

		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: 0053355 Facility Name: Ballard Respiratory & Rehab Address: 9300 Ballard Road Des Plaines 60016 County: Cook Telephone Number: (847) 294-2300 Fax #: (847) 299-4012 HFS ID Number: Date of Initial License for Current Owners: 12/08/2014 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Charles J. Fischer Telephone Number: (312) 634-4580 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 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. Officer or Administrator of Provider (Signed) (Type or Print Name) Sidney Glenner (Title) President Paid Preparer (Signed) (Print Name and Title) (Firm Name & Address) RSM US LLP One S. Wacker Drive, Suite 800, Chicago, IL 60606-4650 (Telephone) (312) 384-6000 Fax #: (312) 634-5518 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number Ballard Respiratory & Rehab

0053355 Report Period Beginning: 01/01/2016 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

N/A

	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>231</u>	Skilled (SNF)	<u>231</u>	<u>84,546</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>0</u>	Intermediate (ICF)	<u>0</u>	<u>0</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>231</u>	TOTALS	<u>231</u>	<u>84,546</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,091</u>	<u>745</u>	<u>7,282</u>	<u>17,118</u>	8
9	SNF/PED					9
10	ICF	<u>27,271</u>	<u>2,236</u>	<u>0</u>	<u>29,507</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>36,362</u>	<u>2,981</u>	<u>7,282</u>	<u>46,625</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.15%

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

12/08/2014

J. Was the facility purchased or leased after January 1, 1978?

YES

☒

Date

12/08/2014

NO

☐

K. Was the facility certified for Medicare during the reporting year?

YES

☒

NO

☐

If YES, enter number

of beds certified

231

and days of care provided

4,740

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

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 **Ballard Respiratory & Rehab** # **0053355** Report Period Beginning: **01/01/2016** 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		40,247	579,364	619,611		619,611		619,611			1
2	Food Purchase		401,812		401,812	(20,629)	381,183	(24,206)	356,977			2
3	Housekeeping	259,618	43,247		302,865		302,865		302,865			3
4	Laundry	126,519	7,295	13,427	147,241		147,241		147,241			4
5	Heat and Other Utilities			240,963	240,963		240,963	3,116	244,079			5
6	Maintenance	98,448	36,678	176,608	311,734		311,734	6,623	318,357			6
7	Other (specify):* Allocated Employee Benefits							352	352			7
8	TOTAL General Services	484,585	529,279	1,010,362	2,024,226	(20,629)	2,003,597	(14,115)	1,989,482			8
	B. Health Care and Programs											
9	Medical Director			111,000	111,000		111,000		111,000			9
10	Nursing and Medical Records	5,606,215	961,931	391,013	6,959,159		6,959,159	(109,347)	6,849,812			10
10a	Therapy	1,242,897	8,621	1,068,809	2,320,327		2,320,327	(167,927)	2,152,400			10a
11	Activities	155,269	3,504	816	159,589		159,589		159,589			11
12	Social Services	98,832		23,154	121,986		121,986		121,986			12
13	CNA Training											13
14	Program Transportation			4,408	4,408		4,408		4,408			14
15	Other (specify):* Allocated Employee Benefits							93,356	93,356			15
16	TOTAL Health Care and Programs	7,103,213	974,056	1,599,200	9,676,469		9,676,469	(183,918)	9,492,551			16
	C. General Administration											
17	Administrative	106,569			106,569		106,569	18,488	125,057			17
18	Directors Fees											18
19	Professional Services			219,746	219,746	(47,279)	172,467	32,721	205,188			19
20	Dues, Fees, Subscriptions & Promotions			62,712	62,712	760	63,472	(4,802)	58,670			20
21	Clerical & General Office Expenses	399,922	112,121	67,555	579,598	(760)	578,838	427,826	1,006,664			21
22	Employee Benefits & Payroll Taxes			1,753,149	1,753,149	20,629	1,773,778		1,773,778			22
23	Inservice Training & Education			1,630	1,630		1,630	2,801	4,431			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			717	717		717	7,652	8,369			25
26	Insurance-Prop.Liab.Malpractice			276,696	276,696		276,696	5,314	282,010			26
27	Other (specify):* Allocated Employee Benefits							76,383	76,383			27
28	TOTAL General Administration	506,491	112,121	2,382,205	3,000,817	(26,650)	2,974,167	566,383	3,540,550			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,094,289	1,615,456	4,991,767	14,701,512	(47,279)	14,654,233	368,350	15,022,583			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			30,982	30,982		30,982	541,429	572,411			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			102,916	102,916		102,916	792,801	895,717			32
33	Real Estate Taxes					47,279	47,279	517,782	565,061			33
34	Rent-Facility & Grounds			1,579,303	1,579,303		1,579,303	(1,540,603)	38,700			34
35	Rent-Equipment & Vehicles			19,427	19,427		19,427	9,209	28,636			35
36	Other (specify):* Amort Intang Assets							313,000	313,000			36
37	TOTAL Ownership			1,732,628	1,732,628	47,279	1,779,907	633,618	2,413,525			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		462,816	181,020	643,836		643,836	(60,648)	583,188			39
40	Barber and Beauty Shops			(601)	(601)		(601)		(601)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			380,246	380,246		380,246		380,246			42
43	Other (specify):* Non-Allowable Costs			3,150,380	3,150,380		3,150,380	(3,150,380)				43
44	TOTAL Special Cost Centers		462,816	3,711,045	4,173,861		4,173,861	(3,211,028)	962,833			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,094,289	2,078,272	10,435,440	20,608,001		20,608,001	(2,209,060)	18,398,941			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	(4,525)	21		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	(1,724)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(205,218)	43		18
19	Entertainment				19
20	Contributions	(5,000)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,915,279)	43		24
25	Fund Raising, Advertising and Promotional	(21,116)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Schedule F:	(276,717)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,429,579)		\$	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)	1,220,519		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,220,519		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,209,060)		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			X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Adjust Mgt Co. medical supplies"A" to cost	\$ (16,093)	10	1
2	Adjust Mgt Co. medical supplies"other" to cost	(93,254)	10	2
3	Adjust Mgt Co. food to cost	(24,206)	2	3
4	Non-allowable patient clothing	(2,043)	43	4
5	Non-allowable professional fees	(71,420)	19	5
6	Non-allowable office expense	(250)	43	6
7	Non-allowable bank fees	(585)	43	7
8	Non-allowable auto expense - marketing	(717)	25	8
9	Non-allowable Illinois Council on Long Term Care Dues	(7,501)	20	9
10	Adjust pharmacy expense to cost	(60,648)	39	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	(276,717)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Ballard Respiratory & Rehab # 0053355 Report Period Beginning: 01/01/2016 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	(24,206)	0	0	0	0	0	0	0	0	0	0	(24,206)	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	3,116	0	0	0	0	0	0	0	0	3,116	5
6	Maintenance	0	0	6,621	0	2	0	0	0	0	0	0	6,623	6
7	Other (specify):*	0	0	352	0	0	0	0	0	0	0	0	352	7
8	TOTAL General Services	(24,206)	0	10,089	0	2	0	0	0	0	0	0	(14,115)	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	(109,347)	0	0	0	0	0	0	0	0	0	0	(109,347)	10
10a	Therapy	0	0	0	0	(167,927)	0	0	0	0	0	0	(167,927)	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	93,356	0	0	0	0	0	0	93,356	15
16	TOTAL Health Care and Programs	(109,347)	0	0	0	(74,571)	0	0	0	0	0	0	(183,918)	16
	C. General Administration													
17	Administrative	0	0	18,488	0	0	0	0	0	0	0	0	18,488	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(71,420)	0	15,483	47,279	41,379	0	0	0	0	0	0	32,721	19
20	Fees, Subscriptions & Promotions	(7,501)	0	1,517	0	1,182	0	0	0	0	0	0	(4,802)	20
21	Clerical & General Office Expenses	(4,525)	0	428,477	0	3,874	0	0	0	0	0	0	427,826	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	1,036	0	1,765	0	0	0	0	0	0	2,801	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(717)	0	6,819	0	1,550	0	0	0	0	0	0	7,652	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,950	0	1,364	0	0	0	0	0	0	5,314	26
27	Other (specify):*	0	0	76,176	0	207	0	0	0	0	0	0	76,383	27
28	TOTAL General Administration	(84,163)	0	551,946	47,279	51,321	0	0	0	0	0	0	566,383	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(217,716)	0	562,035	47,279	(23,248)	0	0	0	0	0	0	368,350	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Ballard Respiratory & Rehab # 0053355 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	7,429	534,000	0	0	0	0	0	0	0	541,429	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	792,801	0	0	0	0	0	0	0	792,801	32
33	Real Estate Taxes	0	0	5,619	512,163	0	0	0	0	0	0	0	517,782	33
34	Rent-Facility & Grounds	0	0	0	(1,540,603)	0	0	0	0	0	0	0	(1,540,603)	34
35	Rent-Equipment & Vehicles	0	0	9,209	0	0	0	0	0	0	0	0	9,209	35
36	Other (specify):*	0	0	0	313,000	0	0	0	0	0	0	0	313,000	36
37	TOTAL Ownership	0	0	22,257	611,361	0	0	0	0	0	0	0	633,618	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	(60,648)	0	0	0	0	0	0	0	0	0	0	(60,648)	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):*	(3,151,215)	0	0	835	0	0	0	0	0	0	0	(3,150,380)	43
44	TOTAL Special Cost Centers	(3,211,863)	0	0	835	0	0	0	0	0	0	0	(3,211,028)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,429,579)	0	584,292	659,475	(23,248)	0	0	0	0	0	0	(2,209,060)	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
Sidney Glenner		See Attached Page 6 -Supplemental		See Attached Schedule A		
Joshua Ray						

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	Total from Page 6A	\$	Glen Health and Home Management, Inc.	A	\$ 584,292	\$ 584,292	1	
2	V							2	
3	V	Total from Page 6B	1,540,603	Ballard Respiratory and Rehabilitation Center Real Estate, LLC	B	2,200,078	659,475	3	
4	V							4	
5	V	Total from Page 6C	1,068,809	Therapy Masters, Inc.	C	1,045,561	(23,248)	5	
6	V							6	
7	V							7	
8	V							8	
9	V			OWNERSHIP REFERENCE:				9	
10	V			A: Sidney Glenner 100.00 % through attribution				10	
11	V			B: Sidney Glenner 50.00 %, Joshua Ray 50.00 %				11	
12	V			C: Sidney Glenner 100.00 %				12	
13	V							13	
14	Total		\$ 2,609,412			\$ 3,829,931	\$ * 1,220,519	14	

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

Facility Name & ID Number

Ballard Respiratory & Rehab

0053355

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	Sidney Glenner	100.00 %	GlenBridge Nursing & Rehabilitation	Niles	See Attached Schedule A			1
2			Centre, Ltd.					2
3								3
4	Sidney Glenner	100.00 %	GlenCrest Nursing & Rehabilitation	Chicago				4
5			Centre, Ltd.					5
6								6
7	Sidney Glenner	100.00 %	Glen Elston Nursing & Rehabilitation	Chicago				7
8			Centre, Ltd.					8
9								9
10	Sidney Glenner	100.00 %	Glen Oaks Nursing & Rehabilitation	Northbrook				10
11			Centre, Ltd.					11
12								12
13	Sidney Glenner	100.00 %	GlenShire Nursing & Rehabilitation	Richton Park				13
14			Centre, Ltd.					14
15								15
16	Sidney Glenner	80.00 %	GlenLake Terrace Nursing & Rehabilitation	Waukegan				16
17	Joshua Ray	20.00 %	Centre, Ltd.					17
18								18
19								19
20	Sidney Glenner	99.00 %	Brentwood North Healthcare and Rehabilitation	Riverwoods				20
21	Joshua Ray	1.00 %	Centre, Inc.					21
22								22
23	Sidney Glenner	50.00 %	Glen Saint Andrew Living Community LLC.	Niles				23
24	Joshua Ray	50.00 %						24
25								25
26								26
27								27
28								28
29								29
30								30

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	17	Management Fees	\$	Glen Health and Home Management, Inc.	A	\$		15
16	V	5	Utilities		Glen Health and Home Management, Inc.	A	3,116	3,116	16
17	V	6	Repairs and Maintenance		Glen Health and Home Management, Inc.	A	4,669	4,669	17
18	V	19	Professional Fees		Glen Health and Home Management, Inc.	A	15,483	15,483	18
19	V	20	Licenses, Permits and Inspection		Glen Health and Home Management, Inc.	A	1,517	1,517	19
20	V	21	Clerical		Glen Health and Home Management, Inc.	A	24,615	24,615	20
21	V	22	Employee Benefits and Payroll		Glen Health and Home Management, Inc.	A	76,528	76,528	21
22	V	23	Training and Education		Glen Health and Home Management, Inc.	A	1,036	1,036	22
23	V	25	Auto Expenses		Glen Health and Home Management, Inc.	A	6,819	6,819	23
24	V	26	Insurance		Glen Health and Home Management, Inc.	A	3,950	3,950	24
25	V	30	Depreciation		Glen Health and Home Management, Inc.	A	7,429	7,429	25
26	V	33	Real Estate Taxes		Glen Health and Home Management, Inc.	A	5,619	5,619	26
27	V	35	Equipment and Vehicle Rental		Glen Health and Home Management, Inc.	A	9,209	9,209	27
28	V	6	Janitorial Salaries		Glen Health and Home Management, Inc.	A	1,952	1,952	28
29	V	17	Officer's Salaries		Glen Health and Home Management, Inc.	A	18,488	18,488	29
30	V	21	Administrative Salaries		Glen Health and Home Management, Inc.	A	403,862	403,862	30
31	V	22	Employee Benefits		Glen Health and Home Management, Inc.	A	(76,528)	(76,528)	31
32	V	7	Employee Benefits - Janitorial		Glen Health and Home Management, Inc.	A	352	352	32
33	V	27	Employee Benefits - Officer's		Glen Health and Home Management, Inc.	A	3,337	3,337	33
34	V	27	Employee Benefits - Admin		Glen Health and Home Management, Inc.	A	72,839	72,839	34
35	V								35
36	V								36
37	V				A - Ownership: Sidney Glenner - 100 % through attribution				37
38	V								38
39	Total			\$			\$ 584,292	\$ * 584,292	39

* 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	32	Interest Expense	\$	Ballard Respiratory and Rehabilitation Center Real Estate, LLC	B	\$ 756,902	\$	756,902 15
16	V	30	Depreciation		Ballard Respiratory and Rehabilitation Center Real Estate, LLC	B	534,000		534,000 16
17	V	33	Real Estate Taxes		Ballard Respiratory and Rehabilitation Center Real Estate, LLC	B	512,163		512,163 17
18	V	34	Rental Income	1,540,603	Ballard Respiratory and Rehabilitation Center Real Estate, LLC	B			(1,540,603) 18
19	V	32	Interest Income		Ballard Respiratory and Rehabilitation Center Real Estate, LLC	B	(610)		(610) 19
20	V	19	Professional Fees		Ballard Respiratory and Rehabilitation Center Real Estate, LLC	B	47,279		47,279 20
21	V	32	Amortization of Mortgage Costs		Ballard Respiratory and Rehabilitation Center Real Estate, LLC	B	36,509		36,509 21
22	V	43	Office Expense		Ballard Respiratory and Rehabilitation Center Real Estate, LLC	B	250		250 22
23	V	43	Bank Fees		Ballard Respiratory and Rehabilitation Center Real Estate, LLC	B	585		585 23
24	V	36	Amortization of Intangible Assets		Ballard Respiratory and Rehabilitation Center Real Estate, LLC	B	313,000		313,000 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				B- Ownership:				34
35	V				Sidney Glenner - 50.00 %				35
36	V				Joshua Ray - 50.00 %				36
37	V								37
38	V								38
39	Total			\$ 1,540,603			\$ 2,200,078	\$ *	659,475 39

* 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	10a	Therapy	\$ 1,068,809	Therapy Masters, Inc.	C	\$ 900,882	\$ (167,927)	15
16	V	19	Professional Fees		Therapy Masters, Inc.	C	41,379	41,379	16
17	V	20	Licenses, Permits, and Inspection		Therapy Masters, Inc.	C	1,182	1,182	17
18	V	6	Repairs and Maintenance		Therapy Masters, Inc.	C	2	2	18
19	V	21	Clerical		Therapy Masters, Inc.	C	1,972	1,972	19
20	V	22	Employee Benefits and Payroll		Therapy Masters, Inc.	C	93,563	93,563	20
21	V	23	Training and Education		Therapy Masters, Inc.	C	1,765	1,765	21
22	V	25	Auto Expenses		Therapy Masters, Inc.	C	1,550	1,550	22
23	V	21	Clerical Salaries		Therapy Masters, Inc.	C	1,902	1,902	23
24	V	22	Employee Benefits		Therapy Masters, Inc.	C	(93,563)	(93,563)	24
25	V	15	Employee Benefits - Therapy		Therapy Masters, Inc.	C	93,356	93,356	25
26	V	27	Employee Benefits - Clerical		Therapy Masters, Inc.	C	207	207	26
27	V	26	Liability Insurance		Therapy Masters, Inc.	C	1,364	1,364	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V				C - Ownership: 100.00 % Sidney Glenner				34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,068,809			\$ 1,045,561	\$ * (23,248)	39

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

Facility Name & ID Number Ballard Respiratory & Rehab # 0053355 Report Period Beginning: 01/01/2016 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	Sidney Glenner	Chairman of Board	Administrative	50.00 %	212,933	6	10.00 %	Salary	\$ 18,488	Ln 17, Col 7	1
2	Jonathan Glenner	Clerical	Clerical	0.00 %	49,526	4	10.00 %	Salary	4,300	Ln 21, Col 7	2
3	Daniel Glenner	President	Administrative	0.00 %	178,196	4	10.00 %	Salary	15,472	Ln 21, Col 7	3
4	Elliot Glenner	Dir of Purchasing	Administrative	0.00 %	84,159	4	10.00 %	Salary	7,307	Ln 21, Col 7	4
5											5
6											6
7											7
8											8
9											9
10		See Schedule B									10
11											11
12											12
13								TOTAL	\$ 45,567		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 Ballard Respiratory & Rehab# 0053355

Report Period Beginning:

01/01/2016Ending: 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

Glen Health & Home Management, Inc.

Street Address

5454 West Fargo Avenue

City / State / Zip Code

Skokie, IL 60077

Phone Number

(847) 674-5454

Fax Number

(847) 674-8311

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, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	5	Utilities	Resident Days	583,629	9	\$ 39,007	\$ 46,625	\$ 3,116	1
2	6	Repairs and Maintenance	Resident Days	583,629	9	58,439	46,625	4,669	2
3	19	Professional Fees	Resident Days	583,629	9	193,812	46,625	15,483	3
4	20	Licenses, Permits and Inspection	Resident Days	583,629	9	18,995	46,625	1,517	4
5	21	Clerical	Resident Days	583,629	9	308,114	46,625	24,615	5
6	22	Employee Benefits and Payroll	Resident Days	583,629	9	957,941	46,625	76,528	6
7	23	Training and Education	Resident Days	583,629	9	12,962	46,625	1,036	7
8	25	Auto Expenses	Resident Days	583,629	9	85,358	46,625	6,819	8
9	26	Insurance	Resident Days	583,629	9	49,447	46,625	3,950	9
10	30	Depreciation	Resident Days	583,629	9	92,988	46,625	7,429	10
11	33	Real Estate Taxes	Resident Days	583,629	9	70,340	46,625	5,619	11
12	35	Equipment and Vehicle Rental	Resident Days	583,629	9	115,277	46,625	9,209	12
13	6	Janitorial Salaries	Resident Days	583,629	9	24,431	24,431	1,952	13
14	17	Officer's Salaries	Resident Days	583,629	9	231,420	231,420	18,488	14
15	21	Administrative Salaries	Resident Days	583,629	9	5,055,342	5,055,342	403,862	15
16	22	Employee Benefits	Payroll					(76,528)	16
17	7	Employee Benefits - Janitorial	Payroll					352	17
18	27	Employee Benefits - Officer's	Payroll					3,337	18
19	27	Employee Benefits - Admin	Payroll					72,839	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 7,313,873	\$ 5,311,193	\$ 584,292	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	The Private Bank		X	Mortgage		12/08/14	\$ 19,418,325	\$ 19,418,325	12/08/2024	0.0400	\$ 756,902	1	
2	The Private Bank		X	Amortization of mortgage costs							36,509	2	
3												3	
4												4	
5												5	
	Working Capital												
6	SLG Limited Partnership	X		Working Capital		12/31/14	800,000	800,000				6	
7	Joshua Ray	X		Working Capital		12/31/14	800,000	800,000				7	
8	The Private Bank		X	Working Capital		12/08/14	2,325,131	2,325,131		0.0400	102,916	8	
9	TOTAL Facility Related						\$ 23,343,456	\$ 23,343,456			\$ 896,327	9	
	B. Non-Facility Related*												
10									Interest Income Offset:			(610)	10
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (610)	14	
15	TOTALS (line 9+line14)						\$ 23,343,456	\$ 23,343,456			\$ 895,717	15	

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

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

** 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

[illegible]

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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ballard Respiratory & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053355

CONTACT PERSON REGARDING THIS REPORT Charles J. Fischer

TELEPHONE (312) 634-4580 FAX #: (312) 634-5518

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) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 09-15-303-013-0000	9300 Ballard Road, Des Plaines, IL	\$ 708,162.70	\$ 708,162.70
2. Allocated from Management Company:		\$ 74,688.61	\$ 5,619.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 782,851.31	\$ 713,781.70

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: 52,917

B. General Construction Type: Exterior Brick Frame 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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient Care	83,740	2014	\$ 1,100,000	1
2	Allocated from Management Company:			6,787	2
3	TOTALS	83,740		\$ 1,106,787	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	231		2014	1974	\$ 10,800,000	\$ 364,000	30	\$ 364,000	\$	\$ 728,000	4	
5											5	
6	See Attached		1996		146,428			4,777	4,777		6	
7	Schedule J										7	
8											8	
	Improvement Type**											
9	Furnish and install free standing building exterior monument sign			2014	17,100	1,710	10	1,710		4,275	9	
10	Furnish and install signage on east exterior wall of building and west exterior			2015	17,970	1,797	10	1,797		2,696	10	
11	wall of building at the fourth floor										11	
12	Install new LED lighting and power supplies on signage on the exterior			2015	6,580	658	10	658		987	12	
13	west and east walls of the building										13	
14	New controllers, operators and wiring for elevator modernization			2015	35,000	3,500	10	3,500		5,250	14	
15	Furnish and install cast iron pipe and drain pipe in kitchen			2016	6,700	335	10	335		335	15	
16	Replace boiler heat exchanger			2016	3,425	171	10	171		171	16	
17	Furnish and install wristband security system and power supply			2016	10,130	507	10	507		507	17	
18	Electrical labor project on generator circuits			2016	9,535	477	10	477		477	18	
19	Remove and re-insulate piping from two chilled water pipes			2016	15,675	784	10	784		784	19	
20	Install electrical panel in the basement, reroute branch circuits			2016	4,380	219	10	219		219	20	
21	Install new 200 amp breaker in the panel in the basement and on second floor			2016	4,000	200	10	200		200	21	
22	Pull new amp circuit from the electrical panel in the medicine room to outside			2016	5,600	280	10	280		280	22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29	See Attached Schedule L:										29	
30	Leasehold Improvements Allocated from Management Company			1998	8,064						30	
31	Leasehold Improvements Allocated from Management Company			1999	3,367						31	
32	Leasehold Improvements Allocated from Management Company			2000	404						32	
33	Leasehold Improvements Allocated from Management Company			2008	1,214						33	
34	Leasehold Improvements Allocated from Management Company			2016	12,030			1,588	1,588	17,535	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

Facility Name & ID Number Ballard Respiratory & Rehab

0053355

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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)		\$ 11,107,602	\$ 374,638		\$ 381,003	\$ 6,365	\$ 761,716	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	\$1,779,126	\$181,054	\$181,054	\$	5, 10 years	\$359,650	71
72	Current Year Purchases	110,103	9,291	9,291		5, 10 years	9,291	72
73	Fully Depreciated Assets							73
74	Allocated from Therapy Masters, Mgt Co:	64,916		737	737		55,430	74
75	TOTALS	\$1,954,145	\$190,345	\$191,082	\$737		\$424,371	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	Allocated from Management Company:			\$13,610	\$	\$326	\$326	5 years	\$13,445
77									
78									
79									
80	TOTALS			\$13,610	\$	\$326	\$326		\$13,445

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)			\$	14,182,144
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	564,983
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	572,411
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	7,428
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,199,532

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: _____

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 N/A.

N/A

N/A

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: \$ 22,469 Description: Copier \$17,477, Postage \$600, Ice-machine \$1,350, Allocated from Mgt Company: \$3,042

(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	<u>Allocated from Management Company:</u>		\$	\$ <u>6,167</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 6,167	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2017 \$ _____

13. /2018 \$ _____

14. /2019 \$ _____

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

It is the policy of this facility to hire only certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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	Ln 10a, Col 2&3	hrs	\$	8,127	\$ 448,807	\$ 150	8,127	\$ 448,957	1
2	Licensed Speech and Language Development Therapist	Ln 10a, Col 3	hrs		1,697	98,536		1,697	98,536	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln10a,Col 2&3	hrs		9,152	521,461	8,471	9,152	529,932	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, Col 2	# of prescrpts				462,816		462,816	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Radiology, Laboratory, Dialysis Other (specify): Respiratory Therapist	Ln 39, Col 2 Ln 39, Col 2	45,585 hours	1,242,897		181,020		45,585	181,020 1,242,897	13
14	TOTAL			\$ 1,242,897	18,976	\$ 1,249,824	\$ 471,437	64,561	\$ 2,964,158	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	\$ (1,619,178)	\$ (537,942)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 44,633)	6,787,940	6,787,940	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	302,773	302,773	7
8	Accounts Receivable (owners or related parties)		939,228	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,471,535	\$ 7,491,999	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,106,787	13
14	Buildings, at Historical Cost		10,946,428	14
15	Leasehold Improvements, at Historical Cost	136,095	161,174	15
16	Equipment, at Historical Cost	189,229	1,967,755	16
17	Accumulated Depreciation (book methods)	(45,122)	(1,199,532)	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) Intangible Assets		2,501,101	22
23	Other(specify): Mortgage Costs (Net):		109,528	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 280,202	\$ 15,593,241	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,751,737	\$ 23,085,240	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,220,418	\$ 5,079,962	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	439,503	439,503	30
31	Accrued Taxes Payable (excluding real estate taxes)	98	98	31
32	Accrued Real Estate Taxes(Sch.IX-B)		744,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule E:	542,118	542,118	36
37	Loans Payable - Bank:	2,325,131	2,325,131	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,527,268	\$ 9,130,812	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		19,418,325	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Shareholder Loans:	1,600,000	1,600,000	43
44	Due to Related Parties:	4,823,769	5,970,269	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,423,769	\$ 26,988,594	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,951,037	\$ 36,119,406	46
47	TOTAL EQUITY(page 18, line 24)	\$ (8,199,300)	\$ (13,034,166)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,751,737	\$ 23,085,240	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,805,309)	1
2	Restatements (describe):		2
3	Y/E 12/31/2015 AJE	32,678	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,772,631)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(5,426,669)	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)	\$ (5,426,669)	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)	\$ (8,199,300)	24

Operating Entity Only

* This must agree with page 17, line 47.

Facility Name & ID Number Ballard Respiratory & Rehab

0053355

Report Period Beginning: 01/01/2016

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	\$ 13,695,964	1
2	Discounts and Allowances for all Levels	(5,508,140)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,187,824	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,472,626	6
7	Oxygen	1,252,232	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,724,858	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	433,117	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	72,201	19
20	Radiology and X-Ray	11,043	20
21	Other Medical Services	2,748,794	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,265,155	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,495	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,495	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)	\$ 15,181,332	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,024,226	31
32	Health Care	9,676,469	32
33	General Administration	3,000,817	33
	B. Capital Expense		
34	Ownership	1,732,628	34
	C. Ancillary Expense		
35	Special Cost Centers	3,793,615	35
36	Provider Participation Fee	380,246	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 20,608,001	40
41	Income before Income Taxes (line 30 minus line 40)**	(5,426,669)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (5,426,669)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,802,467	44
45	Private Pay - Net Inpatient Revenue	721,387	45
46	Medicare - Net Inpatient Revenue	3,151,379	46
47	Other-(specify) <u>Insurance - Net Inpatient Revenue</u>	1,512,591	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,187,824	49

* 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	2,112	2,248	\$ 102,885	\$ 45.77	1
2	Assistant Director of Nursing	1,611	1,667	66,680	40.00	2
3	Registered Nurses	91,204	127,937	3,879,580	30.32	3
4	Licensed Practical Nurses	333	333	9,603	28.84	4
5	CNAs & Orderlies	73,224	105,582	1,544,974	14.63	5
6	CNA Trainees					6
7	Licensed Therapist	24,617	45,585	1,242,897	27.27	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,344	54,559	23.28	9
10	Activity Assistants	6,187	6,891	100,710	14.61	10
11	Social Service Workers	4,144	4,422	101,325	22.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,477	5,913	98,448	16.65	17
18	Housekeepers	17,602	21,001	259,618	12.36	18
19	Laundry	10,279	11,311	126,519	11.19	19
20	Administrator	1,981	2,130	106,569	50.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,608	19,825	399,922	20.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	259,459	357,189	\$ 8,094,289 *	\$ 22.66	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	Monthly	\$ 34,364	Ln 1, Col 3	35
36	Medical Director	Monthly	111,000	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,710	Ln10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	816	Ln11, Col 3	44
45	Social Service Consultant	56	3,414	Ln12, Col 3	45
46	Other(specify)				46
47	Religious Consultant	Monthly	19,740	Ln12, Col 3	47
48					48
49	TOTAL (lines 35 - 48)	72	\$ 180,044		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	12,150	\$ 328,063	Ln10, Col 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	12,150	\$ 328,063		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	%	Amount	Description		Amount	Description		Amount	
Marla Costello		Administrator	0.00 %	\$ 56,277	Workers' Compensation Insurance		\$ 240,814	IDPH License Fee		\$ 1,990	
Jomarie Silver		Administrator	0.00 %	50,292	Unemployment Compensation Insurance		121,312	Advertising: Employee Recruitment		650	
					FICA Taxes		589,602	Health Care Worker Background Check		650	
					Employee Health Insurance		779,152	(Indicate # of checks performed)			
					Employee Meals		20,629	Patient Background Checks		11	
					Illinois Municipal Retirement Fund (IMRF)*						
					401K Match		17,902	See Attached Schedule K:		52,571	
					Other Employee Benefits		4,367				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 106,569				Allocated from Therapy Masters, Inc.:		1,182	
B. Administrative - Other								Allocated from Management Company:		1,517	
Description				Amount				Less: Public Relations Expense		()	
				\$	See Attached Schedule D:		0	Non-allowable advertising		()	
								Yellow page advertising		()	
					TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,773,778	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 58,670	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
Vendor/Payee		Type		Amount	Description		Line #	Amount	Description		Amount
				\$					Out-of-State Travel		\$
See Attached Schedule C:				205,188							
									In-State Travel		
									Seminar Expense		
									Entertainment Expense		()
									(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 205,188	TOTAL			\$	TOTAL		\$

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

(1)

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

Yes

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes

Illinois Council on Long Term Care \$15,229

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

Yes

Yes

(4)

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

No

N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes

5, 10 years

(6)

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

\$

94,862

Line

10

(7)

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

Yes

(8)

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

No

N/A

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

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

N/A

(11)

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

\$

380,246

(12)

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

No

(13)

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

Yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)
If YES, attach a schedule which explains how all related costs were allocated to these functions.

No

(15)

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

\$

20,629

No

Indicate the amount.

\$

N/A

(16)

Travel and Transportation

a.

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

No

b.

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

No

N/A

c.

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

N/A

d.

Have vehicle usage logs been maintained?

Yes

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f.

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

Yes

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

N/A

(17)

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

No

N/A

(18)

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

Yes

(19)

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

Yes

HFS 3745 (N-4-99)

IL478-2471

Ballard Respiratory and Rehabilitation Center, LLC.
Provider I.D. # 0053355
12/31/2016

SCHEDULE A

SCHEDULE VII. RELATED PARTIES
Part A. Col.3

3 OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
Glen Health & Home Management, Inc.	Skokie	Management Company
Ballard Respiratory and Rehabilitation Center Real Estate LLC.	Skokie	Building Lessor
Fargo Real Estate & Development, LLC	Skokie	Building Lessor - Management Co.
Therapy Masters	Skokie	Therapy company

SCHEDULE B

SCHEDULE VII RELATED PARTIES

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

Name	Compensation Received From Other Nursing Homes								Total
	Glen Oaks Nursing & Rehab. Centre, Ltd.	GlenCrest Nursing & Rehab. Centre, Ltd.	Glen Bridge Nursing & Rehab. Centre, Ltd.	Glen Elston Nursing & Rehab. Centre, Ltd.	GlenShire Nursing & Rehab. Centre, Ltd.	Glen Lake Terrace Nursing & Rehab	Brentwood North Healthcare & Rehabilitation	Glen Saint Andrew Living Comm	
Sidney Glenner	34,326	35,426	34,327	13,643	23,658	28,487	17,403	25,663	212,933
Jonathan Glenner	7,984	8,240	7,984	3,173	5,502	6,626	4,048	5,969	49,526
Daniel Glenner	28,726	29,647	28,727	11,417	19,798	23,840	14,564	21,477	178,196
Elliot Glenner	13,567	14,002	13,568	5,392	9,350	11,259	6,878	10,143	84,159
Total compensation received from other Nursing Homes	84,603	87,315	84,606	33,625	58,308	70,212	42,893	63,252	524,814

SCHEDULE C

XIX. SUPPORT SCHEDULES

C. Professional Services
Page 21

Vendor/Payee	Type	AMOUNT
Kronos	Computers	16,620
Point ClickCare	Computers	50,594
American Healthtech	Computers	35
Comcast Business Solutions	Computers	9,388
EHealth Data Solutions	Computers	1,350
Net Health	Computers	10,018
Creative Technology Solutions	Computers	10,402
Microsoft Corporation	Computers	6,901
CDW	Computers	1,500
RSM US LLP	Accounting	1,500
Marcum	Accounting	0
Much Shelist	Legal	16,934
Gutnicki LLP	Legal	33,366
Marilyn P. Dunn	Legal	180
Polsinelli	Legal	10,147
Vanek, Larson & Kolb LLC	Legal	885
Admiral Environmental Services, Inc.	Environmental Consulting	1,904
2401 Incorporated	Architectural Consulting	2,500
Jase Consulting	Marketing Consulting	125
Creative Technology Solutions	IT Consulting	10,000
Platinum Billing Solutions	A/R Collections	26,897
Professional Search Network	Employment Consulting	8,500
Total Schedule V, Line 19, Col. 3		219,746
Allocated from Management Co:		
Point ClickCare - Computer Services		1,399
Lexis Nexis - Computer Services		2
Health Data Systems, Inc. - Computer Services		95
Microsoft - Computer Services		551
Rosie Connectivity Solutions - Computer Services		40
Creative Technology Solutions - Computer Services		624
MB Financial - Legal		2,695
Marcum - Accounting		611
Govig - Recruiting		7,190
Perfect Staffing - Recruiting		1,258
Personnel Planners - Financial Consulting		18
Polsinelli - Legal		634
Marilyn Dunn - Legal		16
Much Shelist - Legal		350
Total allocated from Management Co.		15,483
Allocated from Therapy Masters, Inc.:		
Casamba - Computer Services		4,432
Health Data Services - Computer Services		141
VIRTU SENES - Computer Services		522
RSM US LLP- Accounting Services		180
O'Hagan LLC - Legal Services		966
Theracore - Business Consulting		30,916
Personnel Planners - Business Consulting		77
Career Tree Network - Therapist Recruitment		4,145
Total allocated from Therapy Masters:		41,379
Allocated from Ballard Respiratory & Rehabilitation Center Real Estate, LLC.:		
Skidelsky & Associates - Real Estate Tax Reduction		42,270
Stout, Risius, Ross, Inc. - Real Estate Tax Reduction		5,009
Total allocated from Ballard Respiratory & Rehabilitation Center Real Estate, LLC:		47,279
Reclass Skidelsky & Associates - Real Estate Tax Reduction to Line 33		-42,270
Reclass Stout, Risius, Ross, Inc. - Real Estate Tax Reduction to Line 33		-5,009
Non-Allowable Expenses:		
Polsinelli - Legal - out of period, financing		-10,147
Gutnicki LLP - loan modification		-33,366
Vanek, Larson & Kolb LLC - A/R Collections		-885
Platinum Business Solutions- A/R Collections		-26,897
Jase Consulting - Marketing Consulting		-125
Total Non-Allowable Expenses:		-71,420
Total adjustments page 21, Sch C.		-14,558
Total Schedule V, line 19, column 8		205,188

SCHEDULE D

XIX. SUPPORT SCHEDULES

D. Employee Benefits and Payroll Taxes
Page 21

DESCRIPTION	AMOUNT
Allocated from Management Co:	
FICA taxes	28,727
FUTA	239
SUTA	1,461
401K Match	2,296
Insurance - Hospital	40,083
Workers Compensation Insurance	3,722
Total allocated from Management Co.	76,528
Employee Benefits reclassified to Lines 7, 27	-76,528
Allocated from Therapy Masters, Inc.:	
FICA taxes	64,545
FUTA	670
SUTA	1,108
401K Match	5,981
Insurance - Hospital	17,136
Workers Compensation Insurance	4,123
Total allocated from Therapy Masters, Inc. Co.	93,563
Employee Benefits reclassified to Lines 15,27	-93,563
Total allocated to Page 21	0

Ballard Respiratory and Rehabilitation Center, LLC.
Provider I.D. # 0053355
12/31/2016

SCHEDULE E

SUPPORT SCHEDULES

Page 17, Line 36

DESCRIPTION	AMOUNT
Insurance Payable	270,452
Accrued Expenses	129,410
Due to Third Party	0
Due to Prior Owner	56,779
Accrued Provider Participation Fee - Tax	85,477
Total, Page 17, Line 36	542,118

SCHEDULE F

SCHEDULE VI. ADJUSTMENT DETAIL

Schedule A. Nonallowable Expenses

Page 5

DESCRIPTION	AMOUNT	REFERENCE
Patient clothing	-2,043	43
Non-allowable office expense	-250	43
Non-allowable bank fees	-585	43
Non-allowable professional fees	-71,420	19
Non-allowable auto expense - marketing	-717	25
Non-allowable Illinois Council on Long Term Care PAC Fees	-7,501	20
Adjust mgt co. med supplies - med'A' to cost	-16,093	10
Adjust mgt co. med supplies - med'other' to cost	-93,254	10
Adjust mgt co. food to cost	-24,206	2
Adjust pharmacy expense to cost	-60,648	39
Total	<u>-276,717</u>	

Ballard Respiratory & Rehab Ctr Real Estate LLC
Accrued Real Estate Taxes
12/31/2016

SCHEDULE G

	Accrued 1/01/16	Payments	Expense	Accrued 12/31/16
Balance @ 1/01/16 - G/L# 230	(940,000.00)		(940,000.00)	
2015 Real Estate Taxes Paid		708,162.70	708,162.70	
Estimated 2016 real estate taxes:				
2015 taxes	708,162.70			
Estimated increase	5.00%			
Estimated 2016 taxes	743,570.84			
USE	744,000.00		744,000.00	(744,000.00)
Totals	(940,000.00)	708,162.70	512,162.70	(744,000.00)

Real estate tax history:

Year	Amount	Increase \$	%
2014	894,749.90		
2015	708,162.70	(186,587.20)	-20.85%

Provider Name: Ballard Respiratory and Rehabilitation Center, LLC.
Provider I.D. #: 0053355
Year Ended: December 31, 2016

SCHEDULE H

Training & Education

Person(s) Attending	Date Attended	Location	Title Sponsor	Total Cost
Marla Costello	3/28/2016	Skokie, IL.	Illinois Council on Long Term Care: What do you know about Sepsis?	250
Yelena Upart	5/17/2016	Skokie, IL.	Illinois Council on Long Term Care: Compliance Reviews or Audits Part 1	300
Saismol Samuel, Marla Costello	8/31/2016	Skokie, IL.	Illinois Council on Long Term Care: SNF Quaility Reporting Program	250
Marla Costello	9/15/16	Skokie, IL	Illinois Council on Long Term Care: October 1 Changes to Section S	80
Nursing Staff	10/13/2016	Des Plaines, IL	RoseConnect 2.0 Training	750
			Allocated From Management Company	1,036
			Allocated From Therapy Masters	1,765
			Total	4,431

SCHEDULE I

Page 3, Schedule V, Line 25, Col 8
Other Admin. Staff Transportation

	Gasoline Allowance	Employee Reimbursement: Mileage, Tolls, Parking	Total
Direct Expense	0	717	717
Non-allowable auto expense - marketing			-717
Allocated from Management Company			6,819
Allocated from Therapy Masters			1,550
TOTAL	0	717	8,369

SCHEDULE K

XIX. SUPPORT SCHEDULES

Page 21
F. Dues, Fees, Subscriptions and Promotions

DESCRIPTION	AMOUNT
Illinois Council on Long Term Care Dues	22,730
Employment Fees	28,000
State Fire Marshall Inspection Fee	560
Joint Commission Annual Certification, Program Fee	6,915
Cook County Environmental Fee	699
Des Plaines Chamber of Commerce Annual Fee	615
Collaborative Healthcare Urgency Group Fee	300
Department of Building and Zoning of Cook County Fee	252
Non-allowable Illinois Council on Long Term Care Dues	-7,501
Total allocated to Page 21	52,571

