

		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>0051631</u></p> <p><b>Facility Name:</b> <u>Bourbonnais Terrace NH</u></p> <p><b>Address:</b> <u>133 Mohawk Drive</u> <u>Bourbonnais</u> <u>60914</u>        Number City Zip Code</p> <p><b>County:</b> <u>Kankakee</u></p> <p><b>Telephone Number:</b> <u>(815) 937-4790</u> <b>Fax #</b> <u>(815) 937-0432</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 style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name &amp; Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ( )</td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE        ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES        201 S. Grand Avenue East        Springfield, IL 62763-0001        Phone # (217) 782-1630</b></p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (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 Bourbonnais Terrace NH

# 0051631 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	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3	97	Intermediate (ICF)	97	35,405	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	71,905	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	50,138	1,165		51,303	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,138	1,165		51,303	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.35%

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 Bourbonnais Terrace NH # 0051631 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	285,193	31,972	9,496	326,661		326,661		326,661		1
2	Food Purchase		252,448		252,448		252,448	(11,016)	241,432		2
3	Housekeeping	301,441	44,358		345,799		345,799		345,799		3
4	Laundry	66,594	4,584		71,178		71,178		71,178		4
5	Heat and Other Utilities			113,351	113,351		113,351		113,351		5
6	Maintenance	75,886	2,447	38,004	116,337		116,337		116,337		6
7	Other (specify):* <b>Waste Disposal</b>			11,783	11,783		11,783		11,783		7
8	<b>TOTAL General Services</b>	729,114	335,809	172,634	1,237,557		1,237,557	(11,016)	1,226,541		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,790,931	46,400	38,879	1,876,210		1,876,210	(440)	1,875,770		10
10a	Therapy										10a
11	Activities	119,190		7,616	126,806		126,806		126,806		11
12	Social Services	286,110		2,135	288,245		288,245		288,245		12
13	CNA Training										13
14	Program Transportation			6,626	6,626		6,626		6,626		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,196,231	46,400	61,256	2,303,887		2,303,887	(440)	2,303,447		16
	<b>C. General Administration</b>										
17	Administrative	101,178		266,043	367,221		367,221		367,221		17
18	Directors Fees										18
19	Professional Services			191,762	191,762		191,762	(1,980)	189,782		19
20	Dues, Fees, Subscriptions & Promotions			11,562	11,562		11,562		11,562		20
21	Clerical & General Office Expenses	157,829	12,969	55,834	226,632		226,632		226,632		21
22	Employee Benefits & Payroll Taxes			655,869	655,869		655,869		655,869		22
23	Inservice Training & Education			545	545		545		545		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			7,650	7,650		7,650		7,650		25
26	Insurance-Prop.Liab.Malpractice			99,392	99,392		99,392		99,392		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	259,007	12,969	1,288,657	1,560,633		1,560,633	(1,980)	1,558,653		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,184,352	395,178	1,522,547	5,102,077		5,102,077	(13,436)	5,088,641		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Bourbonnais Terrace NH

#0051631

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							248,883	248,883			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			131,770	131,770		131,770	341,774	473,544			32
33	Real Estate Taxes							112,195	112,195			33
34	Rent-Facility & Grounds			1,100,625	1,100,625		1,100,625	(1,100,625)				34
35	Rent-Equipment & Vehicles			19,384	19,384		19,384		19,384			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,251,779	1,251,779		1,251,779	(397,773)	854,006			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											42
43	Other (specify):* <b>Disallowed Costs</b>			104,111	104,111		104,111	(103,996)	115			43
44	<b>TOTAL Special Cost Centers</b>			104,111	104,111		104,111	(103,996)	115			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,184,352	395,178	2,878,437	6,457,967		6,457,967	(515,205)	5,942,762			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

**Bourbonnais Terrace NH**

**Period Beginning 1/1/2018**  
**Period End 12/31/2018**

**Schedule 4A**

**V. Cost Center Expenses**

		Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					5	6
		1	2	3	4						
	Ancillary Expense										
	<b>E. Special Cost Centers</b>										
43	Other (specify):*				0		0		0		
	Laboratory Expense			115	115		115		115		
	Radiology Expenses				0		0		0		
	Non-Allowable Expenses			103,996	103,996		103,996	(103,996)	0		
					0		0		0		
					0		0		0		
	<b>TOTAL Other Special Cost Centers</b>	0	0	104,111	104,111	0	104,111	(103,996)	115		

**SEE ACCOUNTANTS' COMPILATION REPORT**

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<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	(14,795)	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	(9,838)	30		9
10	Interest and Other Investment Income	(16,882)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(105)	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	(7,330)	43		18
19	Entertainment	(813)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,980)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(80,597)	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	(495,584)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (627,924)		\$	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)	112,719		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 112,719		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (515,205)		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	52

SEE ACCOUNTANTS' PREPARATION REPORT

Bourbonnais Terrace NH

ID# 0051631

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (11,016)	2	1
2	Resident Needs/Charity	(356)	43	2
3	Building Co. - Admin Expenses	(2,222)	21	3
4	Building Co. - Amortization of Goodwill	(461,021)	36	4
5	Building Co. - Other Financing Costs	(20,529)	36	5
6	Medical Records Income/Rebate Income	(440)	10	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(495,584)		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	\$	BT Bourbonnais, LLC	100.00%	\$ 2,222	\$ 2,222	1
2	V	30 Depreciation		BT Bourbonnais, LLC	100.00%	258,721	258,721	2
3	V	32 Interest		BT Bourbonnais, LLC	100.00%	358,656	358,656	3
4	V	33 Real Estate Taxes		BT Bourbonnais, LLC	100.00%	112,195	112,195	4
5	V	34 Rent	1,100,625	BT Bourbonnais, LLC	100.00%		(1,100,625)	5
6	V	36 Amortization Exp-Goodwill		BT Bourbonnais, LLC	100.00%	461,021	461,021	6
7	V	36 Finance Costs		BT Bourbonnais, LLC	100.00%	20,529	20,529	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,100,625			\$ 1,213,344	\$ * 112,719	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Bourbonnais Terrace NH

# 0051631

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	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			Terrace Nursing Home, The	Waukegan				7
8			West Chicago Terrace NH	West Chicago				8
9								9
10								10
11								11
12								12
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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: 1/1/2018 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 Bourbonnais Terrace NH

# 0051631

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number

Bourbonnais Terrace NH

# 0051631

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			\$	\$ 13,105,647			\$	357,622	1					
2													2					
3													3					
4													4					
5													5					
<b>Working Capital</b>																		
6	MidCap		X	Line of Credit				2,664				129,444	6					
7													7					
8													8					
9	TOTAL Facility Related						\$	\$ 13,108,311			\$	487,066	9					
<b>B. Non-Facility Related*</b>																		
10								Amortization Expense				3,360	10					
11								Interest Income Offset				(16,882)	11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$	(13,522)	14					
15	TOTALS (line 9+line14)						\$	\$ 13,108,311			\$	473,544	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.)



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

FACILITY NAME Bourbonnais Terrace NH COUNTY Kankakee

FACILITY IDPH LICENSE NUMBER 0051631

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>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>17-09-17-300-020</u>	<u>Long Term Care Property</u>	\$ <u>112,195.24</u>	\$ <u>112,195.24</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>112,195.24</u></u>	\$ <u><u>112,195.24</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 Bourbonnais Terrace NH

# 0051631 Report Period Beginning:

1/1/2018 Ending:

12/31/2018

**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

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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.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2012</u>	<u>\$ 600,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 600,000</b>	<b>3</b>

SEE ACCOUNTANTS' PREPARATION REPORT

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

# **0051631**

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	197		2012	1975	\$ 3,438,746	\$	35	\$ 98,250	\$ 98,250	\$ 687,750	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Annunciator Panel		2013	2,530		20	127	127	645	9
10		Masonry Tuckpointing		2014	2,774		20	139	139	926	10
11		Sidewalk Pavement Outside of D Wing		2014	10,000		20	500	500	2,722	11
12		74 Gallon Hot Water Heater		2018	2,871		20	72	72	72	12
13		Repair AC Unit - Condensing Unit and Coil		2018	2,936		20	73	73	73	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

\*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	<u>Leasehold Improvements (Real Estate Entity):</u>		\$	\$		\$	\$	\$	37
38	<u>Rooftop A/C Unit &amp; Ductwork</u>	2012	5,219		20	261	261	1,827	38
39	<u>Sewer Pipe</u>	2013	7,500		20	375	375	2,250	39
40	<u>Roof AC Unit</u>	2013	2,652		20	133	133	798	40
41	<u>Cooling w/Heat</u>	2012	2,922		20	146	146	1,168	41
42	<u>Kitchen Hood</u>	2013	3,751		20	188	188	1,128	42
43	<u>B &amp; D Wing Kitchen, Dining Room, Storage Room,</u>	2014	50,000		20	2,500	2,500	12,500	43
44	<u>Hallway Debris Hauling, Doors, Tiling</u>	2014			20				44
45	<u>Mold Remediation in B &amp; D Wing Kitchen, Dining Room,</u>	2014	17,081		20	854	854	4,270	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	2,170	47
48	<u>Drainage Repair</u>	2014	3,250		20	163	163	814	48
49	<u>Roof Repair - Ridges, pipes, valley</u>	2014	12,325		20	616	616	3,081	49
50	<u>Drainage Repair</u>	2014	7,374		20	369	369	1,844	50
51	<u>Excavation - Tree Removal, pipe protection,asphalt, pavement, fer</u>	2014	398,778		20	19,939	19,939	99,695	51
52	<u>Engineering Fees - Drainage Improvements/Excavation</u>	2015	22,820		20	1,141	1,141	4,564	52
53	<u>Plumbing &amp; Heating</u>	2015	14,605		20	730	730	2,920	53
54	<u>Roofing</u>	2015	6,209		20	310	310	1,240	54
55	<u>Windows</u>	2015	2,559		20	128	128	512	55
56	<u>Compressor/Roof Curb</u>	2015	4,565		20	228	228	912	56
57	<u>Excavation - Tree Removal, pipe protection,asphalt, pavement, fer</u>	2016	48,646		20	2,432	2,432	7,296	57
58	<u>Roof Repairs above Unit C4</u>	2016	2,742		20	137	137	411	58
59	<u>81 Gallon Water Heater</u>	2016	4,034		20	202	202	606	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 4,085,571	\$		\$ 130,447	\$ 130,447	\$ 842,194	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	\$ 1,179,072	\$	\$ 117,907	\$ 117,907	10	\$ 794,465	71
72	Current Year Purchases	5,285		529	529	10	529	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,184,357	\$	\$ 118,436	\$ 118,436		\$ 794,994	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)	\$ 5,869,928	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)	\$ 248,883	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 248,883	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,637,188	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								5
6								6
7	<b>TOTAL</b>				\$			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: \$ 4,384 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			\$	\$	17
18	<u>Resident Transport</u>	<u>Ford E350 2013</u>	<u>1,250</u>	<u>15,000</u>	18
19					19
20					20
21	<b>TOTAL</b>		\$ <u>1,250</u>	\$ <u>15,000</u>	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:** 12/31/2018

**Schedule 14A**

**XIV. Rental Costs**

**Line 16 Rental Amount for Moveable Equipment**

<b>Rental Description</b>	<b>Amount</b>
Copier	2,869
Dishwasher	1,495
Dollie	20
<b>Total - Line 16</b>	<b><u>4,384</u></b>

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

# **0051631**

Report Period Beginning: **1/1/2018**

Ending:

**12/31/2018**

**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	\$ 370,494	\$ 386,165	1
2	Cash-Patient Deposits	15,872	15,872	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>397,631</u> )	1,301,554	1,301,554	3
4	Supply Inventory (priced at <u>Cost</u> )	2,150	2,150	4
5	Short-Term Investments			5
6	Prepaid Insurance	37,044	81,559	6
7	Other Prepaid Expenses	10,044	10,044	7
8	Accounts Receivable (owners or related parties)	125,440	125,440	8
9	Other(specify): <u>See Attached Schedule 17A</u>	3,536,813	4,083,528	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 5,399,411	\$ 6,006,312	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		600,000	13
14	Buildings, at Historical Cost		4,064,460	14
15	Leasehold Improvements, at Historical Cost	16,362	21,111	15
16	Equipment, at Historical Cost	33,596	1,184,357	16
17	Accumulated Depreciation (book methods)	(3,291)	(1,637,188)	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>	540,030	2,384,117	22
23	Other(specify): <u>Loan Costs, Net</u>		26,099	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 586,697	\$ 6,642,956	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,986,108	\$ 12,649,268	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,252,974	\$ 3,329,781	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,664	2,664	29
30	Accrued Salaries Payable	425,637	425,637	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		237,073	32
33	Accrued Interest Payable		499,134	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>	2,777,813	2,797,813	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,459,088	\$ 7,292,102	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,105,647	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule 17A</u>	3,751,241	52,567	43
44	<u>Mortgage Premium</u>		509,278	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,751,241	\$ 13,667,492	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 8,210,329	\$ 20,959,594	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,224,221)	\$ (8,310,326)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,986,108	\$ 12,649,268	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

Facility Name: **Bourbonnais Terrace NH**  
 IDPH License ID Number: **0051631**  
 Fiscal Year End: **12/31/2018**

**Schedule 17A**

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

Description	Operating	After Consolidation
DUE FROM EKS	49,148	49,148
IMPOUND RESERVE	12,122	12,122
DUE TO MID CAP LINE OF CRED	3,475,543	3,475,543
DEPOSITS		100,000
MORTGAGE ESCROWS		446,715
<b>Total - Line 9</b>	<b>3,536,813</b>	<b>4,083,528</b>

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

Description	Operating	After Consolidation
ACCRUED EXPENSES	96,760	96,760
ALLIED ACCRUAL	37,748	37,748
PAYROLL WITHHOLDINGS	(7,309)	(7,309)
DUE TO/FROM INSURANCE	191,328	191,328
DUE TO PA (AUDIT ADJ)	15,658	15,658
DUE TO BLUE CROSS	2,443,628	2,443,628
<b>Total - Line 36</b>	<b>2,777,813</b>	<b>2,777,813</b>

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

Description	Operating	After Consolidation
ACCRUED RENT	510,524	45,605
DUE TO/FROM FACILITIES		6,962
DUE TO/FROM PROPERTY	3,240,717	-
<b>Total - Line 43</b>	<b>3,751,241</b>	<b>52,567</b>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,139,169)</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>(1,139,169)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(1,056,511)	<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	(28,541)	<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>(1,085,052)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(2,224,221)</b>	<b>24</b> *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Bourbonnais Terrace NH

# 0051631

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	\$ 5,373,118	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,373,118	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***	16,882	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 16,882	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Income</u>	440	28
28a	<u>Vending Income</u>	11,016	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 11,456	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,401,456	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,237,557	31
32	Health Care	2,303,887	32
33	General Administration	1,560,633	33
<b>B. Capital Expense</b>			
34	Ownership	1,251,779	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	104,111	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,457,967	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,056,511)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,056,511)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,187,797	44
45	Private Pay - Net Inpatient Revenue	185,321	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>	\$ 5,373,118	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: 1/1/2018

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	1,900	2,080	\$ 83,779	\$ 40.28	1
2	Assistant Director of Nursing	1,920	2,080	62,130	29.87	2
3	Registered Nurses	5,979	6,167	202,036	32.76	3
4	Licensed Practical Nurses	15,084	16,806	405,168	24.11	4
5	CNAs & Orderlies	50,976	57,042	919,260	16.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,832	2,080	27,756	13.34	9
10	Activity Assistants	7,078	8,024	91,434	11.40	10
11	Social Service Workers	15,308	16,783	286,110	17.05	11
12	Dietician					12
13	Food Service Supervisor	1,944	2,080	29,529	14.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,664	18,599	255,664	13.75	15
16	Dishwashers					16
17	Maintenance Workers	4,751	5,048	75,886	15.03	17
18	Housekeepers	21,199	23,855	301,441	12.64	18
19	Laundry	3,274	3,831	66,594	17.38	19
20	Administrator	1,888	2,080	101,178	48.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,850	10,542	157,829	14.97	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>	3,694	4,025	118,558	29.46	33
34	TOTAL (lines 1 - 33)	163,341	181,122	\$ 3,184,352 *	\$ 17.58	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	193	\$ 9,496	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	407	19,030	L10, C3	38
39	Pharmacist Consultant	Monthly	16,056	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					47
48					48
49	TOTAL (lines 35 - 48)	600	\$ 50,582		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Debra Wood	Administrator	0	\$ 101,178	Workers' Compensation Insurance	\$ 134,567	IDPH License Fee	\$ 1,992	
				Unemployment Compensation Insurance	35,556	Advertising: Employee Recruitment		
				FICA Taxes	241,503	Health Care Worker Background Check		
				Employee Health Insurance	192,435	(Indicate # of checks performed <u>19</u> )	568	
				Employee Meals	11,974	Patient Background Checks <u>99</u>	2,629	
				Illinois Municipal Retirement Fund (IMRF)*				
				Union Pension Fund	35,503			
				Other Employee Benefits	4,331	Licenses & Fees	6,373	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 101,178	TOTAL (agree to Schedule V, line 22, col.8)		\$ 655,869	TOTAL (agree to Sch. V, line 20, col. 8)	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
TM Healthcare Management - Management Fees			\$ 266,043	N/A			Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 266,043	TOTAL		\$	In-State Travel	
C. Professional Services							Seminar Expense	
Vendor/Payee	Type		Amount				N/A	
See Attached Schedule	Legal		\$ 53,643				Entertainment Expense	( )
Marcum LLP	Accounting		13,068				(agree to Sch. V, line 24, col. 8)	
Templin Healthcare Accounting Svc	Accounting		2,182				TOTAL	\$
Development Specialists	Accounting		9,664					
PointClickCare	Data Processing		40,398					
Information Controls	Data Processing		7,327					
Personnel Planners	Unemployment Consulting		1,350					
HSA Payroll Billing	Payroll Processing		9,268					
US Trustee Payment Center	Trustee Fee		54,862					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 191,762					

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

\*\*See instructions.

Facility Name & ID Number Bourbonnais Terrace NH# 0051631Report 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. \$ 1,128 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 benefit on Schedule V. \$ 11,974 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**