

		FOR BHF USE					

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**2018**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2018)**

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>0051698</u></p> <p><b>Facility Name:</b> <u>Joliet Terrace Nursing Center</u></p> <p><b>Address:</b> <u>2230 McDonough Streer</u> <u>Joliet</u> <u>60436</u>          Number City Zip Code</p> <p><b>County:</b> <u>Will</u></p> <p><b>Telephone Number:</b> <u>(815) 729-3801</u> Fax # <u>(815) 730-0960</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%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><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 checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><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>1/1/2018</u> to <u>12/31/2018</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td rowspan="2" style="width:20%; vertical-align: top;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) _____ (Date) _____</td> </tr> <tr> <td rowspan="3" style="width:20%; vertical-align: top;"><b>Paid Preparer</b></td> <td>(Title) _____</td> </tr> <tr> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Larry Templin Partner</u></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(630) 361-2868</u> Fax # ( )</td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>      201 S. Grand Avenue East      Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) _____ (Date) _____	<b>Paid Preparer</b>	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____		(Print Name and Title) <u>Larry Templin Partner</u>		(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u>		(Telephone) <u>(630) 361-2868</u> Fax # ( )
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Joliet Terrace Nursing Center

# 0051698 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	120	Intermediate (ICF)	120	43,800	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	39,294			39,294	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,294			39,294	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.71%

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 6/27/12

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Joliet Terrace Nursing Center # 0051698 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

**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	247,839	26,830	9,656	284,325		284,325		284,325		1
2	Food Purchase		235,578		235,578		235,578	(5,028)	230,550		2
3	Housekeeping	200,663	56,425		257,088		257,088		257,088		3
4	Laundry	78,816	14,303		93,119		93,119		93,119		4
5	Heat and Other Utilities			115,696	115,696		115,696		115,696		5
6	Maintenance	46,722	4,848	31,422	82,992		82,992	1,220	84,212		6
7	Other (specify):* <b>Waste Disposal</b>			16,337	16,337		16,337		16,337		7
8	<b>TOTAL General Services</b>	574,040	337,984	173,111	1,085,135		1,085,135	(3,808)	1,081,327		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,350	15,350		15,350		15,350		9
10	Nursing and Medical Records	1,374,608	63,136	27,397	1,465,141		1,465,141	(100)	1,465,041		10
10a	Therapy										10a
11	Activities	114,114		6,112	120,226		120,226		120,226		11
12	Social Services	251,673		2,860	254,533		254,533		254,533		12
13	CNA Training										13
14	Program Transportation			1,034	1,034		1,034		1,034		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,740,395	63,136	52,753	1,856,284		1,856,284	(100)	1,856,184		16
	<b>C. General Administration</b>										
17	Administrative	88,502		210,449	298,951		298,951		298,951		17
18	Directors Fees										18
19	Professional Services			167,258	167,258		167,258		167,258		19
20	Dues, Fees, Subscriptions & Promotions			8,885	8,885		8,885		8,885		20
21	Clerical & General Office Expenses	206,346	27,661	67,494	301,501		301,501		301,501		21
22	Employee Benefits & Payroll Taxes			535,323	535,323		535,323		535,323		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,671	2,671		2,671		2,671		24
25	Other Admin. Staff Transportation			3,438	3,438		3,438		3,438		25
26	Insurance-Prop.Liab.Malpractice			94,727	94,727		94,727		94,727		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	294,848	27,661	1,090,245	1,412,754		1,412,754		1,412,754		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,609,283	428,781	1,316,109	4,354,173		4,354,173	(3,908)	4,350,265		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 Joliet Terrace Nursing Center

#0051698

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

## 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							139,106	139,106			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			130,938	130,938		130,938	139,928	270,866			32
33	Real Estate Taxes							52,491	52,491			33
34	Rent-Facility & Grounds			508,604	508,604		508,604	(500,987)	7,617			34
35	Rent-Equipment & Vehicles			15,669	15,669		15,669		15,669			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			655,211	655,211		655,211	(169,462)	485,749			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			304,214	304,214		304,214		304,214			42
43	Other (specify):* <b>Disallowed Costs</b>			87,094	87,094		87,094	(87,094)				43
44	<b>TOTAL Special Cost Centers</b>			391,308	391,308		391,308	(87,094)	304,214			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,609,283	428,781	2,362,628	5,400,692		5,400,692	(260,464)	5,140,228			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(16,531)	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	(23,175)	30		9
10	Interest and Other Investment Income	(6,448)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(43)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,029)	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	(63,920)	43		24
25	Fund Raising, Advertising and Promotional	(356)	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	(119,833)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (234,335)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(26,129)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (26,129)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (260,464)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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

<b>BHF USE ONLY</b>							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Joliet Terrace Nursing Center

ID# 0051698

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Vending Income	\$ (5,028)	2	1
2	Resident Needs/Charity	(2,215)	43	2
3	Medical Records Income	(100)	10	3
4	Expense Capitalized Repair	1,220	6	4
5	Building Co. - Admin Expenses	(2,222)	21	5
6	Building Co. - Amortization of Goodwill	(103,476)	36	6
7	Building Co. - Other Financing Costs	(8,012)	36	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(119,833)		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	21 Bank Charges	\$	JT Joliet, LLC	100.00%	\$ 2,222	\$ 2,222	1
2	V	30 Depreciation		JT Joliet, LLC	100.00%	162,281	162,281	2
3	V	32 Interest		JT Joliet, LLC	100.00%	146,376	146,376	3
4	V	33 Real Estate Taxes		JT Joliet, LLC	100.00%	52,491	52,491	4
5	V	34 Rent	500,987	JT Joliet, LLC	100.00%		(500,987)	5
6	V	36 Amortization Exp-Goodwill		JT Joliet, LLC	100.00%	103,476	103,476	6
7	V	36 Finance Costs		JT Joliet, LLC	100.00%	8,012	8,012	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 500,987			\$ 474,858	\$ * (26,129)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Joliet Terrace Nursing Center

# 0051698

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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	JT Joliet, LLC	Frankfort	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			Kankakee Terrace Nursing Ctr	Bourbonnais				5
6			Southview Manor Nursing Ctr	Chicago				6
7			Terrace Nursing Home, The	Waukegan				7
8			West Chicago Terrace NH	West Chicago				8
9								9
10								10
11								11
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26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT



Facility Name & ID Number Joliet Terrace Nursing Center # 0051698 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Joliet Terrace Nursing Center

# 0051698

Report Period Beginning:

1/1/2018

Ending: 2/31/2018

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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Joliet Terrace Nursing Center

# 0051698

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

**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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	First Mortgage		X	Mortgage Payable			\$	\$ 5,356,222			\$	145,649	1					
2													2					
3													3					
4													4					
5													5					
<b>Working Capital</b>																		
6	MidCap		X	Line of Credit				1,620,699				129,444	6					
7													7					
8													8					
9	<b>TOTAL Facility Related</b>						\$	\$ 6,976,921			\$	275,093	9					
<b>B. Non-Facility Related*</b>																		
10								Amortization Expense				2,221	10					
11								Interest Income Offset				(6,448)	11					
12													12					
13													13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	(4,227)	14					
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 6,976,921			\$	270,866	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.     \$ None                      Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2017 report.		\$	<b>114,934</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.)	2017	\$	<b>52,491</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(62,443)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>114,934</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>52,491</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	<b>56,828</b>	<b>8</b>
	2014	<b>57,549</b>	<b>9</b>
	2015	<b>60,689</b>	<b>10</b>
	2016	<b>55,658</b>	<b>11</b>
	2017	<b>52,491</b>	<b>12</b>

**Accrual based on prior year tax bill.**

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2017	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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

**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Joliet Terrace Nursing Center COUNTY Will

FACILITY IDPH LICENSE NUMBER 0051698

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 2017 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 2017.

(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>30-07-18-300-016-0000</u>	<u>Long Term Care Property</u>	\$ <u>52,490.90</u>	\$ <u>52,490.90</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>52,490.90</u></u>	\$ <u><u>52,490.90</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

**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 Joliet Terrace Nursing Center

# 0051698 Report Period Beginning:

1/1/2018 Ending:

12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,836 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, \$700,000. Row 2: (blank). Row 3: TOTALS, \$700,000.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Joliet Terrace Nursing Center

# 0051698

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

**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	\$ 2,142,595	\$	35	\$ 61,217	\$ 61,217	\$ 428,519	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Porcelain Tile		2012			20				9
10	Circuit Breakers		2012	4,947		20	247	247	1,565	10
11	Frozen Pipe & Water Damage Repair		2014	3,200		20	160	160	641	11
12	Fireline		2014	8,140		20	407	407	1,662	12
13	Plumbing, Toilet Seat, Motar, Johnston-Ac		2015	2,519		20	126	126	504	13
14	Plumbing, Fans, Toilet Parts, Ac		2015	3,812		20	191	191	764	14
15	Bathroom Remodel-Tile, Vanity, Faucet		2018	6,000		20	150	150	150	15
16	Security Camera System- Indoor/Outdoor Infrared Domc		2018	3,195		20	80	80	80	16
17	Install Rooftop AC Unit		2018	3,158		20	79	79	79	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Leasehold Improvements (Real Estate Entity):						\$	\$	37
38	Rooftop A/C Unit & Ductwork	2012	5,218		20	261	261	1,827	38
39	Backflow Protector for Fire Sprinkler System	2013	11,668		20	583	583	3,499	39
40	Fire Alarm System	2013	6,873		20	344	344	2,063	40
41	Water Heater	2013	6,470		20	324	324	1,942	41
42	Kitchen Hood	2013	4,351		20	218	218	1,307	42
43	Digital Phone System	2013	7,507		20	375	375	2,251	43
44	Roof	2014	37,600		20	1,880	1,880	9,400	44
45	Roofing and Sheet Metal	2015	48,473		20	2,424	2,424	9,696	45
46	Roof Replacement	2016	42,975		20	2,149	2,149	6,447	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,348,701	\$		\$ 71,215	\$ 71,215	\$ 472,396	70

SEE ACCOUNTANTS' PREPARATION REPORT

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



Facility Name & ID Number Joliet Terrace Nursing Center

# 0051698

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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	\$ 673,156	\$	\$ 67,316	\$ 67,316	10	\$ 464,193	71
72	Current Year Purchases	5,753		575	575	10	575	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 678,909	\$	\$ 67,891	\$ 67,891		\$ 464,768	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)	\$ 3,727,610	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)	\$ 139,106	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 139,106	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 937,164	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 Joliet Terrace Nursing Center

# 0051698

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

**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				7,617			5
6								6
7	TOTAL				\$ 7,617			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. \_\_\_\_\_ /2019 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2020 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2021 \$ \_\_\_\_\_

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: \$ 4,370

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	Facility	2013 Ford XL	\$ 395.00	\$ 4,740	17
18	Facility	2013 Ford E150	546.60	6,559	18
19					19
20					20
21	TOTAL		\$ 942	\$ 11,299	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:** Joliet Terrace Nursing Center  
**IDPH License ID Number:** 0051698  
**Fiscal Year End:** 12/31/2018

**Schedule 14A**

**XIV. Rental Costs**

**Line 16 Rental Amount for Moveable Equipment**

<b>Rental Description</b>	<b>Amount</b>
Copier	2,497
Postage Machine	355
Dishwasher	1,482
Miscellaneous	36
<b>Total - Line 16</b>	<b><u>4,370</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

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2018**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (542,356)	\$ (536,700)	1
2	Cash-Patient Deposits	4,747	4,747	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>376,874</u> )	1,272,848	1,272,848	3
4	Supply Inventory (priced at <u>Cost</u> )	2,925	2,925	4
5	Short-Term Investments			5
6	Prepaid Insurance	31,092	46,098	6
7	Other Prepaid Expenses	20,558	20,558	7
8	Accounts Receivable (owners or related parties)	141,849	151,751	8
9	Other(specify): <u>See Attached Schedule 17A</u>	4,077	242,788	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 935,740	\$ 1,205,015	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		700,000	13
14	Buildings, at Historical Cost	22,048	2,180,382	14
15	Leasehold Improvements, at Historical Cost		168,319	15
16	Equipment, at Historical Cost	34,993	678,909	16
17	Accumulated Depreciation (book methods)	(3,580)	(937,164)	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 (specify) <u>Goodwill</u>	275,517	689,419	22
23	Other(specify): <u>Loan Costs, Net</u>		18,357	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 328,978	\$ 3,498,222	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,264,718	\$ 4,703,237	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,256,746	\$ 2,129,882	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,620,699	1,620,699	29
30	Accrued Salaries Payable	301,744	301,744	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,918	9,918	31
32	Accrued Real Estate Taxes(Sch.IX-B)		114,934	32
33	Accrued Interest Payable		203,732	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule 17A</u>	237,091	237,091	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,426,198	\$ 4,618,000	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,356,222	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule 17A</u>	1,814,683	(2,000)	43
44	<u>Mortgage Premium</u>		214,570	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,814,683	\$ 5,568,792	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,240,881	\$ 10,186,792	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (3,976,163)	\$ (5,483,555)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,264,718	\$ 4,703,237	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

Facility Name: Joliet Terrace Nursing Center  
 IDPH License ID Number: 0051698  
 Fiscal Year End: 12/31/2018

**Schedule 17A**

**XV. Balance Sheet**

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

Description	Operating	After Consolidation
DUE FROM EKS	1,508	1,508
IMPOUND RESERVE	2,569	2,569
MORTGAGE ESCROWS		238,711
<b>Total - Line 9</b>	<b>4,077</b>	<b>242,788</b>

**XV. Balance Sheet**

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

Description	Operating	After Consolidation
ACCRUED EXPENSES	75,639	75,639
ALLIED ACCRUAL	152,145	152,145
PAYROLL WITHHOLDINGS	(2,009)	(2,009)
DUE TO/FROM ALIEN RECIPIENT	6,773	6,773
DUE TO/FROM PRIOR PERIOD	3,439	3,439
DUE TO HFS	1,104	1,104
<b>Total - Line 36</b>	<b>237,091</b>	<b>237,091</b>

**XV. Balance Sheet**

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

Description	Operating	After Consolidation
ACCRUED RENT	219,794	(2,000)
DUE TO/FROM FACILITIES	-	
DUE TO/FROM PROPERTY	1,594,889	
<b>Total - Line 43</b>	<b>1,814,683</b>	<b>(2,000)</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>(2,830,983)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</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>(2,830,983)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(1,127,793)	<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>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(17,387)	<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>(1,145,180)</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>(3,976,163)</b>	<b>24</b> *

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

SEE ACCOUNTANTS' PREPARATION REPORT



Facility Name &amp; ID Number Joliet Terrace Nursing Center

# 0051698

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

**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	\$ 4,261,323	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,261,323	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***	6,448	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 6,448	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Income</u>	100	28
28a	<u>Vending Income</u>	5,028	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 5,128	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,272,899	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,085,135	31
32	Health Care	1,856,284	32
33	General Administration	1,412,754	33
<b>B. Capital Expense</b>			
34	Ownership	655,211	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	87,094	35
36	Provider Participation Fee	304,214	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,400,692	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,127,793)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,127,793)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,261,323	44
45	Private Pay - Net Inpatient Revenue		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>	\$ 4,261,323	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 Joliet Terrace Nursing Center

# 0051698

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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	1,824	2,080	\$ 85,577	\$ 41.14	1
2	Assistant Director of Nursing	2,008	2,080	78,214	37.60	2
3	Registered Nurses	7,794	8,020	251,148	31.32	3
4	Licensed Practical Nurses	13,936	15,052	399,132	26.52	4
5	CNAs & Orderlies	35,252	37,421	446,459	11.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,923	2,080	33,371	16.04	9
10	Activity Assistants	7,864	8,555	80,743	9.44	10
11	Social Service Workers	14,580	15,667	251,673	16.06	11
12	Dietician					12
13	Food Service Supervisor	1,635	1,696	33,807	19.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,448	20,411	214,032	10.49	15
16	Dishwashers					16
17	Maintenance Workers	4,025	4,161	46,722	11.23	17
18	Housekeepers	16,337	17,747	200,663	11.31	18
19	Laundry	5,142	6,240	78,816	12.63	19
20	Administrator	1,928	2,120	88,502	41.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,624	15,505	206,346	13.31	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	2,843	3,143	50,608	16.10	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MDS Coordinator</u>	1,975	2,219	63,470	28.60	33
34	TOTAL (lines 1 - 33)	152,138	164,197	\$ 2,609,283 *	\$ 15.89	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	189	\$ 9,656	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	334	16,349	L10, C3	38
39	Pharmacist Consultant	Monthly	11,048	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	9,350	L9,C3	47
48					48
49	TOTAL (lines 35 - 48)	523	\$ 52,403		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			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Amy Wallace	Administrator	0	\$ 80,579	Workers' Compensation Insurance	\$ 105,440	IDPH License Fee	\$ 1,990	
Adayomi Adebogun	Administrator	0	7,923	Unemployment Compensation Insurance	16,604	Advertising: Employee Recruitment	50	
				FICA Taxes	200,426	Health Care Worker Background Check (Indicate # of checks performed <u>3</u> )	180	
				Employee Health Insurance	197,172	Patient Background Checks <u>46</u>	1,353	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
				Employee Benefits	4,423	Licenses & Fees	5,212	
				Severance & Retirement	10,738	Inspection Fees	100	
				Employee Drug Screening	520			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 88,502			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	( )	
Description			Amount			Yellow page advertising	( )	
TM Healthcare Management - Management Fees			\$ 210,449					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 210,449	TOTAL (agree to Schedule V, line 22, col.8)	\$ 535,323	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 8,885	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
See Attached Schedule	Legal		\$ 55,771	N/A			Out-of-State Travel	\$
Marcum LLP	Accounting		13,068					
Templin Healthcare Accounting Svc	Accounting		2,182					
Development Specialists, Inc.	Accounting		9,664				In-State Travel	
Personnel Planners	Unemployment Consultant		1,079					
Howard Simon & Associates	Payroll Processing		10,468					
Point Click Care	Data Processing		24,254					
Information Controls	Data Processing		7,327				Seminar Expense	2,671
US Trustee Payment Center	Trustee Fee		43,445					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 167,258	TOTAL		\$	Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 2,671

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

\*\*See instructions.

Facility Name & ID Number Joliet Terrace Nursing Center# 0051698Report Period Beginning: 1/1/2018Ending: 12/31/2018**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,038 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 304,214  
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 benefit 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**