

		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>I. IDPH License ID Number: <u>0046128</u></p> <p>Facility Name: <u>Elmwood Terrace Healthcare Center</u></p> <p>Address: <u>1017 W Galena Blvd</u> <u>Aurora</u> <u>60506</u> Number City Zip Code</p> <p>County: <u>Kane</u></p> <p>Telephone Number: <u>630-897-3100</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>02/01/03</u></p> <p>Type of Ownership:</p> <table border="0"> <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>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input 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>In the event there are further questions about this report, please contact: Name: <u>Mendel S Schneider</u> Telephone Number: <u>847-933-1274</u> Email Address: _____</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	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2018</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"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) _____ (Date) _____</td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Title) _____</td> </tr> <tr> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) <u>See Accountant's Report Attached</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Mendel S Schneider & Associates CPA PC</u> <u>4051 Old Orchard Rd Skokie, Illinois 60076</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u></td> </tr> <tr> <td colspan="2"> 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 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____ (Date) _____	Paid Preparer	(Title) _____	(Signed) _____	(Print Name and Title) <u>See Accountant's Report Attached</u>	(Firm Name & Address) <u>Mendel S Schneider & Associates CPA PC</u> <u>4051 Old Orchard Rd Skokie, Illinois 60076</u>		(Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u>	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	
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Facility Name & ID Number Elmwood Terrace Healthcare Center

0046128 Report Period Beginning: 01/01/2018 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 _____

	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	68	Skilled (SNF)	68	24,820	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	68	TOTALS	68	24,820	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	1,850	100	1,912	3,862	8
9	SNF/PED					9
10	ICF	16,596	584		17,180	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,446	684	1,912	21,042	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.78%

D. How many bed reserve days during this year were paid by the Department? 0 (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

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 02/18/03

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/18/03 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 68 and days of care provided 1,912

Medicare Intermediary Riverbend

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Elmwood Terrace Healthcare Center # 0046128 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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	159,550	11,145	5,822	176,517		176,517		176,517		1
2	Food Purchase		130,711		130,711	(3,000)	127,711		127,711		2
3	Housekeeping	172,536	3,084	32,909	208,529		208,529		208,529		3
4	Laundry		5,557		5,557		5,557		5,557		4
5	Heat and Other Utilities			95,958	95,958		95,958		95,958		5
6	Maintenance	51,861		75,980	127,841		127,841		127,841		6
7	Other (specify):*										7
8	TOTAL General Services	383,947	150,497	210,669	745,113	(3,000)	742,113		742,113		8
	B. Health Care and Programs										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	1,660,608	138,447	19,284	1,818,339		1,818,339		1,818,339		10
10a	Therapy										10a
11	Activities	67,912	1,106		69,018		69,018		69,018		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,728,520	139,553	30,084	1,898,157		1,898,157		1,898,157		16
	C. General Administration										
17	Administrative	84,876		42,000	126,876		126,876		126,876		17
18	Directors Fees										18
19	Professional Services			56,679	56,679		56,679	8,500	65,179		19
20	Dues, Fees, Subscriptions & Promotions			16,704	16,704		16,704	(11,330)	5,374		20
21	Clerical & General Office Expenses	72,681	64,770	89,345	226,796		226,796	(6,926)	219,870		21
22	Employee Benefits & Payroll Taxes			310,122	310,122	3,000	313,122		313,122		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,142	6,142		6,142		6,142		24
25	Other Admin. Staff Transportation			1,497	1,497		1,497	(1,497)			25
26	Insurance-Prop.Liab.Malpractice			10,609	10,609		10,609	101,814	112,423		26
27	Other (specify):* MIP							45,967	45,967		27
28	TOTAL General Administration	157,557	64,770	533,098	755,425	3,000	758,425	136,528	894,953		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,270,024	354,820	773,851	3,398,695		3,398,695	136,528	3,535,223		29

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

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

Elmwood Terrace Healthcare Center

#0046128

Report Period Beginning:

01/01/2018

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	
	D. Ownership											
30	Depreciation			31,969	31,969		31,969	35,910	67,879			30
31	Amortization of Pre-Op. & Org.			3,920	3,920		3,920	7,723	11,643			31
32	Interest			54,045	54,045		54,045	274,795	328,840			32
33	Real Estate Taxes							43,652	43,652			33
34	Rent-Facility & Grounds			655,281	655,281		655,281	(655,281)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			745,215	745,215		745,215	(293,201)	452,014			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			151,874	151,874		151,874		151,874			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			151,874	151,874		151,874		151,874			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,270,024	354,820	1,670,940	4,295,784		4,295,784	(156,673)	4,139,111			45

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

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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	17,541	30		9
10	Interest and Other Investment Income	(82)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,497)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,102)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(11,330)	20		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,470)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(154,203)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (154,203)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (156,673)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Elmwood Terrace Healthcare Center

ID# 0046128

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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
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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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmwood Terrace Healthcare Center# 0046128

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,500	0	0	0	0	0	0	0	0	0	8,500	19
20	Fees, Subscriptions & Promotions	(11,330)	0	0	0	0	0	0	0	0	0	0	(11,330)	20
21	Clerical & General Office Expenses	(7,102)	176	0	0	0	0	0	0	0	0	0	(6,926)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(1,497)	0	0	0	0	0	0	0	0	0	0	(1,497)	25
26	Insurance-Prop.Liab.Malpractice	0	101,814	0	0	0	0	0	0	0	0	0	101,814	26
27	Other (specify):*	0	45,967	0	0	0	0	0	0	0	0	0	45,967	27
28	TOTAL General Administration	(19,929)	156,457	0	0	0	0	0	0	0	0	0	136,528	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(19,929)	156,457	0	0	0	0	0	0	0	0	0	136,528	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmwood Terrace Healthcare Center

0046128

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	17,541	18,369	0	0	0	0	0	0	0	0	0	35,910	30
31	Amortization of Pre-Op. & Org.	0	7,723	0	0	0	0	0	0	0	0	0	7,723	31
32	Interest	(82)	274,877	0	0	0	0	0	0	0	0	0	274,795	32
33	Real Estate Taxes	0	43,652	0	0	0	0	0	0	0	0	0	43,652	33
34	Rent-Facility & Grounds	0	(655,281)	0	0	0	0	0	0	0	0	0	(655,281)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	17,459	(310,660)	0	(293,201)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,470)	(154,203)	0	(156,673)	45								

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
Ari Haas	40			Elmwood LLC	Aurora	Bldg Rental
David Abell	30					
Joseph Brandman	30					

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	34 Rent	\$ 655,281	Elmwood Terrace LLC	100.00%	\$	(655,281)	1
2	V	32 Interest		Elmwood Terrace LLC		274,877	274,877	2
3	V	33 Real Estate Taxes		Elmwood Terrace LLC		43,652	43,652	3
4	V	30 Depreciation		Elmwood Terrace LLC		18,369	18,369	4
5	V	31 Amortization		Elmwood Terrace LLC		7,723	7,723	5
6	V	26 Insurance		Elmwood Terrace LLC		101,814	101,814	6
7	V	27 MIP		Elmwood Terrace LLC		45,967	45,967	7
8	V	19 Professional Fees		Elmwood Terrace LLC		8,500	8,500	8
9	V	21 Office		Elmwood Terrace LLC		176	176	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 655,281			\$ 501,078	\$ * (154,203)	14

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

Facility Name & ID Number

Elmwood Terrace Healthcare Center

0046128

Report Period Beginning:

01/01/2018

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								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Elmwood Terrace Healthcare Center # 0046128 Report Period Beginning: 01/01/2018 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	David Abell		Management	30.00		30	50.00	Mgmt Fee	\$ 21,000	17-3	1
2	Joseph Brandman		Management	30.00		30	50.00	Mgmt Fee	21,000	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 42,000		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

Facility Name & ID Number Elmwood Terrace Healthcare Center

0046128

Report Period Beginning:

01/01/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Elmwood Terrace Healthcare Center

0046128

Report Period Beginning:

01/01/2018

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			
A. Directly Facility Related																		
Long-Term																		
1	Pillar		X	Mortgage	\$56,307.00	11/21/14	\$ 7,760,000	\$ 7,160,458		3.8000	\$ 274,877	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	MB		X	Line of Credit		06/01/12	890,000	621,530		3.5000	54,045	6						
7												7						
8												8						
9	TOTAL Facility Related				\$56,307.00		\$ 8,650,000	\$ 7,781,988			\$ 328,922	9						
B. Non-Facility Related*																		
10	Interest Income										(82)	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (82)	14						
15	TOTALS (line 9+line14)						\$ 8,650,000	\$ 7,781,988			\$ 328,840	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

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

** 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 Elmwood Terrace Healthcare Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0046128

CONTACT PERSON REGARDING THIS REPORT David Abell

TELEPHONE 773-338-4400 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>15-20-276-014</u>	<u></u>	\$ <u>41,985.98</u>	\$ <u>41,985.98</u>
2. <u>15-20-276-013</u>	<u></u>	\$ <u>6,071.90</u>	\$ <u>6,071.90</u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u><u>48,057.88</u></u>	\$ <u><u>48,057.88</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 Elmwood Terrace Healthcare Center

0046128

Report Period Beginning:

01/01/2018 Ending:

12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,481 B. General Construction Type: Exterior Brick Frame Brick 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).

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: 124885/231699 2. Number of Years Over Which it is Being Amortized: 10
3. Current Period Amortization: 3920 7723 4. Dates Incurred: 2012,2015

Nature of Costs: Mortgage Costs,HUD 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>14,166</u>	<u>2003</u>	<u>\$ 50,000</u>	1
2					2
3	TOTALS	14,166		\$ 50,000	3

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	68		2003		\$ 300,000	\$ 10,909	27.5	\$ 10,909	\$	\$ 173,180	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Paving		2005		11,969	435	27.5	435		5,818	9
10	Tiling		2005		3,895	142	27.5	142		1,932	10
11	Alarms		2005		9,818	357	27.5	357		4,924	11
12	Corridor Renovation										12
13	New Floor		2010		37,224		27.5	1,354	1,354	12,186	13
14	Wallcovering		2010		8,400		27.5	305	305	2,745	14
15	Hand Rails, Bumper Guards, Corner Guards		2010		21,479		27.5	781	781	7,029	15
16	Installation of Door Casings		2010		10,125		27.5	368	368	3,312	16
17	Light Fixtures		2010		9,880		27.5	359	359	3,231	17
18	Custom Signage		2010		3,661		27.5	133	133	1,197	18
19	Resident Room Renovation										19
20	Remove Existing Cove Base and Install New Cove Base		2010		38,334		27.5	1,394	1,394	12,546	20
21	Room Renovations		2010		32,671		27.5	1,188	1,188	10,692	21
22	Bumper Guards		2010		6,984		27.5	254	254	2,286	22
23	Cubicle Curtains		2010		14,852		27.5	540	540	4,860	23
24	Head and Foot Boards		2010		7,300		27.5	265	265	2,385	24
25	Window Treatments		2010		10,531		27.5	383	383	3,447	25
26	Wall Scones		2010		5,321		27.5	193	193	1,737	26
27	Light Fixtures		2010		17,953		27.5	653	653	5,877	27
28	Bathroom Renovation										28
29	New Floor		2010		10,185		27.5	370	370	3,330	29
30	Mirror		2010		2,657		27.5	97	97	873	30
31	Lighting		2010		3,408		27.5	124	124	1,116	31
32	Nurses Station Renovation		2010		10,348		27.5	376	376	3,384	32
33	Dining Room Renovation										33
34	New Floor		2010		8,103		27.5	295	295	2,655	34
35	Wallcovering		2010		2,053		27.5	75	75	675	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

Facility Name & ID Number Elmwood Terrace Healthcare Center# 0046128

Report Period Beginning:

01/01/2018 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Living Room Renovations		\$	\$		\$	\$	\$	37
38	New Carpeting	2010	1,859		27.5	68	68	612	38
39	Wallcoverings	2010	1,524		27.5	55	55	495	39
40	Window Treatments	2010	699		27.5	25	25	225	40
41	Renovated Beauty Salon								41
42	New Roof	2010	1,812		27.5	66	66	594	42
43	Wallcoverings	2010	1,415		27.5	51	51	459	43
44	Custom Cabinets	2010	8,125		27.5	295	295	2,655	44
45	Lighting	2010	1,354		27.5	49	49	441	45
46	Shampoo Station	2010	1,950		27.5	71	71	639	46
47	Corridors,Business Office,Small Dining Room								47
48	Main Dining Room,DON Office,Lounge								48
49	Painting and Wallcovers	2010	69,500		27.5	2,527	2,527	22,743	49
50	Install New Windows	2010	32,000		27.5	1,164	1,164	10,476	50
51	Install Dining Room,Window Treatments	2010	743		27.5	27	27	243	51
52	Repave Parking Lot	2010	39,550		27.5	1,438	1,438	12,942	52
53	Enlarge Therapy Room and Install New Flooring								53
54	Plumbing,Lighting and Electric Install, New Sliding Doors	2012	356,721	24,246	27.5	23,781	(465)	154,577	54
55	Replace all Doorstands,Install New Lighting in Res. Rooms								55
56	New Nursing Stations and Medication Rooms								56
57	New Bathroom in Dialysis Rooms, Built 2 New Showers								57
58	Generator	2014	122,400	8,477	15	10,465	1,988	49,143	58
59	Sign	2014	5,021	448	7	878	430	4,581	59
60	Paving	2014	15,098	1,046	15	1,291	245	6,062	60
61	Water Heaters	2016	11,090	739	15	739		1,848	61
62	Convert Storage Area to ADA Compliant Bathroom	2016	14,200	947	15	947		2,367	62
63	Replace Concrete Sidewalk on East and South Side of Bldg	2016	15,301	1,020	15	1,020		2,550	63
64	Air Ducts,Fan Coil,Condenser,New Drain Pipe	2018	31,448	1,572	15	1,572		1,572	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,318,961	\$ 50,338		\$ 67,879	\$ 17,541	\$ 546,641	70

**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	\$ 292,100	\$	\$	\$	10	\$ 292,100	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 292,100	\$	\$	\$		\$ 292,100	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,661,061	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 50,338	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 67,879	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,541	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 838,741	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					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			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.

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	TOTAL				\$ _____			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: \$ _____ Description: _____

(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			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	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.

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.

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		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.

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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (320,756)	\$ (301,149)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,391,854	4,391,854	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,699	17,207	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrows		401,014	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,085,797	\$ 4,508,926	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost	236,700	536,700	14
15	Leasehold Improvements, at Historical Cost	1,083,647	1,155,686	15
16	Equipment, at Historical Cost	172,484	272,484	16
17	Accumulated Depreciation (book methods)	(926,677)	(1,213,052)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	242,999	474,698	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(125,252)	(156,789)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 683,901	\$ 1,119,727	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,769,698	\$ 5,628,653	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 411,278	\$ 411,278	26
27	Officer's Accounts Payable	1,599,253	1,599,253	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	621,530	651,530	29
30	Accrued Salaries Payable	109,027	109,027	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,101	10,101	31
32	Accrued Real Estate Taxes(Sch.IX-B)		43,652	32
33	Accrued Interest Payable		22,675	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Others	372,532	355,264	36
37	Due to LLC	902,602		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,026,323	\$ 3,202,780	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,160,458	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 7,160,458	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,026,323	\$ 10,363,238	46
47	TOTAL EQUITY(page 18, line 24)	\$ 743,375	\$ (4,734,585)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,769,698	\$ 5,628,653	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,066,786	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,066,786	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(323,411)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		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)	\$ (323,411)	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)	\$ 743,375	24 *

* This must agree with page 17, line 47.

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	\$ 3,972,291	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,972,291	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***	82	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 82	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,972,373	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	745,113	31
32	Health Care	1,898,157	32
33	General Administration	755,425	33
B. Capital Expense			
34	Ownership	745,215	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	151,874	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,295,784	40
41	Income before Income Taxes (line 30 minus line 40)**	(323,411)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (323,411)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,070,075	44
45	Private Pay - Net Inpatient Revenue	187,931	45
46	Medicare - Net Inpatient Revenue	714,285	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,972,291	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.

Facility Name & ID Number Elmwood Terrace Healthcare Center

0046128

Report Period Beginning: 01/01/2018

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	1,952	2,264	\$ 93,593	\$ 41.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,264	13,118	358,260	27.31	3
4	Licensed Practical Nurses	15,469	16,613	473,118	28.48	4
5	CNAs & Orderlies	45,176	47,941	678,683	14.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,348	6,815	67,912	9.97	10
11	Social Service Workers	1,960	2,112	56,954	26.97	11
12	Dietician					12
13	Food Service Supervisor	1,920	2,091	44,829	21.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,852	10,324	114,721	11.11	15
16	Dishwashers					16
17	Maintenance Workers	3,039	3,230	51,861	16.06	17
18	Housekeepers	12,775	14,408	172,536	11.98	18
19	Laundry					19
20	Administrator	1,904	2,096	84,876	40.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,790	4,031	72,681	18.03	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)					33
34	TOTAL (lines 1 - 33)	116,449	125,043	\$ 2,270,024 *	\$ 18.15	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	55	\$ 5,822	1-3	35
36	Medical Director	96	10,800	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	255	19,284	10-3	38
39	Pharmacist Consultant				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)	406	\$ 35,906		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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	
Catherine Larson	Administrator	0	\$ 84,876	Workers' Compensation Insurance	\$ 56,451	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	14,122	Advertising: Employee Recruitment		
				FICA Taxes	173,660	Health Care Worker Background Check		
				Employee Health Insurance	65,889	(Indicate # of checks performed <u>100</u>)	2,500	
				Employee Meals	3,000	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	11,330	
						Kane Cty Health-Food License	721	
						Various Inspections	163	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 84,876			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	(11,330)	
Description			Amount			Yellow page advertising	()	
David Abell-Management Fees			\$ 21,000					
Joseph Brandman-Management Fees			21,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 42,000					
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
Mendel S Schneider CPA	Accounting		\$ 19,350				Out-of-State Travel	\$
Matt Gotter	Bookkeeping		9,000					
MIX Solutions	Insurance Consultant		3,125				In-State Travel	
Neal Gerber & Eisenberg	Legal		3,153					
Meyer Magence	Legal		1,843				Seminar Expense	
Ohagen Meyer	Legal		8,937				Business Solutions	299
Stephen Sher	Legal		8,448				Relias Learning	5,843
Skidelsky & Associates	Legal		2,823				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 56,679	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 6,142

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Elmwood Terrace Healthcare Center# 0046128Report Period Beginning: 01/01/2018Ending: 12/31/2018**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. No
- (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? _____
- (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? _____
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period? Yes
15
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,000 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. _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 151,874
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. \$ 3,000 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (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. N/A
Attach invoices and a summary of services for all architect and appraisal fees