

Facility Name & ID Number Joliet Terrace Nursing Center

0051698 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	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 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	38,351	59		38,410	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,351	59		38,410	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.69%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

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

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Joliet Terrace Nursing Center # 0051698 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	243,928	27,395	9,525	280,848		280,848		280,848		1
2	Food Purchase		214,436		214,436		214,436	(5,028)	209,408		2
3	Housekeeping	194,989	54,877		249,866		249,866		249,866		3
4	Laundry	90,466	7,103		97,569		97,569		97,569		4
5	Heat and Other Utilities			106,693	106,693		106,693		106,693		5
6	Maintenance	58,580	1,338	32,823	92,741		92,741		92,741		6
7	Other (specify):* Waste Disposal			15,942	15,942		15,942		15,942		7
8	TOTAL General Services	587,963	305,149	164,983	1,058,095		1,058,095	(5,028)	1,053,067		8
	B. Health Care and Programs										
9	Medical Director			16,200	16,200		16,200		16,200		9
10	Nursing and Medical Records	1,244,295	58,308	34,113	1,336,716		1,336,716	(115)	1,336,601		10
10a	Therapy										10a
11	Activities	122,505		5,289	127,794		127,794		127,794		11
12	Social Services	274,429		3,048	277,477		277,477		277,477		12
13	CNA Training										13
14	Program Transportation			1,241	1,241		1,241		1,241		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,641,229	58,308	59,891	1,759,428		1,759,428	(115)	1,759,313		16
	C. General Administration										
17	Administrative	102,371		196,485	298,856		298,856		298,856		17
18	Directors Fees										18
19	Professional Services			78,057	78,057		78,057	(1,500)	76,557		19
20	Dues, Fees, Subscriptions & Promotions			22,944	22,944		22,944	(8,132)	14,812		20
21	Clerical & General Office Expenses	213,983	13,798	63,494	291,275		291,275		291,275		21
22	Employee Benefits & Payroll Taxes			484,933	484,933		484,933		484,933		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,572	1,572		1,572		1,572		24
25	Other Admin. Staff Transportation			1,846	1,846		1,846		1,846		25
26	Insurance-Prop.Liab.Malpractice			58,804	58,804		58,804	7,743	66,547		26
27	Other (specify):*										27
28	TOTAL General Administration	316,354	13,798	908,135	1,238,287		1,238,287	(1,889)	1,236,398		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,545,546	377,255	1,133,009	4,055,810		4,055,810	(7,032)	4,048,778		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:

1/1/2017

Ending:

12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							138,222	138,222			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			96,236	96,236		96,236	144,256	240,492			32
33	Real Estate Taxes							54,435	54,435			33
34	Rent-Facility & Grounds			507,091	507,091		507,091	(500,986)	6,105			34
35	Rent-Equipment & Vehicles			17,940	17,940		17,940		17,940			35
36	Other (specify):*											36
37	TOTAL Ownership			621,267	621,267		621,267	(164,073)	457,194			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			299,209	299,209		299,209		299,209			42
43	Other (specify):* Disallowed Costs			89,920	89,920		89,920	(89,920)				43
44	TOTAL Special Cost Centers			389,129	389,129		389,129	(89,920)	299,209			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,545,546	377,255	2,143,405	5,066,206		5,066,206	(261,025)	4,805,181			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(15,832)	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	138,222	30		9
10	Interest and Other Investment Income	(2,119)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,500)	19		17
18	Fines and Penalties	(12,622)	43		18
19	Entertainment	(33)	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	(59,733)	43		24
25	Fund Raising, Advertising and Promotional	(31)	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	(127,392)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (81,046)		\$	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)	(179,979)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (179,979)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (261,025)		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

Joliet Terrace Nursing Center

ID# 0051698

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (5,028)	2	1
2	Resident Needs/Charity	(1,663)	43	2
3	Medical Records Income	(115)	10	3
4	PAC Dues	(8,132)	20	4
5	Building Co. - Admin Expenses	(781)	21	5
6	Building Co. - Amortization of Goodwill	(103,476)	36	6
7	Building Co. - Other Financing Costs	(7,947)	36	7
8	Building Co. - Licenses & Fees	(250)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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
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	(127,392)		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	\$	JT Joliet, LLC	100.00%	\$ 250	\$	250	1
2	V	21 Bank Charges		JT Joliet, LLC	100.00%	781		781	2
3	V	26 Property Insurance		JT Joliet, LLC	100.00%	7,743		7,743	3
4	V	32 Interest		JT Joliet, LLC	100.00%	146,375		146,375	4
5	V	33 Real Estate Taxes		JT Joliet, LLC	100.00%	54,435		54,435	5
6	V	34 Rent	500,986	JT Joliet, LLC	100.00%			(500,986)	6
7	V	36 Amortization Exp-Goodwill		JT Joliet, LLC	100.00%	103,476		103,476	7
8	V	36 Finance Costs		JT Joliet, LLC	100.00%	7,947		7,947	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 500,986			\$ 321,007	\$ *	(179,979)	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:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jimmy Nassour	50	Bourbonnais Terrace NH	Bourbonnais	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			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 Joliet Terrace Nursing Center # 0051698 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Joliet Terrace Nursing Center

0051698

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' PREPARATION REPORT

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

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>30-07-18-300-016-0000</u>	<u>Long Term Care Property</u>	\$ <u>54,434.80</u>	\$ <u>54,434.80</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>54,434.80</u></u>	\$ <u><u>54,434.80</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number Joliet Terrace Nursing Center

0051698 Report Period Beginning:

1/1/2017 Ending:

12/31/2017

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:

1/1/2017

Ending:

12/31/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120	2012	1976	\$ 2,142,595	\$	35	\$ 61,217	\$ 61,217	\$ 367,302	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Porcelain Tile		2012			20				9
10	Circuit Breakers		2012	4,947		20	247	247	1,318	10
11	Frozen Pipe & Water Damage Repair		2014	3,200		20	160	160	481	11
12	Fireline		2014	8,140		20	407	407	1,255	12
13	Plumbing, Toilet Seat, Motar, Johnston-Ac		2015	2,519		20	126	126	378	13
14	Plumbing, Fans, Toilet Parts, Ac		2015	3,812		20	191	191	573	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37						\$	\$	37
38	2012	5,218		20	261	261	1,566	38
39	2013	11,668		20	583	583	2,916	39
40	2013	6,873		20	344	344	1,719	40
41	2013	6,470		20	324	324	1,618	41
42	2013	4,351		20	218	218	1,089	42
43	2013	7,507		20	375	375	1,876	43
44	2014	37,600		20	1,880	1,880	7,520	44
45	2015	48,473		20	2,424	2,424	7,272	45
46	2016	42,975		20	2,149	2,149	4,298	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		\$ 2,336,348	\$		\$ 70,906	\$ 70,906	\$ 401,181	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:

1/1/2017

Ending:

12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 671,926	\$	\$ 67,193	\$ 67,193	10 Yrs	\$ 396,754	71
72	Current Year Purchases	1,230		123	123	10 Yrs	123	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 673,156	\$	\$ 67,316	\$ 67,316		\$ 396,877	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)	\$ 3,709,504	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)	\$ 138,222	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 138,222	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 798,058	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				6,105			5
6								6
7	TOTAL				\$ 6,105			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 5,072 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	\$ 690.00	\$ 6,805	17
18	Facility	2013 Ford E150	546.00	6,063	18
19					19
20					20
21	TOTAL		\$ 1,236	\$ 12,868	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: 12/31/2017

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	2,497
Postage Machine	354
Dishwasher	2,221
Total - Line 16	<u>5,072</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2017**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 78,326	\$ 78,393	1
2	Cash-Patient Deposits	6,833	6,833	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>312,954</u>)	996,057	996,057	3
4	Supply Inventory (priced at <u>Cost</u>)	1,425	1,425	4
5	Short-Term Investments			5
6	Prepaid Insurance	22,042	37,048	6
7	Other Prepaid Expenses	18,027	18,027	7
8	Accounts Receivable (owners or related parties)	125,010	137,134	8
9	Other(specify): <u>See Attached Schedule 17A</u>	4,077	180,834	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,251,797	\$ 1,455,751	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		700,000	13
14	Buildings, at Historical Cost	12,890	2,180,382	14
15	Leasehold Improvements, at Historical Cost		155,966	15
16	Equipment, at Historical Cost	24,823	673,156	16
17	Accumulated Depreciation (book methods)	(3,580)	(798,058)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Goodwill</u>)	275,517	792,895	22
23	Other(specify): <u>Loan Costs, Net</u>		19,084	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 309,650	\$ 3,723,425	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,561,447	\$ 5,179,176	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 992,766	\$ 1,437,508	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	291,150	291,150	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
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule 17A</u>	164,201	164,201	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,078,734	\$ 3,842,142	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,493,910	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule 17A</u>	1,313,696	(1,999)	43
44	<u>Mortgage Premium</u>		231,580	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,313,696	\$ 5,723,491	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,392,430	\$ 9,565,633	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,830,983)	\$ (4,386,457)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,561,447	\$ 5,179,176	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name: Joliet Terrace Nursing Center
 IDPH License ID Number: 0051698
 Fiscal Year End: 12/31/2017

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		176,757
Total - Line 9	4,077	180,834

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
ACCRUED EXPENSES	64,129	64,129
ALLIED ACCRUAL	90,943	90,943
PAYROLL WITHHOLDINGS	(1,873)	(1,873)
DUE TO/FROM ALIEN RECIPIEN'	6,459	6,459
DUE TO/FROM PRIOR PERIOD	3,439	3,439
DUE TO HFS	1,104	1,104
Total - Line 36	164,201	164,201

XV. Balance Sheet

Line 43 Long-Term Liabilities (specify):

Description	Operating	After Consolidation
ACCRUED RENT	219,794	(1,999)
DUE TO/FROM PROPERTY	1,093,902	-
Total - Line 43	1,313,696	(1,999)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,830,270)	1
2	Restatements (describe):		2
3	Prior Period Adj-Cash Reconciliation	(1,216)	3
4	Rounding	2	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,831,484)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,076,769)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	77,270	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)	\$ (999,499)	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)	\$ (2,830,983)	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	\$ 3,982,175	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,982,175	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,119	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,119	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	115	28
28a	<u>Vending Income</u>	5,028	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,143	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,989,437	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,058,095	31
32	Health Care	1,759,428	32
33	General Administration	1,238,287	33
B. Capital Expense			
34	Ownership	621,267	34
C. Ancillary Expense			
35	Special Cost Centers	89,920	35
36	Provider Participation Fee	299,209	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,066,206	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,076,769)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,076,769)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,974,446	44
45	Private Pay - Net Inpatient Revenue	7,729	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,982,175	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:

1/1/2017

Ending:

12/31/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,888	2,080	\$ 85,751	\$ 41.23	1
2	Assistant Director of Nursing	1,741	1,782	59,244	33.25	2
3	Registered Nurses	6,253	6,455	214,843	33.28	3
4	Licensed Practical Nurses	11,837	12,551	325,111	25.90	4
5	CNAs & Orderlies	35,485	37,335	441,888	11.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,678	1,882	30,205	16.05	9
10	Activity Assistants	9,181	9,987	92,300	9.24	10
11	Social Service Workers	18,152	19,274	274,429	14.24	11
12	Dietician					12
13	Food Service Supervisor	1,367	1,754	20,777	11.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,353	22,907	223,151	9.74	15
16	Dishwashers					16
17	Maintenance Workers	5,482	5,778	58,580	10.14	17
18	Housekeepers	12,807	14,600	194,989	13.36	18
19	Laundry	6,236	6,964	90,466	12.99	19
20	Administrator	1,952	2,247	102,371	45.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,582	14,716	213,983	14.54	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	2,857	3,612	40,049	11.09	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MDS Coordinator</u>	2,067	2,259	77,409	34.27	33
34	TOTAL (lines 1 - 33)	153,918	166,183	\$ 2,545,546 *	\$ 15.32	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	\$ 9,525	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	214	10,312	L10, C3	38
39	Pharmacist Consultant	Monthly	9,360	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	10,200	L9,C3	47
48	<u>Administrative</u>	96	5,372	L21,C3	48
49	TOTAL (lines 35 - 48)	496	\$ 50,769		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	107	\$ 6,378	L10,C3	50
51	Licensed Practical Nurses	16	735	L10,C3	51
52	Certified Nurse Assistants/Aides	226	5,900	L10,C3	52
53	TOTAL (lines 50 - 52)	349	\$ 13,013		53

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Joliet Terrace Nursing Center

0051698

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Sandra Erickson	Administrator	0	\$ 50,871	Workers' Compensation Insurance	\$ 75,710	IDPH License Fee	\$ 1,990	
Adayomi Adebogun	Administrator	0	51,500	Unemployment Compensation Insurance	35,277	Advertising: Employee Recruitment	1,489	
				FICA Taxes	192,649	Health Care Worker Background Check		
				Employee Health Insurance	163,277	(Indicate # of checks performed 24)	724	
				Employee Meals		Patient Background Checks	50 1,336	
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on LTC	16,263	
				Employee Benefits	3,704	Licenses & Fees	1,142	
				Severance & Retirement	12,908			
				Employee Drug Screening	1,408			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 102,371					
B. Administrative - Other								
Description			Amount					
TM Healthcare Management - Management Fees			\$ 196,485					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 196,485					
(Attach a copy of any management service agreement)								
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		\$ 5,158	N/A			Out-of-State Travel	\$
Marcum LLP	Accounting		24,000					
Templin Healthcare Accounting Svc	Accounting		2,107				In-State Travel	
Personnel Planners	Unemployment Consultant		1,378					
Howard Simon & Associates	Payroll Processing		9,894				Seminar Expense	1,572
Point Click Care	Data Processing		22,612					
Information Controls	Data Processing		5,719				Entertainment Expense	()
S4 Group	Data Processing		1,500				(agree to Sch. V,	
Change Healthcare	Data Processing		814				line 24, col. 8)	
US Trustee Payment Center	Trustee Fee		4,875				TOTAL	\$ 1,572
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$		
(For legal fee disclosure, see page 39 of instructions)			\$ 78,057					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number Joliet Terrace Nursing Center# 0051698

Report Period Beginning:

1/1/2017

Ending:

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

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 16,263 IL Council on LTC
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,324 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. \$ 299,209
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