

		FOR BHF USE					

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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: <u>0051680</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Kankakee Terrace Nursing Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/16</u> to <u>12/31/16</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>100 Belle Aire Ave</u> <u>Bourbonnais</u> <u>60914</u>																									
Number City Zip Code																									
County: <u>Kankakee</u>																									
Telephone Number: <u>(815) 939-0910</u> Fax # <u>(815) 939-0973</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name <u>Larry Templin</u> and Title <u>Partner</u>)</td></tr><tr><td>(Firm Name <u>Templin Healthcare Accounting Services, LLP</u> & Address <u>P.O. Box 9, Dunlap, IL 61525</u>)</td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr></table> 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		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Date) _____	(Print Name <u>Larry Templin</u> and Title <u>Partner</u>)	(Firm Name <u>Templin Healthcare Accounting Services, LLP</u> & Address <u>P.O. Box 9, Dunlap, IL 61525</u>)	(Telephone) <u>(630) 361-2868</u> Fax # ()												
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	(Telephone) <u>(630) 361-2868</u> Fax # ()																								
Date of Initial License for Current Owners: <u>41087</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Larry Templin</u>																									
Telephone Number: <u>(630) 361-2868</u>																									
Email Address: _____																									
SEE ACCOUNTANTS' PREPARATION REPORT																									

Facility Name & ID Number Kankakee Terrace Nursing Ctr

0051680 Report Period Beginning: 1/1/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	146	Intermediate (ICF)	146	53,436	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,436	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					8
9	SNF/PED					9
10	ICF	42,927	733	618	44,278	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,927	733	618	44,278	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.86%

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

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

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

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

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

I. On what date did you start providing long term care at this location? Date started 06/27/2012

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 06/27/2012 NO ☐

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Kankakee Terrace Nursing Ctr** # **0051680** Report Period Beginning: **1/1/16** Ending: **12/31/16**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	227,096	15,781	10,256	253,133		253,133		253,133			1
2	Food Purchase		241,288		241,288		241,288	(5,184)	236,104			2
3	Housekeeping	198,664	29,207		227,871		227,871		227,871			3
4	Laundry	64,647	7,697		72,344		72,344		72,344			4
5	Heat and Other Utilities			120,305	120,305		120,305		120,305			5
6	Maintenance	77,419	5,552	52,129	135,100		135,100	1,308	136,408			6
7	Other (specify):* Waste Removal			17,855	17,855		17,855		17,855			7
8	TOTAL General Services	567,826	299,525	200,545	1,067,896		1,067,896	(3,876)	1,064,020			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,278,227	54,526	26,363	1,359,116		1,359,116	1,099	1,360,215			10
10a	Therapy											10a
11	Activities	69,435		13,520	82,955		82,955		82,955			11
12	Social Services	229,136		1,173	230,309		230,309		230,309			12
13	CNA Training											13
14	Program Transportation			2,633	2,633		2,633		2,633			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,576,798	54,526	53,289	1,684,613		1,684,613	1,099	1,685,712			16
	C. General Administration											
17	Administrative	91,768		236,657	328,425		328,425		328,425			17
18	Directors Fees											18
19	Professional Services			77,198	77,198		77,198		77,198			19
20	Dues, Fees, Subscriptions & Promotions			6,923	6,923		6,923		6,923			20
21	Clerical & General Office Expenses	114,097	18,038	57,155	189,290		189,290	1,398	190,688			21
22	Employee Benefits & Payroll Taxes			471,430	471,430		471,430		471,430			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,433	2,433		2,433		2,433			24
25	Other Admin. Staff Transportation			2,025	2,025		2,025		2,025			25
26	Insurance-Prop.Liab.Malpractice			32,546	32,546		32,546	8,887	41,433			26
27	Other (specify):*											27
28	TOTAL General Administration	205,865	18,038	886,367	1,110,270		1,110,270	10,285	1,120,555			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,350,489	372,089	1,140,201	3,862,779		3,862,779	7,508	3,870,287			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							173,943	173,943			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			89,883	89,883		89,883	338,559	428,442			32
33	Real Estate Taxes							121,854	121,854			33
34	Rent-Facility & Grounds			1,012,527	1,012,527		1,012,527	(1,011,607)	920			34
35	Rent-Equipment & Vehicles			16,641	16,641		16,641		16,641			35
36	Other (specify):*											36
37	TOTAL Ownership			1,119,051	1,119,051		1,119,051	(377,251)	741,800			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):* See Att Sch 4A			94,575	94,575		94,575	(94,492)	83			43
44	TOTAL Special Cost Centers			94,575	94,575		94,575	(94,492)	83			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,350,489	372,089	2,353,827	5,076,405		5,076,405	(464,235)	4,612,170			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Period Beginning 1/1/16
Period End 12/31/16

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
		1	2	3	4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory Expense			83	83		83		83			
	Radiology Expenses				0		0		0			
	Non-Allowable Expenses			94,492	94,492		94,492	(94,492)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	0	0	94,575	94,575	0	94,575	(94,492)	83			

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

	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	(14,024)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	173,943	30		9
10	Interest and Other Investment Income	(3,263)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(73)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,520)	43		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	(71,936)	43		24
25	Fund Raising, Advertising and Promotional	(296)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(606,908)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (527,077)		\$	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)	62,842		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 62,842		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (464,235)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (5,184)	2	1
2	Medical Records Income	(901)	10	2
3	Resident Needs/Charity	(3,643)	43	3
4	Building Co. - Admin Expenses	(250)	21	4
5	Building Co. - Amortization of Goodwill	(569,000)	36	5
6	Building Co. - Other Financing Costs	(32,017)	36	6
7	Building Co. - Licenses & Fees	(619)	20	7
8	Additional Repairs & Maintenance	1,308	6	8
9	Additional Nursing Equipment	2,000	10	9
10	Additional Office Supplies	1,398	21	10
11				11
12				12
13				13
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(606,908)		49

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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	20	Licenses & Fees	\$	KT Bourbonnais LLC	100.00%	\$ 619	\$ 619	1
2	V	21	Bank Charges		KT Bourbonnais LLC	100.00%	250	250	2
3	V	26	Property Insurance		KT Bourbonnais LLC	100.00%	8,887	8,887	3
4	V	32	Interest		KT Bourbonnais LLC	100.00%	341,822	341,822	4
5	V	33	Real Estate Taxes		KT Bourbonnais LLC	100.00%	121,854	121,854	5
6	V	34	Rent	1,011,607	KT Bourbonnais LLC	100.00%		(1,011,607)	6
7	V	36	Amortization Exp-Goodwill		KT Bourbonnais LLC	100.00%	569,000	569,000	7
8	V	36	Finance Costs		KT Bourbonnais LLC	100.00%	32,017	32,017	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,011,607			\$ 1,074,449	\$ * 62,842	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	<u>Jimmy Nassour</u>	<u>50</u>	<u>Bourbonnais Terrace NH</u>	<u>Bourbonnais</u>	<u>KT Bourbonnais LLC</u>	<u>Bourbonnais</u>	<u>Lessor</u>	1
2	<u>Carl Meyer</u>	<u>50</u>	<u>Community Care Center</u>	<u>Chicago</u>				2
3			<u>Crestwood Terrace Nursing Ctr</u>	<u>Crestwood</u>				3
4			<u>Frankfort Terrace Nursing Center</u>	<u>Frankfort</u>				4
5			<u>Joliet Terrace Nursing Center</u>	<u>Joliet</u>				5
6			<u>Southview Manor Nursing Ctr</u>	<u>Chicago</u>				6
7			<u>Sycamore Healthcare Center</u>	<u>Quincy</u>				7
8			<u>Terrace Nursing Home, The</u>	<u>Waukegan</u>				8
9			<u>West Chicago Terrace NH</u>	<u>West Chicago</u>				9
10								10
11								11
12								12
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28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kankakee Terrace Nursing Ctr # 0051680 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Ending: 12/31/16

Name of Related Organization

Fax NumberNO ☒

()

SEE ACCOUNTANTS' PREPARATION REPORT

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	First Mortgage		X	Mortgage Payable			\$	13,092,842			\$	340,820	1
2													2
3													3
4													4
5													5
	Working Capital												
6	MidCap		X	Line of Credit				1,974				74,087	6
7													7
8													8
9	TOTAL Facility Related						\$	13,094,816			\$	414,907	9
	B. Non-Facility Related*												
10								Amortization Expense				16,798	10
11								Interest Income Offset				(3,263)	11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	13,535	14
15	TOTALS (line 9+line14)						\$	13,094,816			\$	428,442	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.					
1. Real Estate Tax accrual used on 2015 report.				\$	57,578	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2015			\$		2
3. Under or (over) accrual (line 2 minus line 1).				\$	(57,578)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	179,432	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.						
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	121,854	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2011	49,759	8			
	2012	51,780	9			
	2013	56,190	10			
	2014	57,304	11			
	2015	121,854	12			
Accrual based on prior year tax bill.						

	2011	49,759	8
	2012	51,780	9
	2013	56,190	10
	2014	57,304	11
	2015	121,854	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

FACILITY NAME Kankakee Terrace Nursing Ctr COUNTY Kankakee
FACILITY IDPH LICENSE NUMBER 0051680
CONTACT PERSON REGARDING THIS REPORT Jerry Harris
TELEPHONE (630) 501-0996 FAX #: (630) 501-0987

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.

B. Real Estate Tax Cost Allocations

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.)

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,663 **B. General Construction Type:** Exterior Brick Frame Number of Stories

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

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

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

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2012	\$ 250,000	1
2					2
3	TOTALS			\$ 250,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	146		2012	1976	\$ 3,006,304	\$	35	\$ 85,894	\$ 85,894	\$ 429,470	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Repair Air Conditioner			2016	5,151		20	258	258	258	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

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kankakee Terrace Nursing Ctr

0051680

Report Period Beginning:

1/1/16

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 Leasehold Improvements (Real Estate Entity):						\$	\$	37
38 Rooftop Air Conditioning Unit	2012	4,927		20	246	246	984	38
39 Cubicle Curtains	2013	10,505		20	525	525	2,100	39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 3,026,887	\$		\$ 86,923	\$ 86,923	\$ 432,812	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$863,312	\$	\$86,331	\$86,331	10	\$335,352	71
72	Current Year Purchases	6,893		689	689	10	689	72
73	Fully Depreciated Assets	3,101					3,101	73
74								74
75	TOTALS	\$873,306	\$	\$87,020	\$87,020		\$339,142	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	2	
	Reference	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)	\$4,150,193	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$173,943	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$173,943	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$771,954	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				920			5
6								6
7	TOTAL				\$920			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?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$7,179
- Description: See Attached Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2013 Ford XL Van	\$788.54	\$9,462	17
18					18
19					19
20					20
21	TOTAL		\$788.54	\$9,462	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:

Kankakee Terrace Nursing Ctr

IDPH License ID Number:

0051680

Fiscal Year End:

12/31/16

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Ice Maker	1,361
Postage Machine	636
Computer Equip	304
Copier	3,412
Dishwasher	1,466
Total - Line 16	7,179

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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		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	N/A	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 75,799	\$ 76,091	1
2	Cash-Patient Deposits	(4,425)	(4,425)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 286,844)	1,146,726	1,146,726	3
4	Supply Inventory (priced at Cost)	3,600	3,600	4
5	Short-Term Investments			5
6	Prepaid Insurance	20,095	68,595	6
7	Other Prepaid Expenses	11,213	11,213	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule 17A	2,160,900	2,295,145	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,413,908	\$ 3,596,945	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		250,000	13
14	Buildings, at Historical Cost	1,471	3,026,104	14
15	Leasehold Improvements, at Historical Cost		783	15
16	Equipment, at Historical Cost	40,507	873,306	16
17	Accumulated Depreciation (book methods)	(6,826)	(771,954)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) Goodwill	487,685	3,902,860	22
23	Other(specify): Loan Costs		27,303	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 522,837	\$ 7,308,402	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,936,745	\$ 10,905,347	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 591,797	\$ 624,023	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,974	1,974	29
30	Accrued Salaries Payable	257,157	257,157	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,138	11,138	31
32	Accrued Real Estate Taxes(Sch.IX-B)		179,432	32
33	Accrued Interest Payable		474,355	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	522,205	522,205	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,384,271	\$ 2,070,284	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,092,842	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule 17A	1,851,042	183,879	43
44	Mortgage Premium		561,420	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,851,042	\$ 13,838,141	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,235,313	\$ 15,908,425	46
47	TOTAL EQUITY(page 18, line 24)	\$ 701,432	\$ (5,003,078)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,936,745	\$ 10,905,347	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name: Kankakee Terrace Nursing Ctr
IDPH License ID Number: 0051680
Fiscal Year End: 12/31/16

Schedule 17A

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

Description	Operating	After Consolidation
DUE FROM EKS	9,624	9,624
IMPOUND RESERVE	2,338	2,338
DUE TO MID CAP LINE OF CRED	2,148,938	2,148,938
MORTGAGE ESCROWS		134,245
Total - Line 9	2,160,900	2,295,145

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

Description	Operating	After Consolidation
ACCRUED EXPENSES	40,555	40,555
ALLIED ACCRUAL	30,499	30,499
PAYROLL WITHHOLDINGS	(1,882)	(1,882)
DUE TO/FROM INSURANCE	452,731	452,731
DUE TO PA (AUDIT ADJ)	302	302
Total - Line 36	522,205	522,205

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

Description	Operating	After Consolidation
ACCRUED RENT	505,629	(2,821)
DUE TO/FROM FACILITIES	183,921	186,700
DUE TO/FROM PROPERTY	1,161,492	-
Total - Line 43	1,851,042	183,879

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 878,460	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 878,458	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(271,328)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	94,302	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)	\$ (177,026)	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)	\$ 701,432	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kankakee Terrace Nursing Ctr

0051680

Report Period Beginning: 1/1/16

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	\$ 4,795,633	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,795,633	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	96	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)	\$ 96	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,263	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,263	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	901	28
28a	<u>Vending Income</u>	5,184	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,085	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,805,077	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,067,896	31
32	Health Care	1,684,613	32
33	General Administration	1,110,270	33
	B. Capital Expense		
34	Ownership	1,119,051	34
	C. Ancillary Expense		
35	Special Cost Centers	94,575	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,076,405	40
41	Income before Income Taxes (line 30 minus line 40)**	(271,328)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (271,328)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,661,923	44
45	Private Pay - Net Inpatient Revenue	45,266	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Veterans</u>	78,690	47
48	Other-(specify) <u>Insurance</u>	9,754	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,795,633	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 80,501	\$ 38.70	1
2	Assistant Director of Nursing	1,952	2,120	57,849	27.29	2
3	Registered Nurses	624	639	14,327	22.42	3
4	Licensed Practical Nurses	16,129	18,238	400,709	21.97	4
5	CNAs & Orderlies	48,967	54,484	593,025	10.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,461	6,060	69,435	11.46	10
11	Social Service Workers	13,186	13,914	229,136	16.47	11
12	Dietician					12
13	Food Service Supervisor	2,191	2,399	30,700	12.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,798	18,713	196,396	10.50	15
16	Dishwashers					16
17	Maintenance Workers	5,517	5,717	77,419	13.54	17
18	Housekeepers	17,707	19,727	198,664	10.07	18
19	Laundry	3,978	4,516	64,647	14.32	19
20	Administrator	2,000	2,080	91,768	44.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,104	9,102	114,097	12.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,868	2,044	19,663	9.62	31
32	Other Health Care(specify)					32
33	Other(specify) MDS Coordinator	3,705	4,158	112,153	26.97	33
34	TOTAL (lines 1 - 33)	150,139	165,991	\$ 2,350,489 *	\$ 14.16	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	166	\$ 10,256	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	278	13,778	L10, C3	38
39	Pharmacist Consultant	Monthly	11,388	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,418	L11, C3	44
45	Social Service Consultant				45
46	Other(specify) Psychosocial	9	567	L12, C3	46
47	Psychiatric Medical Director	Monthly	3,600	L9,C3	47
48	Administrative	60	14,715	L21,C3	48
49	TOTAL (lines 35 - 48)	537	\$ 61,722		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Carolyn Bessette	Administrator	0.00%	\$ 91,768
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 91,768
B. Administrative - Other			
Description			Amount
TM Healthcare Management - Management Fees			\$ 236,657
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 236,657
C. Professional Services			
Vendor/Payee	Type		Amount
See Attached Schedule	Legal		\$ 8,534
FR&R/Marcum LLP	Accounting		24,000
First Advantage Tax	Accounting		7,463
Howard Simon & Associates	Payroll Processing		6,082
Point Click Care	Data Processing		23,666
Information Controls	Data Processing		4,411
E-Health Data Solutions	Data Processing		1,400
Change Healthcare	Data Processing		786
Personnel Planners	Unemployment Consultant		856
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 77,198
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 66,127
Unemployment Compensation Insurance			27,040
FICA Taxes			181,588
Employee Health Insurance			162,522
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Union Pension Fund			30,802
Employee Benefits			3,351
TOTAL (agree to Schedule V, line 22, col.8)			\$ 471,430
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
N/A			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 497
Advertising: Employee Recruitment			99
Health Care Worker Background Check (Indicate # of checks performed)	29		832
Patient Background Checks	205		3,965
Licenses & Fees			1,530
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 6,923
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			2,433
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 2,433

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

****See instructions.**

Facility Name & ID Number Kankakee Terrace Nursing Ctr	STATE OF ILLINOIS # 0051680	Report Period Beginning: 1/1/16	Ending: 12/31/16
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report? No
 If YES, give association name and amount. N/A

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
 What was the average life used for new equipment added during this period? 10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,847 Line 10

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

(8) Are you presently operating under a sale and leaseback arrangement? No
 If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14

d. Have vehicle usage logs been maintained? No

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
 Firm Name: N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
 Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT