

		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>0054189</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>ABINGTON OF GLENVIEW NSG</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>04/01/2016</u> to <u>12/31/2016</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>3901 GLENVIEW ROAD</u> <u>GLENVIEW</u> <u>60025</u>			
NumberCityZip Code			
County: <u>COOK</u>			
Telephone Number: <u>(847) 729-0000</u> Fax # <u>(847) 729-1552</u>			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>2/22/16</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____ ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other _____			

☐ GOVERNMENTAL☐ State☐ County☐ Other _____

Facility Name & ID Number ABINGTON OF GLENVIEW NSG

0054189 Report Period Beginning: 04/01/2016 Ending: 12/31/2016

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	<u>192</u>	Skilled (SNF)	<u>192</u>	<u>52,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>192</u>	TOTALS	<u>192</u>	<u>52,800</u>	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			<u>13,149</u>	<u>13,149</u>	8
9	SNF/PED					9
10	ICF	<u>2,145</u>	<u>16,548</u>		<u>18,693</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>2,145</u>	<u>16,548</u>	<u>13,149</u>	<u>31,842</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.31%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 4/1/16

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date 4/1/16 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 13,106

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **ABINGTON OF GLENVIEW NSG** # **0054189** Report Period Beginning: **04/01/2016** Ending: **12/31/2016**
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	364,864	38,417	12,464	415,745		415,745		415,745			1
2	Food Purchase		191,577		191,577	(50,188)	141,389	(1,786)	139,603			2
3	Housekeeping	234,419	36,109		270,528		270,528		270,528			3
4	Laundry	61,902	31,538	177	93,617		93,617		93,617			4
5	Heat and Other Utilities			147,333	147,333		147,333		147,333			5
6	Maintenance	84,916	21,213	56,081	162,210		162,210	2,997	165,207			6
7	Other (specify):*			10,581	10,581		10,581		10,581			7
8	TOTAL General Services	746,101	318,854	226,636	1,291,591	(50,188)	1,241,403	1,211	1,242,614			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,722,640	230,926	16,052	2,969,618		2,969,618		2,969,618			10
10a	Therapy	1,513,625	6,099	39,585	1,559,309		1,559,309		1,559,309			10a
11	Activities	196,828	14,481	1,918	213,227		213,227		213,227			11
12	Social Services	66,441			66,441		66,441		66,441			12
13	CNA Training											13
14	Program Transportation			3,430	3,430		3,430		3,430			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,499,534	251,506	60,985	4,812,025		4,812,025		4,812,025			16
	C. General Administration											
17	Administrative	119,688		615,727	735,415		735,415	(552,129)	183,286			17
18	Directors Fees											18
19	Professional Services			89,961	89,961		89,961		89,961			19
20	Dues, Fees, Subscriptions & Promotions			100,312	100,312		100,312	(91,143)	9,169			20
21	Clerical & General Office Expenses	476,872	48,442	284,468	809,782		809,782	(273,667)	536,115			21
22	Employee Benefits & Payroll Taxes			1,035,993	1,035,993	50,188	1,086,181		1,086,181			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,982	1,982		1,982		1,982			24
25	Other Admin. Staff Transportation			6,494	6,494		6,494	(6,494)				25
26	Insurance-Prop.Liab.Malpractice			146,654	146,654		146,654	14,740	161,394			26
27	Other (specify):*			20,000	20,000		20,000	657	20,657			27
28	TOTAL General Administration	596,560	48,442	2,301,591	2,946,593	50,188	2,996,781	(908,036)	2,088,745			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,842,195	618,802	2,589,212	9,050,209		9,050,209	(906,825)	8,143,384			29

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

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

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	10,646
	REPAIRS & MAINTENANCE		69
	OUTSIDE SERVICES		1,749
3	HOUSEKEEPING		
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		177
			177
5	HEAT & OTHER UTILITIES		
	GAS HEAT		25,375
	ELECTRICITY		74,730
	WATER		34,151
	CABLE TV - LOBBY		13,077
			147,333
6	MAINTENANCE		
	GROUNDS MAINTENANCE		38,254
	PAINTING & DECORATING		0
	BUILDING REPAIRS		630
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		5,252
	ELEVATOR MAINTENANCE & REPAIR		8,575
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		1,304
	FIRE SERVICE		2,066
			56,081
7	OTHER		
	SCAVENGER		10,332
	SECURITY SERVICE		249
			10,581
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	0
			0

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		9,664
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	5,083
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
	NURSING		1,305
			16,052
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		3,000
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	36,585
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			39,585
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,918
			1,918
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	0
			0
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	3,430	
			3,430
17	ADMINISTRATIVE		
	MANAGEMENT FEES XIX B	615,727	615,727
	DIRECTORS FEES		
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING XIX C	55,306	
	ADMINISTRATIVE CONSULTANTS XIX C	12,050	
	PROFESSIONAL FEES XIX C	22,605	
			89,961
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	67,113	
	EMPLOYEE WANT ADS XIX F	0	
	CONTRIBUTIONS VI 20 XIX F	24,030	
	DUES & SUBSCRIPTIONS XIX F	4,216	
	LICENSES & PERMITS XIX F	4,763	
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0	
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	190	
	PATIENT BACKGROUND CHECKS XIX F	0	
			100,312
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	6,164	
	EQUIPMENT REPAIR & MAINTENANCE	2,148	
	OUTSIDE CLERICAL SERVICES	251,771	
	PENALTIES / OVERDRAFT CHARGES VI 18	0	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	24,385	
	MESSENGER SERVICE	0	
			284,468

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES XIX D	428,098	
	UNEMPLOYMENT COMPENSATION XIX D	37,692	
	WORKERS COMPENSATION INSURANCE XIX D	148,097	
	HOSPITALIZATION INSURANCE XIX D	413,055	
	EMPLOYEE BENEFITS - OTHER XIX D	9,051	
	EMPLOYEE PHYSICAL EXAMS XIX D	0	
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS XIX D	0	
			1,035,993
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	0	
			0
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS XIX G	1,982	
	TRAVEL XIX G	0	
			1,982
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	6,494	
			6,494
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	146,654	
			146,654
27	OTHER		
	BAD DEBTS VI 24	20,000	
			20,000

GRAND TOTAL COLUMN 3 OTHER

2,589,212

ABINGTON OF GLENVIEW NSG
SCHEDULES
12/31/2016

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	191,577
LESS SALES TAX	(1,786)
NET FOOD	<u>189,791</u>
TOTAL PATIENT CENSUS	31,842
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	95,526
ADD # EMPLOYEE MEALS/DAY	125
TIMES # DAYS	<u>275</u>
TOTAL EMPLOYEE MEALS	34,375
PATIENT MEALS	95,526
ADD EMPLOYEE MEALS	<u>34,375</u>
TOTAL MEALS/YEAR	129,901
NET FOOD	189,791
DIVIDE TOTAL MEALS/YEAR	<u>129,901</u>
COST PER MEAL	1.46
TIMES EMPLOYEE MEALS	<u>34,375</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>50,188</u></u>

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			58,750	58,750		58,750	(53,444)	5,306			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			85,358	85,358		85,358	(2,708)	82,650			32
33	Real Estate Taxes					374,126	374,126		374,126			33
34	Rent-Facility & Grounds			1,078,964	1,078,964	(374,126)	704,838	(20,104)	684,734			34
35	Rent-Equipment & Vehicles			68,889	68,889		68,889		68,889			35
36	Other (specify):*											36
37	TOTAL Ownership			1,291,961	1,291,961		1,291,961	(76,256)	1,215,705			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		465,654	29,291	494,945		494,945	16,943	511,888			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			186,519	186,519		186,519		186,519			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		465,654	215,810	681,464		681,464	16,943	698,407			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,842,195	1,084,456	4,096,983	11,023,634		11,023,634	(966,138)	10,057,496			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(53,444)	30		9
10	Interest and Other Investment Income	(58)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,786)	2		13
14	Non-Care Related Interest	(2,650)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(24,030)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,000)	27		24
25	Fund Raising, Advertising and Promotional	(67,113)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PG 5A	(165,388)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (334,469)		\$	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)	(631,669)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (631,669)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (966,138)		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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	BANK CHARGE	\$ (6,164)	21	1
2	MARKETING SALARIES	(77,336)	21	2
3	DIRECTOR OF BUSINESS DEVELOP. SALARY	(75,394)	21	3
4	NON ALLOWABLE STAFF TRANSPORTATION	(6,494)	25	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
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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	(165,388)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ABINGTON OF GLENVIEW NSG# 0054189

Report Period Beginning:

04/01/2016

Ending:

12/31/2016**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	(1,786)	0	0	0	0	0	0	0	0	0	0	(1,786)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	2,997	0	0	0	0	0	0	0	0	2,997	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,786)	0	2,997	0	0	0	0	0	0	0	0	1,211	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	(552,129)	0	0	0	0	0	0	0	0	(552,129)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(91,143)	0	0	0	0	0	0	0	0	0	0	(91,143)	20
21	Clerical & General Office Expenses	(158,894)	0	(114,773)	0	0	0	0	0	0	0	0	(273,667)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(6,494)	0	0	0	0	0	0	0	0	0	0	(6,494)	25
26	Insurance-Prop.Liab.Malpractice	0	14,740	0	0	0	0	0	0	0	0	0	14,740	26
27	Other (specify):*	(20,000)	0	20,657	0	0	0	0	0	0	0	0	657	27
28	TOTAL General Administration	(276,531)	14,740	(646,245)	0	0	0	0	0	0	0	0	(908,036)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(278,317)	14,740	(643,248)	0	0	0	0	0	0	0	0	(906,825)	29

Summary B

12/31/2016

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

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ELISHA ATKIN	40.505	OAKRIDGE HEALTHCARE CENTER,LLC	HILLSIDE, ILL	ABINGTON OF		
DACT MANAGEMENT LLC	12.00			GLENVIEW, PROP	GLENVIEW	REAL ESTATE
SANFORD BOKOR TRUST	4.99	MCALLISTER NURSING & REHAB LLC	COUNTRY CLUB	MCALLISTER		
LAWRENCE SCHWARTZ	2.00		HILS	PROPERTY,LLC	COUNTRY CLUB HILLS	REAL ESTATE
JOEL ATKIN	40.505			INNOVATIVE MGT	MORTON GROVE	MANAGEMENT
				OAKRIDGE		
				PROPERTY, LLC	HILLSIDE	REAL ESTATE

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 1,078,964	ABINGTON OF GLENVIEW PROPERTIES, LLC		\$	(1,078,964)	1
2	V	26	INSURANCE - PROPERTY				14,740	14,740	2
3	V	34	RENT				680,860	680,860	3
4	V	34	RENT- REAL ESTATE				378,000	378,000	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,078,964			\$ 1,073,600	\$ * (5,364)	14

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

VII. RELATED PARTIES (continued)

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)	
15	V	39	THERAPY EXPENSE	\$ 7,424	INNOVATIVE MANAGEMENT		\$	\$ (7,424)	15
16	V	21	OUTSIDE CLERICAL	251,771				(251,771)	16
17	V	17	MANAGEMENT FEES	615,727				(615,727)	17
18	V	6	MAINTENANCE SALARIES				2,997	2,997	18
19	V	17	ADMINISTRATOR- ELI ATKIN				31,799	31,799	19
20	V	17	ADMINISTRATION- JOEL ATKIN				31,799	31,799	20
21	V	21	CLERICAL SALARIES				136,998	136,998	21
22	V	39	REHAB DIRECTOR				24,367	24,367	22
23	V	27	EMPLOYEE BENEFITS				20,657	20,657	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 874,922			\$ 248,617	\$ * (626,305)	39

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

Facility Name & ID Number ABINGTON OF GLENVIEW NSG # 0054189 Report Period Beginning: 04/01/2016 Ending: 12/31/2016

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	TZVI (STEVE) ATKIN	OTHER ADMIN	Administration		see attached	see attached		SALARY	\$ 10,970	21-7	1
2								SALARY	29,232	21-1	2
3						10	25.00	P/R TAXES	3,230	27-7	3
4	JOEL ATKIN	OTHER ADMIN	Administration and	40.50	see attached	see attached		SALARY	31,799	17-7	4
5			Financial Service			0	0.00	P/R TAXES	2,882	27-7	5
6	ELISHA ATKIN	ADMINISTRATOR	Adiministator	40.50	see attached	see attached		SALARY	31,799	27-7	6
7						10	16.67	P/R TAXES	2,882	27-7	7
8	YOSEF TZADOK	CLERICAL	Asst in Fin Analysis		see attached	see attached]		SALARY	68,994	21-7	8
9						40	100.00	P/R TAXES	7,782	27-7	9
10								SALARY	20,002	17-1	10
11	COREY FUCHS	CLERICAL	Bookkeeping		see attached	see attached		SALARY	4,772	21-7	11
12						0	0.00	P/R TAXES	835	27-7	12
13								TOTAL	\$ 215,179		13

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

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

Facility Name & ID Number ABINGTON OF GLENVIEW NSG # 0054189 Report Period Beginning: 04/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

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

Facility Name & ID Number ABINGTON OF GLENVIEW NSG # 0054189 Report Period Beginning: 04/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization INNOVATIVE MANAGEMENT ASSOCIATES,
Street Address 8140 RIVER DRIVE
City / State / Zip Code MORTON GROVE ILL 60053
Phone Number (708) 798-2272
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	MAINTENANCE SALARIES	DIRECT	1	1	\$ 2,997	\$ 2,997	1	\$ 2,997	1
2	17	ADMINISTRATOR- ELI ATKIN	DIRECT	1	1	31,799	31,799	1	31,799	2
3	17	ADMINISTRATION- JOEL ATK	DIRECT	1	1	31,799	31,799	1	31,799	3
4	21	CLERICAL SALARIES	DIRECT	1	1	136,998	136,998	1	136,998	4
5	39	REHAB DIRECTOR	DIRECT	1	1	24,367	24,367	1	24,367	5
6	27	EMPLOYEE BENEFITS	DIRECT	1	1	20,657		1	20,657	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 248,617	\$ 227,960		\$ 248,617	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	DACT MANAGEMENT	X		WORKING CAPITAL	INT ONLY	4/1/16	1,000,000	1,300,000	REVOLV	0.0700	67,419	6	
7	BANK LEUMI		X	WORKING CAPITAL	INT ONLY	6/8/16	300,000	1,060,000	REVOLV	PRIME +	13,536	7	
8	MEDLINE		X	THERAPY EQUIPMENT	\$6,492.96	5/19/16	75,846	32,063	05/01/17	0.0500	1,753	8	
9	TOTAL Facility Related				\$6,492.96		\$ 1,375,846	\$ 2,392,063			\$ 82,708	9	
	B. Non-Facility Related*												
10				BED TAX							2,650	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 2,650	14	
15	TOTALS (line 9+line14)						\$ 1,375,846	\$ 2,392,063			\$ 85,358	15	

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

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

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

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.	\$		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.)	\$		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 \$ 200 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		8	
	2012		9	
	2013		10	
	2014		11	
	2015		12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				
THE PAYMENT ON LINE 2 APPLIES TO THE 2015 TAX BILL.				

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

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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ABINGTON OF GLENVIEW NSG COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0054189

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

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.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 04-32-401-167-0000	NURSING HOME	\$ 497,928.32	\$ 374,126.00
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 497,928.32	\$ 374,126.00

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 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.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies of their original second installment tax bill.

A. Square Feet: 73,817

B. General Construction Type: Exterior BRICK MASONRY Frame STEEL Number of Stories 3

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).

N/A

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				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

*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

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			\$	\$		\$	\$		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)		\$	\$		\$	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 106,126	\$ 58,750	\$ 5,306	\$ (53,444)	10 YR	\$ 5,306	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 106,126	\$ 58,750	\$ 5,306	\$ (53,444)		\$ 5,306	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$	106,126
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	58,750
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	5,306
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(53,444)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	5,306

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: GLENRIDGE ASSOCIATES II D/B/A/ THE ABINGTON OF GLENVIEW

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:	1989	192	4/1/16	\$ 1,078,964			3
4	Additions							4
5								5
6								6
7	TOTAL		192		\$ 1,078,964			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: \$95,000 per bed or \$18,240,000 *

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: \$ 68,889 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 4/1/16

Ending 3/31/21

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>4/1/2017</u>	\$ <u>950,000</u>
13.	<u>4/1/2018</u>	\$ <u>950,000</u>
14.	<u>4/1/2019</u>	\$ <u>950,000</u>

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

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

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

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

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

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		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	39-3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			600			600	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			7,424			7,424	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				463,206		463,206	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Radiology, EKG, Dentals Other (specify): Med. Supplies					21,267	2,448		21,267 2,448	13
14	TOTAL			\$		\$ 29,291	\$ 465,654		\$ 494,945	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 19,302	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (20,000))	2,669,446		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,720		6
7	Other Prepaid Expenses	5,253		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE FROM AFFILIATES	1,332,341		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,123,062	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	106,126		16
17	Accumulated Depreciation (book methods)	(58,750)		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 (spec Deposit on Fixed Asse	485,960		22
23	Other(specify): Due From Abington of Glenview	659,899		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,193,235	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,316,297	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 930,621	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,060,000		29
30	Accrued Salaries Payable	334,949		30
31	Accrued Taxes Payable (excluding real estate taxes)	50,077		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	Due to Prior Owner	45,089		36
37	Note Payable - Medline	32,063		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,452,799	\$	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	Members' Loans Payable	60,000		43
44	Note Payable _ Dact	1,300,000		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,360,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,812,799	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,503,498	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,316,297	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,553,698	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	(50,200)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,503,498	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)	\$ 1,503,498	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number ABINGTON OF GLENVIEW NSG

0054189

Report Period Beginning: 04/01/2016

Ending: 12/31/2016

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	\$ 11,921,590	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,921,590	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	387,965	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 387,965	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	(1,334)	13
14	Non-Patient Meals	5,000	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)	\$ 3,666	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	58	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 58	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VACATION PAY SETTLEMENT	264,053	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 264,053	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,577,332	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,291,591	31
32	Health Care	4,812,025	32
33	General Administration	2,946,593	33
	B. Capital Expense		
34	Ownership	1,291,961	34
	C. Ancillary Expense		
35	Special Cost Centers	494,945	35
36	Provider Participation Fee	186,519	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,023,634	40
41	Income before Income Taxes (line 30 minus line 40)**	1,553,698	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,553,698	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 331,685	44
45	Private Pay - Net Inpatient Revenue	4,153,072	45
46	Medicare - Net Inpatient Revenue	7,408,489	46
47	Other-(specify) INSURANCE	28,344	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,921,590	49

****TAX RETURN PREPARED ON CASH BASIS**

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? **NO**** If not, please attach a reconciliation.

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,456	1,568	\$ 76,736	\$ 48.94	1
2	Assistant Director of Nursing	1,471	1,647	67,581	41.03	2
3	Registered Nurses	29,028	31,622	988,074	31.25	3
4	Licensed Practical Nurses	6,955	7,922	228,751	28.88	4
5	CNAs & Orderlies	73,833	78,925	1,133,654	14.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	36,091	37,450	1,513,625	40.42	8
9	Activity Director	2,859	3,171	69,549	21.93	9
10	Activity Assistants	8,904	9,469	127,279	13.44	10
11	Social Service Workers	2,507	2,954	66,441	22.49	11
12	Dietician					12
13	Food Service Supervisor	1,448	1,568	42,775	27.28	13
14	Head Cook	5,915	6,339	95,356	15.04	14
15	Cook Helpers/Assistants	18,896	20,392	226,733	11.12	15
16	Dishwashers					16
17	Maintenance Workers	3,590	3,950	84,916	21.50	17
18	Housekeepers	16,512	18,199	234,419	12.88	18
19	Laundry	4,240	4,776	61,902	12.96	19
20	Administrator	1,848	2,279	99,686	43.74	20
21	Assistant Administrator	1,008	1,040	20,002	19.23	21
22	Other Administrative					22
23	Office Manager	936	960	37,500	39.06	23
24	Clerical	16,960	18,901	439,372	23.25	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	2,702	3,086	51,352	16.64	31
32	Other Health Care(specify)	7,053	7,897	176,492	22.35	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	244,212	264,115	\$ 5,842,195 *	\$ 22.12	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	M	\$ 10,646	1-3	35
36	Medical Director	O	0	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,083	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		36,585	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,918	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 54,232		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

Facility Name & ID Number

ABINGTON OF GLENVIEW NSG

STATE OF ILLINOIS

0054189

Report Period Beginning:

04/01/2016

Page 21

Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JASON LEE	ADMINISTRATOR		\$ 72,194
YOSEF TSADOK	ASST ADMIN		20,002
	OTHER ADMIN		0
MARILYN NOVAK	ADMINISTRATOR		27,492
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 119,688

B. Administrative - Other

Description	Amount
MANAGEMENT FEES- INNOVATIVE	615,727
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 615,727

C. Professional Services

Vendor/Payee	Type	Amount
		\$
SEE SCHEDULE ATTACHED		89,961
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 89,961

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 148,097
Unemployment Compensation Insurance	37,692
FICA Taxes	428,098
Employee Health Insurance	413,055
Employee Meals	50,188
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	9,051
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,086,181

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 0
Advertising: Employee Recruitment	0
Health Care Worker Background Check (Indicate # of checks performed)	190
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	24,030
MARKETING/ADV/PROMO	67,113
LICENSES/DUES/SUBSCRIPTIONS	8,979
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	(24,030)
Less: Public Relations Expense	(0)
Non-allowable advertising	(67,113)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,169

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
	0
Seminar Expense	
	1,982
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 1,982

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

**ABINGTON OF GLENVIEW NSG
SCHEDULE-LEGAL
12/31/2016**

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report?

NO

If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization?

NO

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?

10 YR

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

\$

Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement?

YES

X

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

186,519

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.

\$

50,188

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

NO

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

5%

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:

(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