	\$ (893,723)	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)	\$ (5,342,008)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Community Care Center

0051722

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,582,219	1
2	Discounts and Allowances for all Levels	(35,381)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,546,838	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	363,613	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 363,613	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***	22,253	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,253	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	922	28
28a	<u>Vending Income</u>	8,088	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,010	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,941,714	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,737,402	31
32	Health Care	3,530,760	32
33	General Administration	1,852,870	33
B. Capital Expense			
34	Ownership	1,625,977	34
C. Ancillary Expense			
35	Special Cost Centers	764,844	35
36	Provider Participation Fee	454,954	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,966,807	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,025,093)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,025,093)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 7,652,272	44
45	Private Pay - Net Inpatient Revenue	47,450	45
46	Medicare - Net Inpatient Revenue	761,456	46
47	Other-(specify) <u>Insurance</u>	21,000	47
48	Other-(specify) <u>Hospice</u>	64,660	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,546,838	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 Community Care Center

0051722

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	2,481	2,565	\$ 102,401	\$ 39.92	1
2	Assistant Director of Nursing	752	760	42,538	55.97	2
3	Registered Nurses	16,665	17,083	488,069	28.57	3
4	Licensed Practical Nurses	35,501	37,240	1,074,255	28.85	4
5	CNAs & Orderlies	60,751	66,414	814,768	12.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,004	10,572	124,879	11.81	8
9	Activity Director	1,755	1,795	30,986	17.26	9
10	Activity Assistants	7,790	8,373	95,290	11.38	10
11	Social Service Workers	14,659	15,625	320,824	20.53	11
12	Dietician					12
13	Food Service Supervisor	1,618	1,723	34,301	19.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,980	27,349	296,730	10.85	15
16	Dishwashers					16
17	Maintenance Workers	18,776	20,090	272,971	13.59	17
18	Housekeepers	26,502	29,686	352,736	11.88	18
19	Laundry	3,477	3,709	46,489	12.53	19
20	Administrator	2,088	2,299	117,206	50.98	20
21	Assistant Administrator	1,152	1,152	41,538	36.06	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,862	8,352	120,333	14.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,945	2,088	31,311	15.00	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MDS Coordinator</u>	3,821	3,913	133,970	34.24	33
34	TOTAL (lines 1 - 33)	241,579	260,788	\$ 4,541,595 *	\$ 17.41	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	406	\$ 20,591	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	336	16,233	L10, C3	38
39	Pharmacist Consultant	Monthly	15,830	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	<u>Psychiatric Medical Director</u>	Monthly	24,000	L9,C3	47
48	<u>Administrative</u>	256	14,333	L21,C3	48
49	TOTAL (lines 35 - 48)	998	\$ 102,987		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	116	3,782	L10,C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	116	\$ 3,782		53

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Community Care Center**

0051722

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

Ending: **12/31/2017**

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		
Cheryl Nelson	Administrator	0	\$ 50,525	Workers' Compensation Insurance	\$ 146,071	IDPH License Fee	\$ 1,990		
Gwendolyn Toney-Simms	Administrator	0	40,845	Unemployment Compensation Insurance	115,058	Advertising: Employee Recruitment			
Kevin Hines	Administrator/Asst Admin	0	44,297	FICA Taxes	349,743	Health Care Worker Background Check			
Della Reese Richardson	Asst Administrator	0	23,077	Employee Health Insurance	66,154	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks	89 1,424		
				Illinois Municipal Retirement Fund (IMRF)*		IL Council on LTC	27,570		
				Severance & Retirement	20,716	Dues & Subscriptions			
				Other Employee Benefits	2,381	Licenses & Fees	1,111		
				Employee Drug Screening	1,970	Advertising & Promotions			
						Less PAC Dues	(13,785)		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 158,744	TOTAL (agree to Schedule V, line 22, col.8)		\$ 702,093	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 18,310
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
TM Healthcare Management - Management Fees			\$ 440,392	N/A			Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 440,392				Seminar Expense	501	
C. Professional Services									
Vendor/Payee	Type		Amount						
See Attached Schedule	Legal		\$ 38,365						
Marcum LLP	Accounting		22,000						
Cohn Reznick	Accounting		4,694						
PointClickCare	Data Processing		39,885						
Templin Healthcare Accounting Svc	Accounting		4,290						
Change Healthcare	Data Processing		774						
Information Controls	Data Processing		5,719						
Ability Network, Inc	Data Processing		3,213						
Personnel Planners	Unemployment Consultant		4,203						
S4 Group	Lobbying		1,500						
US Trustee Payment Center	Trustee Fee		650						
See Attached Schedule 21A			15,279						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 140,572	TOTAL		\$	Entertainment Expense () (agree to Sch. V, line 24, col. 8)		\$ 501

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Community Care Center

Period Beginning **1/1/2017**
Period End **12/31/2017**

Schedule 21A

XIX. Support Schedules, Section C. Professional Services

Vendor/Payee	Type	Amount
Howard Simon & Associates	Payroll Processing	15,071
Prospect Resources, Inc.	Benchmarking	208
		<hr/>
		15,279
		<hr/> <hr/>

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. 27,570 IL Council on LTC
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,179 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. \$ 454,954
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% 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