

		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: 0052720

Facility Name: Lewis Terrace

Address: 1916 16th Street North Chicago 60064

County: Lake

Telephone Number: See Attached Fax # See Attached

HFS ID Number:

Date of Initial License for Current Owners: See Attached

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code 501 (c) 3

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Lisa Winnett

(Title) Director of Operations

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT

(Print Name and Title) Larry Templin Partner

(Firm Name & Address) Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525

(Telephone) (630) 361-2868 Fax # ()

In the event there are further questions about this report, please contact:

Name: Ron Wilson Telephone Number: (309) 343-1550

Email Address:

CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 4/1/2015 to 3/31/2016 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.

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lewis Terrace

0052720 Report Period Beginning: 4/1/2015 Ending: 3/31/2016

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		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,697			5,697	13
14	TOTALS	5,697			5,697	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.28%

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed-hold days during this year were paid by the Department?
21 (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 See Attached

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date See Attached 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: 3/31/2016 Fiscal Year: 3/31/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lewis Terrace # 0052720 Report Period Beginning: 4/1/2015 Ending: 3/31/2016
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	76,965	7,012	3,469	87,446		87,446		87,446			1
2	Food Purchase		64,949		64,949		64,949		64,949			2
3	Housekeeping	28,690	12,915		41,605		41,605		41,605			3
4	Laundry		5,702		5,702		5,702		5,702			4
5	Heat and Other Utilities			18,899	18,899		18,899		18,899			5
6	Maintenance	21,644	8,767	30,291	60,702		60,702	67	60,769			6
7	Other (specify):*											7
8	TOTAL General Services	127,299	99,345	52,659	279,303		279,303	67	279,370			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200		4,200			9
10	Nursing and Medical Records	356,971	22,306	3,987	383,264		383,264		383,264			10
10a	Therapy											10a
11	Activities		1,148	2,668	3,816		3,816		3,816			11
12	Social Services											12
13	CNA Training	25,283			25,283		25,283		25,283			13
14	Program Transportation			9,467	9,467		9,467		9,467			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	382,254	23,454	20,322	426,030		426,030		426,030			16
	C. General Administration											
17	Administrative	22,552			22,552		22,552		22,552			17
18	Directors Fees							2,299	2,299			18
19	Professional Services			75,173	75,173		75,173	9,110	84,283			19
20	Dues, Fees, Subscriptions & Promotions			2,875	2,875		2,875	15	2,890			20
21	Clerical & General Office Expenses	18,025	5,048	13,859	36,932		36,932	1	36,933			21
22	Employee Benefits & Payroll Taxes			88,381	88,381		88,381	2	88,383			22
23	Inservice Training & Education			10,653	10,653		10,653		10,653			23
24	Travel and Seminar			1,432	1,432		1,432		1,432			24
25	Other Admin. Staff Transportation			3,988	3,988		3,988	1	3,989			25
26	Insurance-Prop.Liab.Malpractice			10,423	10,423		10,423	1,030	11,453			26
27	Other (specify):*											27
28	TOTAL General Administration	40,577	5,048	206,784	252,409		252,409	12,458	264,867			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	550,130	127,847	279,765	957,742		957,742	12,525	970,267			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			32,716	32,716		32,716		32,716			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			339	339		339		339			35
36	Other (specify):*											36
37	TOTAL Ownership			33,055	33,055		33,055		33,055			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			71,670	71,670		71,670		71,670			42
43	Other (specify):* Disallowed Costs			2,216	2,216		2,216	(2,216)				43
44	TOTAL Special Cost Centers			73,886	73,886		73,886	(2,216)	71,670			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	550,130	127,847	386,706	1,064,683		1,064,683	10,309	1,074,992			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

	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				9
10	Interest and Other Investment Income				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)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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	(1,952)	43		24
25	Fund Raising, Advertising and Promotional	(264)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,216)		\$	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)	12,525		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 12,525		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 10,309		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		\$		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 Lewis Terrace# 0052720

Report Period Beginning:

4/1/2015

Ending:

3/31/2016

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	67	0	0	0	0	0	0	0	0	0	67	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	67	0	0	0	0	0	0	0	0	0	67	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	2,299	0	0	0	0	0	0	0	0	0	2,299	18
19	Professional Services	0	9,110	0	0	0	0	0	0	0	0	0	9,110	19
20	Fees, Subscriptions & Promotions	0	15	0	0	0	0	0	0	0	0	0	15	20
21	Clerical & General Office Expenses	0	1	0	0	0	0	0	0	0	0	0	1	21
22	Employee Benefits & Payroll Taxes	0	2	0	0	0	0	0	0	0	0	0	2	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	0	1	0	0	0	0	0	0	0	0	0	1	25
26	Insurance-Prop.Liab.Malpractice	0	1,030	0	0	0	0	0	0	0	0	0	1,030	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	12,458	0	0	0	0	0	0	0	0	0	12,458	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	12,525	0	0	0	0	0	0	0	0	0	12,525	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lewis Terrace # 0052720 Report Period Beginning: 4/1/2015 Ending: 3/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(2,216)	0	0	0	0	0	0	0	0	0	0	(2,216)	43
44	TOTAL Special Cost Centers	(2,216)	0	0	0	0	0	0	0	0	0	0	(2,216)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,216)	12,525	0	0	0	0	0	0	0	0	0	10,309	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Frances House, Inc.	100	Frances House, Inc. (FH)		See Page 6 Supplemental		
		Pioneer Concepts, Inc. (FH is sole member)				
		Pinnacle Opportunities, Inc. (FH is sole member)				
		Residential Alternatives of Illinois, Inc. (FH is sole member)				
		See Page 6 Supplemental for specific homes				

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	18	Director Fees	\$	Frances House, Inc.	100.00%	\$ 2,299	\$ 2,299	1
2	V	19	Professional Services		Frances House, Inc.	100.00%	9,110	9,110	2
3	V	26	Property Insurance		Frances House, Inc.	100.00%	1,030	1,030	3
4	V	6	Maintenance Supplies		Frances House, Inc.	100.00%	67	67	4
5	V	20	Dues, Fees & Subscriptions		Frances House, Inc.	100.00%	15	15	5
6	V	21	Clerical & General Office Exp		Frances House, Inc.	100.00%	1	1	6
7	V	22	Employee Benefits		Frances House, Inc.	100.00%	2	2	7
8	V	25	Vehicle Expense		Frances House, Inc.	100.00%	1	1	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 12,525	\$ * 12,525	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Lewis Terrace

0052720

Report Period Beginning:

4/1/2015

Ending:

3/31/2016

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	Residential Alternatives of Illinois	100%	Hawthorne Inn of Danville	Danville				1
2	Residential Alternatives of Illinois	100%	Manor Court of Clinton	Clinton				2
3	Residential Alternatives of Illinois	100%	Manor Court of Freeport	Freeport				3
4	Residential Alternatives of Illinois	100%	Manor Court of Peoria	Peoria				4
5	Residential Alternatives of Illinois	100%	Manor Court of Peru	Peru				5
6	Residential Alternatives of Illinois	100%	Manor Court of Princeton	Princeton				6
7	Residential Alternatives of Illinois	100%			Hawthorne Inn of Freeport	Freeport, IL	Supportive Living Facility	7
8	Residential Alternatives of Illinois	100%			Hawthorne Inn of Peoria	Peoria, IL	Assisted Living Facility	8
9	Residential Alternatives of Illinois	100%			Hawthorne Inn of Peru	Peru, IL	Assisted Living Facility	9
10	Residential Alternatives of Illinois	100%			Liberty Estates of Geneseo	Geneseo, IL	Asst'd & Ind Living	10
11	Residential Alternatives of Illinois	100%			Liberty Estates of Streator	Streator, IL	Asst'd & Ind Living	11
12	Residential Alternatives of Illinois	100%			Liberty Estates of Danville	Danville, IL	Indendent Living Facility	12
13	Residential Alternatives of Illinois	100%			Liberty Estates of Freeport	Freeport, IL	Indendent Living Facility	13
14	Residential Alternatives of Illinois	100%			Liberty Estates of Peoria	Peoria, IL	Indendent Living Facility	14
15	Residential Alternatives of Illinois	100%			Liberty Estates of Peru	Peru, IL	Indendent Living Facility	15
16	Residential Alternatives of Illinois	100%	Windmill Manor	Coralville IA				16
17	Frances House, Inc.	100%	Casa Willis	Sterling, IL	Woodburn	Sterling, IL	CILA	17
18	Frances House, Inc.	100%	Freeport Terrace	Freeport, IL				18
19	Frances House, Inc.	100%	Gordon Jones Terrace	Lanark, IL				19
20	Frances House, Inc.	100%	Hallam Terrace	Rockford, IL				20
21	Frances House, Inc.	100%	Hammett House	Sterling, IL				21
22	Frances House, Inc.	100%	Kanthak House	Ottawa, IL				22
23	Frances House, Inc.	100%	Olson Terrace	Rockford, IL				23
24	Frances House, Inc.	100%	Ridge Terrace	Freeport, IL				24
25	Frances House, Inc.	100%	Cantebury Place	Rockford, IL				25
26	Frances House, Inc.	100%	Glenwood Villa	Rockford, IL				26
27	Frances House, Inc.	100%	Rockton Court	Rockford, IL				27
28	Frances House, Inc.	100%	Rose House	Moline, IL				28
29	Frances House, Inc.	100%	Seborg Terrace	Rockford, IL				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Lewis Terrace# 0052720

Report Period Beginning:

4/1/2015

Ending:

3/31/2016

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>Frances House, Inc.</u>	<u>100%</u>	<u>Smith Square</u>	<u>Moline, IL</u>				1
2	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Stern Square</u>	<u>Sterling, IL</u>				2
3	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Stouffer Terrace</u>	<u>Oregon, IL</u>				3
4	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Lewis Terrace</u>	<u>North Chicago, IL</u>				4
5	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Seymour Terrace</u>	<u>North Chicago, IL</u>				5
6	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Waukegan Terrace</u>	<u>Waukegan, IL</u>				6
7	<u>Frances House, Inc.</u>	<u>100%</u>	<u>Pine Terrace</u>	<u>Waukegan, IL</u>				7
8	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Broadway Terrace</u>	<u>Chicago Heights, IL</u>	<u>Woodgate</u>	<u>Matteson</u>	<u>CILA</u>	8
9	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Carole Lane Terrace</u>	<u>Sauk Village, IL</u>	<u>Thornton</u>	<u>Thornton</u>	<u>CILA</u>	9
10	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Flossmoor Terrace</u>	<u>Flossmoor, IL</u>				10
11	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Ravisloe Terrace</u>	<u>Country Club Hills, IL</u>				11
12	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Spaulding Terrace</u>	<u>Markham, IL</u>				12
13	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Calumet City Terrace</u>	<u>Calumet City, IL</u>				13
14	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Dolton Terrace</u>	<u>Dolton, IL</u>				14
15	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Lynwood Terrace</u>	<u>Lynwood, IL</u>				15
16	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Holland Terrace</u>	<u>South Holland, IL</u>				16
17	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Matteson Court</u>	<u>Matteson, IL</u>				17
18	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Priarie House</u>	<u>Sauk Village, IL</u>				18
19	<u>Pioneer Concepts, Inc.</u>	<u>100%</u>	<u>Torrence Place</u>	<u>Sauk Village, IL</u>				19
20	<u>Pinnacle Opportunities</u>	<u>100%</u>	<u>Chambness Square</u>	<u>Bourbannais, IL</u>	<u>Gravlin Square</u>	<u>Bradley, IL</u>	<u>CILA</u>	20
21	<u>Pinnacle Opportunities</u>	<u>100%</u>	<u>Collins Square</u>	<u>Bradley, IL</u>				21
22	<u>Pinnacle Opportunities</u>	<u>100%</u>	<u>Dearborn Court</u>	<u>Kankakee, IL</u>				22
23	<u>Pinnacle Opportunities</u>	<u>100%</u>	<u>River Court</u>	<u>Kankakee, IL</u>				23
24	<u>Pinnacle Opportunities</u>	<u>100%</u>	<u>Station Court</u>	<u>Kankakee, IL</u>				24
25	<u>Pinnacle Opportunities</u>	<u>100%</u>	<u>Eagle Court</u>	<u>Kankakee, IL</u>				25
26	<u>Pinnacle Opportunities</u>	<u>100%</u>	<u>Kankakee Court</u>	<u>Kankakee, IL</u>				26
27	<u>Pinnacle Opportunities</u>	<u>100%</u>	<u>Roy Court</u>	<u>Bourbannais, IL</u>				27
28	<u>Pinnacle Opportunities</u>	<u>100%</u>	<u>Hunt Terrace</u>	<u>Kankakee, IL</u>				28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lewis Terrace # 0052720 Report Period Beginning: 4/1/2015 Ending: 3/31/2016

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	See Attached Schedule 7A								\$ 2,299	L18, C7	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	\$ 2,299		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

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							\$					\$	1
2	N/A												2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	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.) 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

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	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).				\$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	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.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	N/A	8	
		2012	N/A	9	
		2013	N/A	10	
		2014	N/A	11	
		2015	N/A	12	
The facility is owned by a non-profit organization. Real estate taxes are not assessed due to the tax exempt status of the facility. Therefore, no accrual for real estate tax is required.				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 Lewis Terrace COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0052720

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ 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: 6,400

B. General Construction Type: Exterior BrickFrame WoodNumber of Stories 1

C. Does the Operating Entity? X(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? X(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 X 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	3 Facilities		1998	\$ 138,576	1
2					2
3	TOTALS			\$ 138,576	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	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	4		1998	1994	\$ 132,627	\$ 5,305	25	\$ 5,305		\$ 93,723
5	6		1998	1994	\$ 198,940	\$ 7,958	25	\$ 7,958		\$ 140,584
6	6		1998	1994	\$ 198,940	\$ 7,958	25	\$ 7,958		\$ 140,584
7										
8										
	Improvement Type**									
9	Lewis Terrace:									
10		Parking Lot/Sidewalk/Landscaping	1998		7,729		15			7,729
11		Carpet	2002		2,949		5			2,949
12		Heating/Cooling System	2004		5,833	389	15	389		4,440
13		Roof	2009		8,590	859	10	859		5,440
14		VCT Tile	2011		5,658	565	10	565		2,970
15										
16										
17	Seymour Terrace:									
18		Parking Lot/Sidewalks/Landscaping	1998		11,594		15			11,594
19		Carpet	2002		3,454		5			3,454
20		Floor Repair	2003		1,806		10			1,806
21		Heating/Cooling System	2004		5,833	389	15	389		4,440
22		Roof	2009		10,390	1,039	10	1,039		6,580
23		VCT Tile	2011		3,000	300	10	300		1,536
24		New Vinyl	2012		4,975	498	10	498		1,991
25										
26										
27	Waukegan Terrace:									
28		Parking Lot/Sidewalks/Landscaping	1998		11,594		15			11,594
29		Carpet	2002		2,880		5			2,880
30		Floor Repair	2003		1,806		10			1,806
31		Heating/Cooling	2004		5,833	389	15	389		4,472
32		Roof	2009		10,990	1,099	10	1,099		7,052
33		New Vinyl	2012		5,370	537	10	537		2,148
34		Concrete Driveway Section/Sidewalk	2015		2,735	91	15	91		91
35		New Vinyl Tile throughout facility	2016		4,769	79	10	79		79
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 Lewis Terrace

0052720

Report Period Beginning:

4/1/2015

Ending:

3/31/2016

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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									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)		\$ 648,295	\$ 27,455		\$ 27,455	\$	\$ 459,942	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	\$71,422	\$4,639	\$4,639	\$	3-15 yrs	\$36,346	71
72	Current Year Purchases	14,453	622	622		5-15 yrs	622	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$85,875	\$5,261	\$5,261	\$		\$36,968	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	Patient Care	2008 Ford E350 Van Terra	2007	\$45,100	\$	\$	\$	4	\$45,100	76
77	Patient Care	2008 Ford E350 Van Terra	2008	\$46,465				4	46,465	77
78										78
79										79
80	TOTALS			\$91,565	\$	\$	\$		\$91,565	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)	\$964,311	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$32,716	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$32,716	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$588,475	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	N/A				86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A- Facility Owned
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: N/A
- *

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: \$339
- Description: Miscellaneous
- (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	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' PREPARATION REPORT

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

☒

☐

☐

138

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)		25,283		25,283
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 25,283	\$	\$ 25,283
10	SUM OF line 9, col. 1 and 2 (e)	\$ 25,283			

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	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	12

(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.)

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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	171,796	171,796	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivable</u>	4,130,129	4,130,129	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,301,925	\$ 4,301,925	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	138,576	138,576	13
14	Buildings, at Historical Cost	303,501	648,295	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	57,637	177,440	16
17	Accumulated Depreciation (book methods)	(128,964)	(588,475)	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):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 370,750	\$ 375,836	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,672,675	\$ 4,677,761	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 12,990	\$ 12,990	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,161	14,161	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,943	1,943	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 29,094	\$ 29,094	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 29,094	\$ 29,094	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,643,581	\$ 4,648,667	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,672,675	\$ 4,677,761	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,432,331	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,432,331	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	211,250	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)	\$ 211,250	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)	\$ 4,643,581	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Lewis Terrace

0052720

Report Period Beginning: 4/1/2015

Ending: 3/31/2016

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	\$ 1,250,198	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,250,198	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	25,283	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)	\$ 25,283	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	452	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 452	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)	\$ 1,275,933	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	279,303	31
32	Health Care	426,030	32
33	General Administration	252,409	33
	B. Capital Expense		
34	Ownership	33,055	34
	C. Ancillary Expense		
35	Special Cost Centers	2,216	35
36	Provider Participation Fee	71,670	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,064,683	40
41	Income before Income Taxes (line 30 minus line 40)**	211,250	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 211,250	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,250,198	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,250,198	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	630	654	15,896	24.31	4
5	CNAs & Orderlies	32,560	35,048	341,129	9.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	5,210	5,282	76,965	14.57	15
16	Dishwashers					16
17	Maintenance Workers	1,936	2,030	21,644	10.66	17
18	Housekeepers	4,414	2,916	28,690	9.84	18
19	Laundry					19
20	Administrator	769	829	22,552	27.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,800	1,800	18,025	10.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,000	2,000	25,229	12.61	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)	49,319	50,559	\$ 550,130 *	\$ 10.88	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 3,469	L1, C3	35
36	Medical Director	Monthly	4,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	567	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychological Consultant	Monthly	3,420	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 11,656		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Lewis Terrace

STATE OF ILLINOIS

0052720

Report Period Beginning:

4/1/2015

Page 21

Ending: 3/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Katherine Starr	Administrator	None	\$ 22,552
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 22,552

B. Administrative - Other

Description	Amount
N/A	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$

C. Professional Services

Vendor/Payee	Type	Amount
RFMS, Inc.	Administrative Services	\$ 40,800
LTC Support Services, LLC	Support Services	25,560
McGladrey LLP	Accounting Services	4,296
Templin Healthcare Accounting	Accounting Services	1,014
Polsinelli Shughart	Legal Services	3,503
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 75,173

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 9,888
Unemployment Compensation Insurance	15,004
FICA Taxes	35,823
Employee Health Insurance	21,710
Employee Meals	1,786
Illinois Municipal Retirement Fund (IMRF)*	
401k	988
Other Employee Benefits	3,182
Indirect costs	2
TOTAL (agree to Schedule V, line 22, col.8)	\$ 88,383

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	\$
Advertising: Employee Recruitment	211
Health Care Worker Background Check (Indicate # of checks performed 7)	73
Patient Background Checks	
Subscriptions	1,424
IHCA Dues	912
Other Licenses & Fees	255
Indirect costs	15
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 2,890

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	1,432
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 1,432

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

