

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

I. IDPH License ID Number: 0046128

Facility Name: Elmwood Terrace Hlthcare Ctr

Address: 1017 West Galena Aurora 60506
Number City Zip Code

County: Kane

Telephone Number: 630-897-3100 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 02/18/03

Type of Ownership:

VOLUNTARY, NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
X "Sub-S" Corp.
Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: Mendel S Schneider Telephone Number: 847-933-1274
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid
Preparer

(Signed) (Date)
(Print Name and Title) See Accountant's Report Attached
(Firm Name & Address) Mendel S Schneider & Associates CPA PC
4051 Old Orchard Rd Skokie IL 60076
(Telephone) 847-933-1274 Fax # 847-933-1283

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

Facility Name & ID Number Elmwood Terrace Hlthcare Ctr

0046128 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	68	Skilled (SNF)	68	24,888	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	24,888	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,885	100	1,892	3,877	8
9	SNF/PED					9
10	ICF	16,971	1,812		18,783	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,856	1,912	1,892	22,660	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.05%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

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 02/1/03

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 1,892

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 Hlthcare Ctr** # **0046128** Report Period Beginning: **01/01/16** Ending: **12/31/16**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	143,190	18,100	3,138	164,428		164,428		164,428			1
2	Food Purchase		134,584		134,584	(3,000)	131,584		131,584			2
3	Housekeeping	175,065	2,592	24,379	202,036		202,036		202,036			3
4	Laundry		9,278		9,278		9,278		9,278			4
5	Heat and Other Utilities			94,394	94,394		94,394		94,394			5
6	Maintenance	44,001		30,545	74,546		74,546		74,546			6
7	Other (specify):*											7
8	TOTAL General Services	362,256	164,554	152,456	679,266	(3,000)	676,266		676,266			8
	B. Health Care and Programs											
9	Medical Director			2,900	2,900		2,900		2,900			9
10	Nursing and Medical Records	1,369,650	122,805	36,182	1,528,637		1,528,637		1,528,637			10
10a	Therapy											10a
11	Activities	47,189	623		47,812		47,812		47,812			11
12	Social Services	55,007			55,007		55,007		55,007			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,471,846	123,428	39,082	1,634,356		1,634,356		1,634,356			16
	C. General Administration											
17	Administrative	149,511		42,000	191,511		191,511		191,511			17
18	Directors Fees											18
19	Professional Services			80,314	80,314		80,314	7,500	87,814			19
20	Dues, Fees, Subscriptions & Promotions			14,450	14,450	6,240	20,690	(9,056)	11,634			20
21	Clerical & General Office Expenses	94,221	67,939	79,111	241,271		241,271	(2,528)	238,743			21
22	Employee Benefits & Payroll Taxes			309,503	309,503	(3,240)	306,263		306,263			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,882	1,882		1,882		1,882			24
25	Other Admin. Staff Transportation			2,680	2,680		2,680	(2,680)				25
26	Insurance-Prop.Liab.Malpractice			10,728	10,728		10,728	72,354	83,082			26
27	Other (specify):* MIP							48,031	48,031			27
28	TOTAL General Administration	243,732	67,939	540,668	852,339	3,000	855,339	113,621	968,960			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,077,834	355,921	732,206	3,165,961		3,165,961	113,621	3,279,582			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			38,272	38,272		38,272	55,891	94,163			30
31	Amortization of Pre-Op. & Org.			3,920	3,920		3,920	7,723	11,643			31
32	Interest			36,683	36,683		36,683	286,421	323,104			32
33	Real Estate Taxes							31,083	31,083			33
34	Rent-Facility & Grounds			696,103	696,103		696,103	(696,103)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			774,978	774,978		774,978	(314,985)	459,993			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			162,101	162,101		162,101		162,101			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			162,101	162,101		162,101		162,101			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,077,834	355,921	1,669,285	4,103,040		4,103,040	(201,364)	3,901,676			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	43,629	30		9
10	Interest and Other Investment Income	(77)	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)	(2,680)	25		16
17	Non-Care Related Fees	(5,257)	20		17
18	Fines and Penalties	(695)	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	(3,799)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,009)	21		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)	\$ 29,112		\$	30

BHF USE ONLY								
48		49		50		51		52

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 Amount	2 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)	(230,476)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (230,476)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (201,364)		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 Yes	2 No	3 Amount	4 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

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
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmwood Terrace Hlthcare Ctr # 0046128 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	7,500	0	0	0	0	0	0	0	0	0	7,500	19
20	Fees, Subscriptions & Promotions	(9,056)	0	0	0	0	0	0	0	0	0	0	(9,056)	20
21	Clerical & General Office Expenses	(2,704)	176	0	0	0	0	0	0	0	0	0	(2,528)	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	(2,680)	0	0	0	0	0	0	0	0	0	0	(2,680)	25
26	Insurance-Prop.Liab.Malpractice	0	72,354	0	0	0	0	0	0	0	0	0	72,354	26
27	Other (specify):*	0	48,031	0	0	0	0	0	0	0	0	0	48,031	27
28	TOTAL General Administration	(14,440)	128,061	0	0	0	0	0	0	0	0	0	113,621	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(14,440)	128,061	0	0	0	0	0	0	0	0	0	113,621	29

Summary B

12/31/16

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

[illegible]

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:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 696,103	Elmwood Terrace LLC	100.00%	\$	(696,103)	1
2	V	32	Interest				286,498	286,498	2
3	V	33	Real Estate Taxes				31,083	31,083	3
4	V	30	Depreciation				12,262	12,262	4
5	V	31	Amortization				7,723	7,723	5
6	V	26	Insurance				72,354	72,354	6
7	V	27	MIP				48,031	48,031	7
8	V	21	Office				176	176	8
9	V	19	Professional Fees				7,500	7,500	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 696,103			\$ 465,627	\$ * (230,476)	14

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

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 Hlthcare Ctr # 0046128 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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 Hlthcare Ctr # 0046128 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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		2		3	4	5	6		7	8	9	10	
	Name of Lender	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	\$ 7,471,597	11/21/44	3.8000	\$ 286,498	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	MB		X	Line of Credit		6/1/12	890,000	964,266		3.5000	36,683	6	
7												7	
8												8	
9	TOTAL Facility Related				\$56,307.00		\$ 8,650,000	\$ 8,435,863			\$ 323,181	9	
	B. Non-Facility Related*												
10	Interest Income										(77)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (77)	14	
15	TOTALS (line 9+line14)						\$ 8,650,000	\$ 8,435,863			\$ 323,104	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.)

FACILITY NAME Elmwood Terrace Hlthcare Ctr COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0046128

CONTACT PERSON REGARDING THIS REPORT David Abell

TELEPHONE 773-338-4400 FAX #: ()

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,481

B. General Construction Type: Exterior BrickFrame BrickNumber of Stories

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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 Cost, Hud Fees

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

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Facility	14,166		2003		\$ 50,000	
2							
3	TOTALS	14,166				\$ 50,000	

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	\$	\$ 151,362
5										
6										
7										
8										
	Improvement Type**									
9	Paving		2005		11,969	435	27.5	435		4,948
10	Tiling		2005		3,895	141	27.5	141		1,649
11	Alarms		2005		9,818	357	27.5	357		4,210
12	Corridor Renovation		2010							
13	New Floor				37,224		27.5	1,354	1,354	9,478
14	Wallcovering				8,400		27.5	305	305	2,135
15	Hand Rails, Bumper Guards, Corner Guards				21,479		27.5	781	781	5,467
16	Installment of Door Casings				10,125		27.5	368	368	2,576
17	Light Fixtures				9,880		27.5	359	359	2,513
18	Custom Signage				3,661		27.5	133	133	931
19	Resident Room Renovation		2010							
20	Remove Existing Cove Base and Install New Cove Base				38,334		27.5	1,394	1,394	9,758
21	Room Renovation				32,671		27.5	1,188	1,188	8,316
22	Bumper Guards				6,984		27.5	254	254	1,778
23	Cubicle Curtains				14,852		27.5	540	540	3,780
24	Head and Foot Boards				7,300		27.5	265	265	1,855
25	Window Treatments				10,531		27.5	383	383	2,681
26	Wall Scones				5,321		27.5	193	193	1,351
27	Light Fixtures				17,953		27.5	653	653	4,571
28	Bathroom Renovation		2010							
29	New Floor				10,185		27.5	370	370	2,590
30	Mirror				2,657		27.5	97	97	679
31	Lighting				3,408		27.5	124	124	868
32	Nurses Station Renovation				10,348		27.5	376	376	2,632
33	Dining Room Renovation		2010							
34	New Floor				8,103		27.5	295	295	2,065
35	Wallcovering				2,053		27.5	75	75	525
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 Hlthcare Ctr

0046128

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Living Room Renovation	2010	\$	\$		\$	\$	\$	37
38 New Carpeting		1,859		27.5	68	68	476	38
39 Wallcovering		1,524		27.5	55	55	385	39
40 Window Treatments		699		27.5	25	25	175	40
41 Renovated Beauty Salon	2010							41
42 New Floor		1,812		27.5	66	66	462	42
43 Wallcovering		1,415		27.5	51	51	357	43
44 Custom Cabinets		8,125		27.5	295	295	2,065	44
45 Lighting		1,354		27.5	49	49	343	45
46 Shampoo Station		1,950		27.5	71	71	497	46
47 Corridors, Business Office, Small Dining Rooms	2010							47
48 Main Dining Room, DON Office, Lounge								48
49 Painting and Wallcovers		69,500		27.5	2,527	2,527	17,689	49
50 Install New Windows	2010	32,000		27.5	1,164	1,164	8,148	50
51 Install Dining Room, Window Treatments	2010	743		27.5	27	27	189	51
52 Repave Parking Lot	2010	39,550		27.5	1,438	1,438	10,066	52
53 Enlarge Therapy Room and Install New Flooring	2012							53
54 Plumbing, Lighting and Electric Install, New Sliding Doors		356,721	24,705	27.5	23,781	(924)	107,015	54
55 Replace all Doorstands, Install New Lighting in Res Rooms								55
56 New Nursing Station and Medication Rooms								56
57 New Bathroom in Dialysis Room, Built 2 New Showers								57
58 Generator	2014	122,400	10,465	15	10,465		28,213	58
59 Sign	2014	5,021	878	7	878		2,825	59
60 Paving	2014	15,098	1,291	15	1,291		3,480	60
61 Water Heaters	2016	11,090	370	15	370		370	61
62 Convert Storage Area to ADA Compliant Bathroom	2016	14,200	473	15	473		473	62
63 Replace Concrete Sidewalk on East and South side of bldg	2016	15,301	510	15	510		510	63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 1,287,513	\$ 50,534		\$ 64,953	\$ 14,419	\$ 412,456	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	\$	\$29,210	\$29,210	10	\$276,151	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$292,100	\$	\$29,210	\$29,210		\$276,151	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)	\$1,629,613	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$50,534	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$94,163	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$43,629	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$688,607	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

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?
16. Rental Amount for movable equipment: \$ Description:
- ☐ YES☐ NO
- (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

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year Ending

Annual Rent

12. /2017 \$

13. /2018 \$

14. /2019 \$

* 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.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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)	\$			

- (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.

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	

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

		1	2	3	4	5	6	7	8	
	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 prescrpts							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.

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	\$ (276,822)	\$ (269,256)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,771,206	3,771,206	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,103	22,409	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Escrows</u>		433,341	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,514,487	\$ 3,957,700	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	1,124,238	15
16	Equipment, at Historical Cost	172,484	272,484	16
17	Accumulated Depreciation (book methods)	(860,433)	(1,113,148)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	242,999	474,698	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(117,412)	(133,503)	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)	\$ 757,985	\$ 1,211,469	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,272,472	\$ 5,169,169	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 365,039	\$ 365,039	26
27	Officer's Accounts Payable	854,253	854,253	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	964,266	964,266	29
30	Accrued Salaries Payable	82,861	82,861	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,946	7,946	31
32	Accrued Real Estate Taxes(Sch.IX-B)		50,874	32
33	Accrued Interest Payable		23,660	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Others</u>	273,572	273,572	36
37	<u>Due to LLC</u>	868,053		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,415,990	\$ 2,622,471	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,471,597	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)	\$	\$ 7,471,597	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,415,990	\$ 10,094,068	46
47	TOTAL EQUITY(page 18, line 24)	\$ 856,482	\$ (4,924,899)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,272,472	\$ 5,169,169	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 758,077	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 758,077	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	98,405	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)	\$ 98,405	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)	\$ 856,482	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Elmwood Terrace Hlthcare Ctr

0046128

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,201,368	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,201,368	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***	77	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 77	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)	\$ 4,201,445	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	679,266	31
32	Health Care	1,634,356	32
33	General Administration	852,339	33
	B. Capital Expense		
34	Ownership	774,978	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	162,101	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,103,040	40
41	Income before Income Taxes (line 30 minus line 40)**	98,405	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 98,405	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,085,061	44
45	Private Pay - Net Inpatient Revenue	451,554	45
46	Medicare - Net Inpatient Revenue	664,753	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,201,368	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No, Cash Bas 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.

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	2,080	\$ 87,550	\$ 42.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,184	13,851	384,947	27.79	3
4	Licensed Practical Nurses	10,967	11,867	337,939	28.48	4
5	CNAs & Orderlies	39,924	43,346	559,214	12.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,741	5,038	47,189	9.37	10
11	Social Service Workers	1,712	2,080	55,007	26.45	11
12	Dietician					12
13	Food Service Supervisor	1,864	2,080	44,059	21.18	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,084	9,545	99,131	10.39	15
16	Dishwashers					16
17	Maintenance Workers	2,607	2,749	44,001	16.01	17
18	Housekeepers	13,380	14,951	175,065	11.71	18
19	Laundry					19
20	Administrator	3,504	3,656	149,511	40.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,230	5,789	94,221	16.28	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)	108,149	117,032	\$ 2,077,834 *	\$ 17.75	34

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	24	\$ 3,138	1-3	35
36	Medical Director	24	2,900	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	525	36,182	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)	573	\$ 42,220		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

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Catherine Larson	Administrator	0	\$ 81,665	Workers' Compensation Insurance	\$ 56,384	IDPH License Fee	\$ 3,980	
Debra Leroy	Administrator	0	67,846	Unemployment Compensation Insurance	14,585	Advertising: Employee Recruitment	6,240	
				FICA Taxes	158,955	Health Care Worker Background Check		
				Employee Health Insurance	73,339	(Indicate # of checks performed)		
				Employee Meals	3,000	Patient Background Checks	50	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	3,799	
						Kane County License	883	
						Various	31	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 149,511					
B. Administrative - Other								
Description			Amount					
David Abell-Management Fees			\$ 21,000					
Joseph Brandman-Management Fees			21,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 42,000					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount
Mendel S Schneider CPA	Accounting	\$ 10,950					Out-of-State Travel	\$
Richard Peelo	Accounting	4,200						
Blueprint Healthcare	Business Broker	7,500						
Meyer Magence	Legal	5,400					In-State Travel	
Stephen Sher	Legal	1,600						
Ohagan Meyer LLC	Legal	6,303						
Larry Schwartz	Legal	120						
Neil Gerber & Eisenberg	Legal	6,241					Seminar Expense	
Nate Montrose	Business Consultant	15,000					Various	1,882
Matt Gotter	Bookkeeper	23,000						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(For legal fee disclosure, see page 39 of instructions)			\$ 80,314				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,882

*** Attach copy of IMRF notifications**

****See instructions.**

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?
If YES, have these costs been properly adjusted out of the cost report?

No

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

(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 Yrs

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 11,000 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

(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.
This amount is to be recorded on line 42 of Schedule V.

\$ 162,101

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 3,000
No

Indicate the amount. \$

(16)

Travel and Transportation

a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b. Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

\$

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

\$

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No

(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.
Attach invoices and a summary of services for all architect and appraisal fees