

		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><b>I. IDPH License ID Number:</b> <u>0051672</u></p> <p><b>Facility Name:</b> <u>West Chicago Terrace NH</u></p> <p><b>Address:</b> <u>928 Joliet Road</u> <u>West Chicago</u> <u>60185</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Dupage</u></p> <p><b>Telephone Number:</b> <u>(630) 231-9292</u> <b>Fax #</b> <u>(630) 2316797</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>6/27/2012</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Larry Templin</u> <b>Telephone Number:</b> <u>(630) 361-2868</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></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%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">           (Signed) _____            (Type or Print Name) _____            (Title) _____            (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>            (Date) _____         </td> </tr> <tr> <td style="width:15%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">           (Print Name and Title) <u>Larry Templin Partner</u>            (Firm Name &amp; Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u>            (Telephone) <u>(630) 361-2868</u> Fax # ( ) _____         </td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630         </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____ (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____	Paid Preparer	(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 # ( ) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____ (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____							
Paid Preparer	(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 # ( ) _____							

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number West Chicago Terrace NH

# 0051672 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	146	Intermediate (ICF)	146	53,290	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,290	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	36,001	1,259		37,260	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,001	1,259		37,260	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.92%

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**

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 West Chicago Terrace NH # 0051672 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
	<b>A. General Services</b>										
1	Dietary	193,303	14,206	9,711	217,220		217,220		217,220		1
2	Food Purchase		191,674		191,674		191,674	(4,632)	187,042		2
3	Housekeeping	169,336	25,850		195,186		195,186		195,186		3
4	Laundry	59,766	6,089		65,855		65,855		65,855		4
5	Heat and Other Utilities			135,962	135,962		135,962		135,962		5
6	Maintenance	52,691	2,107	43,272	98,070		98,070		98,070		6
7	Other (specify):* <b>Waste Disposal</b>			12,204	12,204		12,204		12,204		7
8	<b>TOTAL General Services</b>	475,096	239,926	201,149	916,171		916,171	(4,632)	911,539		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,710,284	66,425	19,486	1,796,195		1,796,195	(417)	1,795,778		10
10a	Therapy	55,222			55,222		55,222		55,222		10a
11	Activities	93,620		8,172	101,792		101,792		101,792		11
12	Social Services	364,310		1,271	365,581		365,581		365,581		12
13	CNA Training										13
14	Program Transportation			4,582	4,582		4,582		4,582		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,223,436	66,425	57,511	2,347,372		2,347,372	(417)	2,346,955		16
	<b>C. General Administration</b>										
17	Administrative	91,872		203,697	295,569		295,569		295,569		17
18	Directors Fees										18
19	Professional Services			76,438	76,438		76,438	(1,500)	74,938		19
20	Dues, Fees, Subscriptions & Promotions			24,700	24,700		24,700	(8,628)	16,072		20
21	Clerical & General Office Expenses	124,295	14,119	49,101	187,515		187,515		187,515		21
22	Employee Benefits & Payroll Taxes			454,062	454,062		454,062		454,062		22
23	Inservice Training & Education										23
24	Travel and Seminar			42	42		42		42		24
25	Other Admin. Staff Transportation			1,668	1,668		1,668		1,668		25
26	Insurance-Prop.Liab.Malpractice			62,313	62,313		62,313	7,702	70,015		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	216,167	14,119	872,021	1,102,307		1,102,307	(2,426)	1,099,881		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,914,699	320,470	1,130,681	4,365,850		4,365,850	(7,475)	4,358,375		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 &amp; ID Number

West Chicago Terrace NH

#0051672

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	
	<b>D. Ownership</b>											
30	Depreciation							131,196	131,196			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			96,322	96,322		96,322	123,937	220,259			32
33	Real Estate Taxes							70,824	70,824			33
34	Rent-Facility & Grounds			496,699	496,699		496,699	(485,929)	10,770			34
35	Rent-Equipment & Vehicles			25,975	25,975		25,975		25,975			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			618,996	618,996		618,996	(159,972)	459,024			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			291,869	291,869		291,869		291,869			42
43	Other (specify):* <b>Disallowed Costs</b>			98,269	98,269		98,269	(98,269)				43
44	<b>TOTAL Special Cost Centers</b>			390,138	390,138		390,138	(98,269)	291,869			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,914,699	320,470	2,139,815	5,374,984		5,374,984	(265,716)	5,109,268			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	(7,049)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	131,196	30		9
10	Interest and Other Investment Income	(4,739)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(132)	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	(27,063)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(61,882)	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	(170,078)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (141,247)		\$	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)	(124,469)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (124,469)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (265,716)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

West Chicago Terrace NH

ID# 0051672

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (4,632)	2	1
2	Medical Records Income	(388)	10	2
3	Purchase Rebate	(29)	10	3
4	PAC Dues	(8,628)	20	4
5	Building Co. - Admin Expenses	(781)	21	5
6	Building Co. - Amortization of Goodwill	(145,229)	36	6
7	Building Co. - Other Financing Costs	(7,998)	36	7
8	Building Co. - Licenses & Fees	(250)	20	8
9	Resident Needs/Charity	(2,143)	43	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
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(170,078)		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	\$	WCT West Chicago LLC	100.00%	\$ 250	\$ 250	1
2	V	21 Bank Charges		WCT West Chicago LLC	100.00%	781	781	2
3	V	26 Property Insurance		WCT West Chicago LLC	100.00%	7,702	7,702	3
4	V	32 Interest		WCT West Chicago LLC	100.00%	128,676	128,676	4
5	V	33 Real Estate Taxes		WCT West Chicago LLC	100.00%	70,824	70,824	5
6	V	34 Rent	485,929	WCT West Chicago LLC	100.00%		(485,929)	6
7	V	36 Amortization Exp-Goodwill		WCT West Chicago LLC	100.00%	145,229	145,229	7
8	V	36 Finance Costs		WCT West Chicago LLC	100.00%	7,998	7,998	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 485,929			\$ 361,460	\$ * (124,469)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

West Chicago Terrace NH

# 0051672

Report Period Beginning:

1/1/2017

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	WCT West Chicago L	West Chicago	Lessor	1
2	Carl Meyer	50	Community Care Center	Chicago				2
3			Crestwood Terrace Nursing Ctr	Crestwood				3
4			Frankfort Terrace Nursing Center	Frankfort				4
5			Joliet Terrace Nursing Center	Joliet				5
6			Southview Manor Nursing Ctr	Chicago				6
7			Kankakee Terrace Nursing Center	Bourbonnais				7
8			Terrace Nursing Home, The	Waukegan				8
9			Sycamore Healthcare Center	Quincy				9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT



Facility Name & ID Number West Chicago Terrace NH # 0051672 Report Period Beginning: 1/1/2017 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 West Chicago Terrace NH

# 0051672

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number

West Chicago Terrace NH

# 0051672

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				
			YES	NO				Original	Balance				
		<b>A. Directly Facility Related</b>											
		<b>Long-Term</b>											
1		First Mortgage		X	Mortgage Payable			\$	4,831,524			\$	127,960
2													
3													
4													
5													
		<b>Working Capital</b>											
6		MidCap		X	Line of Credit				2,501,641				89,530
7													
8													
9		<b>TOTAL Facility Related</b>					\$	7,333,165				\$	217,490
		<b>B. Non-Facility Related*</b>											
10									Amortization Expense				7,508
11									Interest Income Offset				(4,739)
12													
13													
14		<b>TOTAL Non-Facility Related</b>					\$					\$	2,769
15		<b>TOTALS (line 9+line14)</b>					\$	7,333,165				\$	220,259

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.			\$	<b>157,672</b>	<b>1</b>
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.)		<b>2016</b>	\$	<b>70,824</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(86,848)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>157,672</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>70,824</b>	<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	<b>2012</b>	<b>82,070</b>	<b>8</b>	<b>FOR BHF USE ONLY</b>	
	<b>2013</b>	<b>85,293</b>	<b>9</b>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2016 \$
	<b>2014</b>	<b>84,496</b>	<b>10</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$
	<b>2015</b>	<b>69,820</b>	<b>11</b>	<b>15</b>	LESS REFUND FROM LINE 6 \$
	<b>2016</b>	<b>70,824</b>	<b>12</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$
<b>Accrual based on prior year tax bill.</b>					

**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 West Chicago Terrace NH COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0051672

CONTACT PERSON REGARDING THIS REPORT Jerry Harris

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

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

Enter the tax index number and real estate tax assessed for 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>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>04-16-202-008</u>	<u>Long Term Care Property</u>	\$ <u>70,824.04</u>	\$ <u>70,824.04</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>70,824.04</u></u>	\$ <u><u>70,824.04</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 West Chicago Terrace NH

# 0051672 Report Period Beginning:

1/1/2017 Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,898 B. General Construction Type: Exterior Brick Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (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: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 2012, \$600,000. Row 2: (blank), (blank), (blank). Row 3: TOTALS, \$600,000.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number West Chicago Terrace NH

# 0051672

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	120		2012	1976	\$ 2,158,459	\$	35	\$ 61,670	\$ 61,670	\$ 370,021
5										
6										
7										
8										
	<b>Improvement Type**</b>									
9	Commercial Heater		2015		2,666		20	133	133	285
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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	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								37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70								70
TOTAL (lines 4 thru 69)			\$ 2,172,636	\$	\$ 62,379	\$ 62,379	\$ 373,523	

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	\$ 663,165	\$	\$ 66,317	\$ 66,317	10 Yrs	\$ 330,373	71
72	Current Year Purchases	3,659		366	366	10 Yrs	366	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 666,824	\$	\$ 66,683	\$ 66,683		\$ 330,739	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	Maintenance	2013 Ford F150	2017	\$ 10,671	\$	\$ 2,134	\$ 2,134	5	\$ 2,134	76
77										77
78										78
79										79
80	TOTALS			\$ 10,671	\$	\$ 2,134	\$ 2,134		\$ 2,134	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,450,131	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 131,196	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 131,196	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 706,396	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number West Chicago Terrace NH

# 0051672

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				10,770			5
6								6
7	TOTAL				\$ 10,770			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: \$ 6,749 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Residents	2012 Ford Ecoline	\$ 797.00	\$ 9,563	17
18	Maintenance	2013 Ford E150	547.00	6,063	18
19	Maintenance	2013 Ford E150	600.00	3,600	19
20					20
21	TOTAL		\$ 1,944	\$ 19,226	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' PREPARATION REPORT

**Facility Name:** West Chicago Terrace NH  
**IDPH License ID Number:** 0051672  
**Fiscal Year End:** 12/31/2017

**Schedule 14A**

**XIV. Rental Costs**

**Line 16 Rental Amount for Moveable Equipment**

<b>Rental Description</b>	<b>Amount</b>
Copier	3,347
Postage Machine	514
Water Cooler	484
Dishwasher	2,204
Tools	200
<b>Total - Line 16</b>	<b><u>6,749</u></b>

**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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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 West Chicago Terrace NH

# 0051672

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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (238,039)	\$ (237,993)	1
2	Cash-Patient Deposits	(3,245)	(3,245)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 291,172 )	2,710,421	2,710,421	3
4	Supply Inventory (priced at Cost )	2,350	2,350	4
5	Short-Term Investments			5
6	Prepaid Insurance	26,284	39,032	6
7	Other Prepaid Expenses	17,915	17,915	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule 17A	65,731	257,335	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,581,417	\$ 2,785,815	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		600,000	13
14	Buildings, at Historical Cost		2,171,886	14
15	Leasehold Improvements, at Historical Cost		750	15
16	Equipment, at Historical Cost	32,492	677,495	16
17	Accumulated Depreciation (book methods)	(1,702)	(706,396)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Goodwill)	546,225	1,272,369	22
23	Other(specify): Loan Costs, Net		18,802	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 577,015	\$ 4,034,906	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,158,432	\$ 6,820,721	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,101,760	\$ 1,515,882	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,501,641	2,501,641	29
30	Accrued Salaries Payable	394,927	394,927	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,898	10,898	31
32	Accrued Real Estate Taxes(Sch.IX-B)		157,672	32
33	Accrued Interest Payable		179,313	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	See Attached Schedule 17A	115,162	115,162	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,124,388	\$ 4,875,495	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,831,524	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	See Attached Schedule 17A	1,544,508	105,191	43
44	Mortgage Premium		205,410	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,544,508	\$ 5,142,125	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,668,896	\$ 10,017,620	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,510,464)	\$ (3,196,899)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,158,432	\$ 6,820,721	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

Facility Name: West Chicago Terrace NH  
 IDPH License ID Number: 0051672  
 Fiscal Year End: 12/31/2017

**Schedule 17A**

**XV. Balance Sheet**

**Line 9 Other Assets (specify):**

Description	Operating	After Consolidation
DUE FROM EKS	9,431	9,431
IMPOUND RESERVE	56,300	56,300
MORTGAGE ESCROWS		191,604
<b>Total - Line 9</b>	<b>65,731</b>	<b>257,335</b>

**XV. Balance Sheet**

**Line 36 Other Current Liabilities (specify):**

Description	Operating	After Consolidation
ACCRUED EXPENSES	52,372	52,372
ALLIED ACCRUAL	6,760	6,760
PAYROLL WITHHOLDINGS	1,457	1,457
DUE TO/FROM ALIEN RECIPIENT	53,407	53,407
DUE TO PA (AUDIT ADJ)	(18)	(18)
DUE TO/FROM PRIOR PERIOD	1,184	1,184
<b>Total - Line 36</b>	<b>115,162</b>	<b>115,162</b>

**XV. Balance Sheet**

**Line 43 Long-Term Liabilities (specify):**

Description	Operating	After Consolidation
ACCRUED RENT	232,438	
DUE TO/FROM FACILITIES	105,191	105,191
DUE TO/FROM PROPERTY	1,206,879	
<b>Total - Line 43</b>	<b>1,544,508</b>	<b>105,191</b>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,331,741)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adj-Cash Reconciliation</b>	<b>(16,839)</b>	<b>3</b>
<b>4</b>	<b>Rounding</b>	<b>(1)</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,348,581)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,239,153)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants	<b>77,270</b>	<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,161,883)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(2,510,464)</b>	<b>24</b> *

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

SEE ACCOUNTANTS' PREPARATION REPORT



Facility Name &amp; ID Number West Chicago Terrace NH

# 0051672

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,125,480	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,125,480	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	4,739	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,739	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>	563	27
28	<b>Miscellaneous Income</b>	417	28
28a	<b>Vending Income/Purchase Discounts</b>	4,632	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 5,612	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,135,831	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	916,171	31
32	Health Care	2,347,372	32
33	General Administration	1,102,307	33
<b>B. Capital Expense</b>			
34	Ownership	618,996	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	98,269	35
36	Provider Participation Fee	291,869	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,374,984	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,239,153)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,239,153)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,980,172	44
45	Private Pay - Net Inpatient Revenue	145,308	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,125,480	49

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

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

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number West Chicago Terrace NH

# 0051672

Report Period Beginning:

1/1/2017

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	1,614	1,692	\$ 64,083	\$ 37.87	1
2	Assistant Director of Nursing	1,944	2,080	65,778	31.62	2
3	Registered Nurses	9,581	9,920	309,941	31.24	3
4	Licensed Practical Nurses	18,949	20,249	508,991	25.14	4
5	CNAs & Orderlies	40,954	43,936	673,578	15.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,395	4,789	55,222	11.53	8
9	Activity Director					9
10	Activity Assistants	6,842	7,380	93,620	12.69	10
11	Social Service Workers	21,796	23,446	364,310	15.54	11
12	Dietician					12
13	Food Service Supervisor	1,490	1,544	26,861	17.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,235	14,181	166,442	11.74	15
16	Dishwashers					16
17	Maintenance Workers	3,745	3,897	52,691	13.52	17
18	Housekeepers	13,772	14,668	169,336	11.54	18
19	Laundry	5,709	6,238	59,766	9.58	19
20	Administrator	3,792	4,160	91,872	22.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,520	10,206	124,295	12.18	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	1,947	2,339	24,761	10.59	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MDS Coordinator</u>	1,957	2,149	63,152	29.39	33
34	TOTAL (lines 1 - 33)	161,242	172,874	\$ 2,914,699 *	\$ 16.86	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	199	\$ 9,711	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	211	10,174	L10, C3	38
39	Pharmacist Consultant	Monthly	9,312	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Psychiatric Medical Director</u>	Monthly	12,000	L9,C3	47
48	<u>Administrative</u>	88	4,876	L21,C3	48
49	TOTAL (lines 35 - 48)	498	\$ 58,073		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					
Amy Wallace	Administrator	0	\$ 91,872	Workers' Compensation Insurance	\$ 74,935	IDPH License Fee	\$ 1,989					
				Unemployment Compensation Insurance	21,714	Advertising: Employee Recruitment	1,495					
				FICA Taxes	217,227	Health Care Worker Background Check						
				Employee Health Insurance	73,930	(Indicate # of checks performed <u>16</u> )	560					
				Employee Meals		Patient Background Checks	81					
				Illinois Municipal Retirement Fund (IMRF)*		IL Council on LTC	17,256					
				Union Pension Fund	64,852	Licenses & Fees	1,474					
				Employee Benefits	1,404							
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 91,872	TOTAL (agree to Schedule V, line 22, col.8)			\$ 454,062	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 16,072		
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			\$ 203,697	N/A				Out-of-State Travel			\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 203,697	TOTAL				In-State Travel				
C. Professional Services				TOTAL				Seminar Expense				42
Vendor/Payee	Type		Amount					Entertainment Expense			( )	
See Attached Schedule	Legal		\$ 5,051					(agree to Sch. V, line 24, col. 8)				
Marcum LLP	Accounting		24,000					TOTAL			\$ 42	
Templin Healthcare Accounting Svc	Accounting		2,107									
Point Click Care	Data Processing		22,876									
Information Controls	Data Processing		5,723									
S4 Group	Lobbying		1,500									
Change Healthcare	Data Processing		774									
Personnel Planners	Unemployment Consulting		690									
Howard Simon & Associates	Payroll Processing		8,842									
US Trustee Payment Center	Trustee Fees		4,875									
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 76,438									

\* Attach copy of IMRF notifications  
 SEE ACCOUNTANTS' PREPARATION REPORT

\*\*See instructions.

Facility Name & ID Number West Chicago Terrace NH# 0051672

Report Period Beginning:

1/1/2017

Ending:

12/31/2017**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. 17,256 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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,653 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. \$ 291,869  
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**