

Facility Name & ID Number Bourbonnais Terrace NH

0051631 Report Period Beginning: 1/1/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,600	1
2		Skilled Pediatric (SNF/PED)			2
3	97	Intermediate (ICF)	97	35,502	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	72,102	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	44,503	1,133		45,636	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,503	1,133		45,636	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.29%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO 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: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Bourbonnais Terrace NH # 0051631 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	246,226	29,094	9,824	285,144		285,144		285,144		1
2	Food Purchase		249,511		249,511		249,511	(11,016)	238,495		2
3	Housekeeping	242,934	35,868		278,802		278,802		278,802		3
4	Laundry	59,479	5,645		65,124		65,124		65,124		4
5	Heat and Other Utilities			115,123	115,123		115,123		115,123		5
6	Maintenance	80,267	3,009	49,105	132,381		132,381	1,402	133,783		6
7	Other (specify):* Waste Removal			11,538	11,538		11,538		11,538		7
8	TOTAL General Services	628,906	323,127	185,590	1,137,623		1,137,623	(9,614)	1,128,009		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,519,765	43,469	30,988	1,594,222		1,594,222	(280)	1,593,942		10
10a	Therapy										10a
11	Activities	74,080		18,601	92,681		92,681		92,681		11
12	Social Services	279,524		3,097	282,621		282,621		282,621		12
13	CNA Training										13
14	Program Transportation			3,383	3,383		3,383		3,383		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,873,369	43,469	62,069	1,978,907		1,978,907	(280)	1,978,627		16
	C. General Administration										
17	Administrative	101,470		222,196	323,666		323,666		323,666		17
18	Directors Fees										18
19	Professional Services			79,222	79,222		79,222		79,222		19
20	Dues, Fees, Subscriptions & Promotions			6,867	6,867		6,867		6,867		20
21	Clerical & General Office Expenses	140,132	19,229	67,928	227,289		227,289		227,289		21
22	Employee Benefits & Payroll Taxes			553,498	553,498		553,498		553,498		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,026	3,026		3,026		3,026		24
25	Other Admin. Staff Transportation			2,236	2,236		2,236		2,236		25
26	Insurance-Prop.Liab.Malpractice			30,048	30,048		30,048	14,957	45,005		26
27	Other (specify):*										27
28	TOTAL General Administration	241,602	19,229	965,021	1,225,852		1,225,852	14,957	1,240,809		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,743,877	385,825	1,212,680	4,342,382		4,342,382	5,063	4,347,445		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation							247,831	247,831		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			121,282	121,282		121,282	357,240	478,522		32
33	Real Estate Taxes							151,180	151,180		33
34	Rent-Facility & Grounds			1,100,691	1,100,691		1,100,691	(1,100,626)	65		34
35	Rent-Equipment & Vehicles			21,470	21,470		21,470		21,470		35
36	Other (specify):*										36
37	TOTAL Ownership			1,243,443	1,243,443		1,243,443	(344,375)	899,068		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee										42
43	Other (specify):* Non-Allow. Costs			87,754	87,754		87,754	(87,754)			43
44	TOTAL Special Cost Centers			87,754	87,754		87,754	(87,754)			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,743,877	385,825	2,543,877	5,673,579		5,673,579	(427,066)	5,246,513		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

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

0051631

Report Period Beginning:

1/1/16

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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	(13,591)	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	247,831	30		9
10	Interest and Other Investment Income	(2,505)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(41)	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	(4,797)	43		18
19	Entertainment	(894)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(67,461)	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	(506,500)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (347,958)		\$	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)	(79,108)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (79,108)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (427,066)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' PREPARATION REPORT

Bourbonnais Terrace NH

ID# 0051631

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Vending Income	\$ (11,016)	2	1
2	Resident Needs/Charity	(970)	43	2
3	Additional R&M	1,402	6	3
4	Building Co. - Admin Expenses	(250)	21	4
5	Building Co. - Amortization of Goodwill	(461,021)	36	5
6	Building Co. - Other Financing Costs	(33,746)	36	6
7	Building Co. - Licenses & Fees	(619)	20	7
8	Medical Records Income	(280)	10	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
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35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(506,500)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	20 Licenses & Fees	\$	BT Bourbonnais, LLC	100.00%	\$ 619	\$ 619	1
2	V	21 Bank Charges		BT Bourbonnais, LLC	100.00%	250	250	2
3	V	26 Property Insurance		BT Bourbonnais, LLC	100.00%	14,957	14,957	3
4	V	32 Interest		BT Bourbonnais, LLC	100.00%	359,745	359,745	4
5	V	33 Real Estate Taxes		BT Bourbonnais, LLC	100.00%	151,180	151,180	5
6	V	34 Rent	1,100,626	BT Bourbonnais, LLC	100.00%		(1,100,626)	6
7	V	36 Amortization Exp-Goodwill		BT Bourbonnais, LLC	100.00%	461,021	461,021	7
8	V	36 Finance Costs		BT Bourbonnais, LLC	100.00%	33,746	33,746	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,100,626			\$ 1,021,518	\$ * (79,108)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jimmy Nassour	50	Community Care Center	Chicago	BT Bourbonnais, LLC	Bourbonnais	Lessor	1
2	Carl Meyer	50	Crestwood Terrace Nursing Ctr	Crestwood				2
3			Frankfort Terrace Nursing Ctr	Frankfort				3
4			Joliet Terrace Nursing Ctr	Joliet				4
5			Kankakee Terrace Nursing Ctr	Bourbonnais				5
6			Southview Manor Nursing Ctr	Chicago				6
7			Sycamore Healthcare Center	Quincy				7
8			Terrace Nursing Home, The	Waukegan				8
9			West Chicago Terrace NH	West Chicago				9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Bourbonnais Terrace NH # 0051631 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 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

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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

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 2015 report.			\$	85,893	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2015	\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$	(85,893)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	237,073	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	151,180	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2011	73,838	8	FOR BHF USE ONLY	
	2012	76,838	9	13	FROM R. E. TAX STATEMENT FOR 2015 \$
	2013	83,392	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2014	85,043	11	15	LESS REFUND FROM LINE 6 \$
	2015	151,180	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
Accrual based on prior year tax bill.					

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

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X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

None

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

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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.

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XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	197		2012	1975	\$ 3,438,746	\$	35	\$ 98,250	\$ 98,250	\$ 491,250
5										
6										
7										
8										
	Improvement Type**									
9		Annunciator Panel	2013		2,530		20	127	127	391
10		Masonry Tuckpointing	2014		2,774		20	139	139	648
11		Sidewalk Pavement Outside of D Wing	2014		10,000		20	500	500	1,722
12										
13										
14										
15										
16										
17										
18										
19										
20										
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26										
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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

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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	<u>Leasehold Improvements (Real Estate Entity):</u>		\$	\$		\$	\$	\$	37
38	<u>Rooftop A/C Unit & Ductwork</u>	2012	5,219		20	261	261	1,305	38
39	<u>Sewer Pipe</u>	2013	7,500		20	375	375	1,500	39
40	<u>Roof AC Unit</u>	2013	2,652		20	133	133	532	40
41	<u>Cooling w/Heat</u>	2012	2,922		20	146	146	876	41
42	<u>Kitchen Hood</u>	2013	3,751		20	188	188	752	42
43	<u>B & D Wing Kitchen, Dining Room, Storage Room,</u>	2014	50,000		20	2,500	2,500	7,500	43
44	<u>Hallway Debris Hauling, Doors, Tiling</u>	2014			20				44
45	<u>Mold Remediation in B & D Wing Kitchen, Dining Room,</u>	2014	17,081		20	854	854	2,562	45
46	<u>Storage Room, Hallway</u>	2014			20				46
47	<u>D-Wing Electrical Wiring, Insulation, Tiling, Roof</u>	2014	8,682		20	434	434	1,302	47
48	<u>Drainage Repair</u>	2014	3,250		20	163	163	488	48
49	<u>Roof Repair - Ridges, pipes, valley</u>	2014	12,325		20	616	616	1,849	49
50	<u>Drainage Repair</u>	2014	7,374		20	369	369	1,106	50
51	<u>Excavation - Tree Removal, pipe protection,asphalt, pavement, fer</u>	2014	398,778		20	19,939	19,939	59,817	51
52	<u>Engineering Fees - Drainage Improvements/Excavation</u>	2015	22,820		20	1,141	1,141	2,282	52
53	<u>Plumbing & Heating</u>	2015	14,605		20	730	730	1,460	53
54	<u>Roofing</u>	2015	6,209		20	310	310	620	54
55	<u>Windows</u>	2015	2,559		20	128	128	256	55
56	<u>Compressor/Roof Curb</u>	2015	4,565		20	228	228	456	56
57	<u>Excavation - Tree Removal, pipe protection,asphalt, pavement, fer</u>	2016	48,646		20	2,432	2,432	2,432	57
58	<u>Roof Repairs above Unit C4</u>	2016	2,742		20	137	137	137	58
59	<u>81 Gallon Water Heater</u>	2016	4,034		20	202	202	202	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,079,764	\$		\$ 130,302	\$ 130,302	\$ 581,445	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,169,818	\$	\$ 116,982	\$ 116,982	10	\$ 558,294	71
72	Current Year Purchases	5,465		547	547	10	547	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,175,283	\$	\$ 117,529	\$ 117,529		\$ 558,841	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,855,047	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)	\$ 247,831	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 247,831	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,140,286	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

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				65			5
6								6
7	TOTAL				\$ 65			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.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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: \$ 6,470 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 E350	\$ 1,250	\$ 15,000	17
18					18
19					19
20					20
21	TOTAL		\$ 1,250	\$ 15,000	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Bourbonnais Terrace NH
IDPH License ID Number: 0051631
Fiscal Year End: 12/31/16

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	3,602
Postage Machine	840
Computer Equipment	304
Dishwasher	1,724
Total - Line 16	<u>6,470</u>

Facility Name & ID Number Bourbonnais Terrace NH # 0051631 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' PREPARATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Bourbonnais Terrace NH
 IDPH License ID Number: 0051631
 Fiscal Year End: 12/31/16

Schedule 17A

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

Description	Operating	After Consolidation
DUE FROM EKS	29,275	29,275
IMPOUND RESERVE	12,122	12,122
DUE TO MID CAP LINE OF CRED	3,763,937	3,763,937
DEPOSITS		100,000
MORTGAGE ESCROWS		146,159
Total - Line 9	3,805,334	4,051,493

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

Description	Operating	After Consolidation
ACCRUED EXPENSES	43,146	43,146
ALLIED ACCRUAL	18,711	18,711
PAYROLL WITHHOLDINGS	(8,130)	(8,130)
DUE TO/FROM INSURANCE	191,328	191,328
DUE TO PA (AUDIT ADJ)	15,658	15,658
DUE TO BLUE CROSS	2,325,777	2,325,777
Total - Line 36	2,586,490	2,586,490

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

Description	Operating	After Consolidation
ACCRUED RENT	510,524	45,606
DUE TO/FROM FACILITIES	337,894	342,637
DUE TO/FROM PROPERTY	1,047,831	-
Total - Line 43	1,896,249	388,243

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 914,338	1
2	Restatements (describe):		2
3	Rounding	(8)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 914,330	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,162,207)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	127,244	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,034,963)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (120,633)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,497,391	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,497,391	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions	180	24
25	Interest and Other Investment Income***	2,505	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,685	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	280	28
28a	<u>Vending Income</u>	11,016	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,296	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,511,372	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,137,623	31
32	Health Care	1,978,907	32
33	General Administration	1,225,852	33
B. Capital Expense			
34	Ownership	1,243,443	34
C. Ancillary Expense			
35	Special Cost Centers	87,754	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,673,579	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,162,207)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,162,207)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,345,940	44
45	Private Pay - Net Inpatient Revenue	136,858	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Hospice</u>	14,593	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,497,391	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Bourbonnais Terrace NH

0051631

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,856	2,080	\$ 75,332	\$ 36.22	1
2	Assistant Director of Nursing	1,790	2,014	65,616	32.58	2
3	Registered Nurses	2,305	2,376	62,356	26.24	3
4	Licensed Practical Nurses	15,552	17,168	375,641	21.88	4
5	CNAs & Orderlies	53,784	60,749	841,713	13.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,904	2,080	27,847	13.39	9
10	Activity Assistants	4,882	5,095	46,233	9.07	10
11	Social Service Workers	15,248	16,853	279,524	16.59	11
12	Dietician					12
13	Food Service Supervisor	1,912	2,080	28,458	13.68	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,234	18,028	217,768	12.08	15
16	Dishwashers					16
17	Maintenance Workers	1,889	2,089	80,267	38.42	17
18	Housekeepers	20,951	22,691	242,934	10.71	18
19	Laundry	3,000	3,675	59,479	16.18	19
20	Administrator	1,888	2,080	101,470	48.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,787	10,515	140,132	13.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>MDS Coordinator</u>	3,815	4,199	99,107	23.60	33
34	TOTAL (lines 1 - 33)	156,797	173,772	\$ 2,743,877 *	\$ 15.79	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	186	\$ 9,824	L1,C3	35
36	Medical Director	Monthly	6,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	283	14,024	L10,C3	38
39	Pharmacist Consultant	Monthly	15,366	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) <u>Psychosocial</u>	20	1,260	L12,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	489	\$ 46,474		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

Facility Name & ID Number Bourbonnais Terrace NH# 0051631

Report Period Beginning:

1/1/16

Ending:

12/31/16**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,624 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% of Line
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT