

		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>0051136</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>BRIA OF PALOS HILLS</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</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>10426 SOUTH ROBERTS</u> <u>PALOS HILLS</u> <u>60465</u>																									
Number City Zip Code																									
County: <u>COOK</u>																									
Telephone Number: <u>(847) 674-5795</u> Fax # <u>(847) 674-5794</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>AVRUM WEINFELD</u></td></tr><tr><td>(Title) <u>MEMBER</u></td></tr><tr><td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u></td></tr><tr><td>(Firm Name & Address) <u>KBKB, LTD</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u></td></tr><tr><td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>AVRUM WEINFELD</u>	(Title) <u>MEMBER</u>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	Paid Preparer	(Date) _____	(Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u>	(Firm Name & Address) <u>KBKB, LTD</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>												
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Date of Initial License for Current Owners: <u>07/01/10</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>SANFORD BOKOR</u> Telephone Number: <u>(847) 675-3585</u>																									
Email Address: _____																									

Facility Name & ID Number

BRIA OF PALOS HILLS

#

0051136

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

	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	150	Skilled (SNF)	150	54,900	1
2		Skilled Pediatric (SNF/PED)			2
3	53	Intermediate (ICF)	53	19,398	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,298	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			7,402	7,402	8
9	SNF/PED					9
10	ICF	38,513	1,994	1,680	42,187	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,513	1,994	9,082	49,589	14

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

66.74%

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

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

07/01/201

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

YES

X

Date

07/01/2010

NO

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

YES

X

NO

If YES, enter number of beds certified

118

and days of care provided

7,402

Medicare Intermediary

ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

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 **BRIA OF PALOS HILLS** # **0051136** 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		13,134	968,978	982,112		982,112		982,112			1
2	Food Purchase		810		810		810		810			2
3	Housekeeping		60,648	408,133	468,781		468,781		468,781			3
4	Laundry		40,842	272,871	313,713		313,713		313,713			4
5	Heat and Other Utilities			178,944	178,944		178,944		178,944			5
6	Maintenance	144,582	102,119	81,481	328,182		328,182		328,182			6
7	Other (specify):*			31,013	31,013		31,013		31,013			7
8	TOTAL General Services	144,582	217,553	1,941,420	2,303,555		2,303,555		2,303,555			8
	B. Health Care and Programs											
9	Medical Director			47,500	47,500		47,500		47,500			9
10	Nursing and Medical Records	3,973,617	401,005	128,019	4,502,641		4,502,641		4,502,641			10
10a	Therapy			150,830	150,830		150,830		150,830			10a
11	Activities	126,650	6,886	2,992	136,528		136,528		136,528			11
12	Social Services	138,139	6,304	624	145,067		145,067		145,067			12
13	CNA Training											13
14	Program Transportation			2,553	2,553		2,553		2,553			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,238,406	414,195	332,518	4,985,119		4,985,119		4,985,119			16
	C. General Administration											
17	Administrative	165,536			165,536		165,536		165,536			17
18	Directors Fees											18
19	Professional Services			132,260	132,260		132,260	3,500	135,760			19
20	Dues, Fees, Subscriptions & Promotions			456,712	456,712		456,712	(401,613)	55,099			20
21	Clerical & General Office Expenses	526,380	60,819	208,999	796,198		796,198	(152,109)	644,089			21
22	Employee Benefits & Payroll Taxes			727,645	727,645		727,645	(1,959)	725,686			22
23	Inservice Training & Education			3,011	3,011		3,011		3,011			23
24	Travel and Seminar			10,524	10,524		10,524		10,524			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			309,544	309,544		309,544		309,544			26
27	Other (specify):*			130,302	130,302		130,302	(130,302)				27
28	TOTAL General Administration	691,916	60,819	1,978,997	2,731,732		2,731,732	(682,483)	2,049,249			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,074,904	692,567	4,252,935	10,020,406		10,020,406	(682,483)	9,337,923			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	0		
	REPAIRS & MAINTENANCE	2,324		
	CONTRACTED DIETARY SERVICES	966,654	968,978	
3	HOUSEKEEPING			
	CONTRACTED HOUSEKKEEPING SERVICES	408,133		
			408,133	
4	LAUNDRY			
	EQUIPMENT REPAIRS & MAINTENANCE	0		
	CONTRACTED LAUNDRY SERVICES	272,871	272,871	
5	HEAT & OTHER UTILITIES			
	GAS HEAT	28,270		
	ELECTRICITY	88,697		
	WATER	55,833		
	CABLE TV - LOBBY	6,144		
			178,944	
6	MAINTENANCE			
	GROUNDS MAINTENANCE	53,383		
	PAINTING & DECORATING	3,443		
	BUILDING REPAIRS	0		
	MAINTENANCE TRAVEL	0		
	EQUIPMENT MAINTENANCE & REPAIR	0		
	ELEVATOR MAINTENANCE & REPAIR	0		
	OUTSIDE LABOR	0		
	EXTERMINATING SERVICE	0		
	FIRE SERVICE	24,655		
			81,481	
7	OTHER			
	SCAVENGER & EXTERMINATING SERVICES	31,013		
	SECURITY SERVICE	0		
			31,013	
9	MEDICAL DIRECTOR			
	MEDICAL DIRECTOR FEES XVIII B 36-2	47,500	47,500	

LINE	SCHED REF	TOTAL		
10	NURSING			
	CONTRACT NURSING XVIII C 53-2	62,247		
	LABORATORY & XRAY EXPENSE	0		
	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	720		
	PHARMACY CONSULTANT XVIII B 39-2	16,153		
	UTILIZATION REVIEW FEES XVIII B __-2	0		
	PHYSICIANS XVIII B __-2	0		
	PSYCHIATRIC XVIII B __-2	6,000		
	RN CONSULTANT XVIII B 38-2	42,899		
			128,019	
10a	THERAPY			
	PHYSICAL THERAPY SERVICES	0		
	SPEECH THERAPY SERVICES	0		
	OCCUPATIONAL THERAPY SERVICES	0		
	REHABILITATION CONSULTANT XVIII B __-2	0		
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	45,270		
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	34,339		
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	57,349		
	SPEECH THERAPY CONSULTANT XVIII B 43-2	13,872		
			150,830	
11	ACTIVITIES			
	CABLE TV - PATIENT ROOMS	0		
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,992		
			2,992	
12	SOCIAL SERVICES			
	SOCIAL REHABILITATION SERVICES	0		
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	624		
	SOCIAL WORKER XVIII B 45-2	0		
			624	
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	2,553		
			2,553	
17				
	ADMINISTRATIVE			
	MANAGEMENT FEES XIX B	0	0	
	DIRECTORS FEES			
18				
	DIRECTORS FEES	0	0	
19				
	PROFESSIONAL SERVICES			
	DATA PROCESSING XIX C	13,566		
	ADMINISTRATIVE CONSULTANTS XIX C	118,694		
	PROFESSIONAL FEES XIX C	0		
			132,260	
20				
	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT & MARKETING VI 19 XIX F	0		
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	394,914		
	EMPLOYEE WANT ADS XIX F	29,443		
	CONTRIBUTIONS VI 20 XIX F	0		
	DUES & SUBSCRIPTIONS XIX F	15,036		
	LICENSES & PERMITS XIX F	5,685		
	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	6,699		
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,100		
	PATIENT BACKGROUND CHECKS XIX F	3,835		
			456,712	
21				
	CLERICAL & GENERAL OFFICE EXPENSES			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,627		
	EQUIPMENT REPAIR & MAINTENANCE	137,085		
	OUTSIDE CLERICAL SERVICES	0		
	PENALTIES / OVERDRAFT CHARGES VI 18	6,192		
	HOME OFFICE EXPENSE	0		
	THEFT & DAMAGE LOSS	0		
	TELEPHONE	57,890		
	MESSENGER SERVICE	5,205		
			208,999	

LINE	SCHED REF	TOTAL		
22				
	EMPLOYEE BENEFITS & PAYROLL TAXES			
	FICA TAXES XIX D	376,101		
	UNEMPLOYMENT COMPENSATION XIX D	111,630		
	WORKERS COMPENSATION INSURANCE XIX D	156,891		
	HOSPITALIZATION INSURANCE XIX D	64,752		
	EMPLOYEE BENEFITS - OTHER XIX D	18,271		
	EMPLOYEE PHYSICAL EXAMS XIX D	0		
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0		
	PENSION/PROFIT SHARING PLANS XIX D	0		
			727,645	
23				
	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS	3,011		
			3,011	
24				
	TRAVEL & SEMINARS			
	EDUCATION & SEMINARS XIX G	0		
	TRAVEL XIX G	10,524		
			10,524	
25				
	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF			
			0	
26				
	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE	309,544		
			309,544	
27				
	OTHER			
	BAD DEBTS VI 24	130,302		
			130,302	

GRAND TOTAL COLUMN 3 OTHER

4,252,935

BRIA OF PALOS HILLS
SCHEDULES
12/31/2016

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

TOTAL FOOD PURCHASE	810	
LESS SALES TAX	<u>0</u>	HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??
NET FOOD	810	
TOTAL PATIENT CENSUS	49,589	
TIMES 3 MEALS PER DAY	<u>3</u>	
TOTAL PATIENT MEALS	148,767	
ADD # EMPLOYEE MEALS/DAY		
TIMES # DAYS	<u>54,900</u>	
TOTAL EMPLOYEE MEALS	0	
PATIENT MEALS	148,767	
ADD EMPLOYEE MEALS	<u>0</u>	
TOTAL MEALS/YEAR	148,767	
NET FOOD	810	
DIVIDE TOTAL MEALS/YEAR	<u>148,767</u>	
COST PER MEAL	0.01	
TIMES EMPLOYEE MEALS	<u>0</u>	
EMPLOYEE MEAL RECLASSIFICATION	<u><u>0</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			60,465	60,465		60,465	700,772	761,237			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,644	24,644		24,644	515,977	540,621			32
33	Real Estate Taxes							451,888	451,888			33
34	Rent-Facility & Grounds			730,800	730,800		730,800	(720,000)	10,800			34
35	Rent-Equipment & Vehicles			41,147	41,147		41,147		41,147			35
36	Other (specify):*											36
37	TOTAL Ownership			857,056	857,056		857,056	948,637	1,805,693			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		448,201	1,022,606	1,470,807		1,470,807		1,470,807			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			363,050	363,050		363,050		363,050			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		448,201	1,385,656	1,833,857		1,833,857		1,833,857			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,074,904	1,140,768	6,495,647	12,711,319		12,711,319	266,154	12,977,473			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	(4,572)	30		9
10	Interest and Other Investment Income	(959)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		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	(6,192)	21		18
19	Entertainment		20		19
20	Contributions	(6,699)	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	(130,302)	27		24
25	Fund Raising, Advertising and Promotional	(394,914)	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	(147,876)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (691,514)		\$	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)	957,668		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 957,668		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 266,154		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	MARKETING SALARIES	\$ (145,917)	21	1
2	CHICAGO BULLS TICKETS	(1,959)	22	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
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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	(147,876)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF PALOS HILLS# 0051136

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,500	0	0	0	0	0	0	0	0	0	3,500	19
20	Fees, Subscriptions & Promotions	(401,613)	0	0	0	0	0	0	0	0	0	0	(401,613)	20
21	Clerical & General Office Expenses	(152,109)	0	0	0	0	0	0	0	0	0	0	(152,109)	21
22	Employee Benefits & Payroll Taxes	(1,959)	0	0	0	0	0	0	0	0	0	0	(1,959)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(130,302)	0	0	0	0	0	0	0	0	0	0	(130,302)	27
28	TOTAL General Administration	(685,983)	3,500	0	0	0	0	0	0	0	0	0	(682,483)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(685,983)	3,500	0	0	0	0	0	0	0	0	0	(682,483)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF PALOS HILLS # 0051136 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	(4,572)	705,344	0	0	0	0	0	0	0	0	0	700,772	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(959)	516,936	0	0	0	0	0	0	0	0	0	515,977	32
33	Real Estate Taxes	0	451,888	0	0	0	0	0	0	0	0	0	451,888	33
34	Rent-Facility & Grounds	0	(720,000)	0	0	0	0	0	0	0	0	0	(720,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,531)	954,168	0	0	0	0	0	0	0	0	0	948,637	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(691,514)	957,668	0	0	0	0	0	0	0	0	0	266,154	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
SEE PAGE 6 - SUPPLEMENTAL						

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 720,000	PM NURSING & REHAB		\$	(720,000)	1
2	V	30	DEPRECIATION				705,344	705,344	2
3	V	32	INTEREST EXPENSE				516,936	516,936	3
4	V	19	PROFESSIONAL FEES				3,500	3,500	4
5	V	33	REAL ESTATE TAXES				451,888	451,888	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			\$ 720,000			\$ 1,677,668	\$ * 957,668	14

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

Facility Name & ID Number

BRIA OF PALOS HILLS

0051136

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								1
2	DANIEL WEISS	16.67	BRIA OF CAHOKIA	CAHOKIA	WEISS MGMT		MANAGEMENT/	2
3	NATAN WEISS	16.67			GROUP, INC	LINCOLNWOOD	CLERICAL	3
4	AVRUM WEINFELD	16.67	BRIA OF BELLEVILLE	BELLEVILLE				4
5	DEANNA KAPLAN	49.99			BRIA HEALTH		MANAGEMENT	5
6			BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO	SERVICES, LLC	LINCOLNWOOD	SERVICES	6
7				HEIGHTS				7
8					PM NURSING &		REAL ESTATE	8
9			BRIA OF FOREST EDGE	CHICAGO	REHAB	LINCOLNWOOD		9
10								10
11			BRIA OF GENEVA	GENEVA				11
12								12
13			LAKE PARK CENTER	WAUKEGAN				13
14								14
15			BRIA OF RIVER OAKS	BURNHAM				15
16								16
17			BRIA OF WESTMONT	WESTMONT				17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number BRIA OF PALOS HILLS # 0051136 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	DANIEL WEISS	SHAREHOLDER	ADMINISTRATIV	16.67		10	9.52		\$		1
2					SEE						2
3	NATAN WEISS	CFO	FINANCE/MGMT	16.67	ATTACHED	10	11.24				3
4					SCHEDULE						4
5	AVRUM WEINDFELD	SHAREHOLDER	ADMINISTRATIV	16.67		15	12.60				5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number BRIA OF PALOS HILLS # 0051136 Report Period Beginning: 01/01/2016 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

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	RELATED PARTY: PM NURSING & REHAB						\$					\$	1
2	THE PRIVATE BANK	X		LOAN				20,054,204			PRIME+	516,936	2
3													3
4													4
5													5
	Working Capital												
6	BANK FINANCIAL	X		WORKING CAPITAL	DEMAND	08/01/10	750,000	637,604			PRIME+	20,263	6
7		X		INSURANCE FINANCE								4,381	7
8													8
9	TOTAL Facility Related						\$ 750,000	\$ 20,691,808				\$ 541,580	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$ 750,000	\$ 20,691,808				\$ 541,580	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # 36

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

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

FACILITY NAME	BRIA OF PALOS HILLS	COUNTY	COOK
---------------	---------------------	--------	------

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

A. Square Feet: 46,000

B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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	NURSING HOME		2012	\$ 812,700	1
2	NURSING HOME		2016	637,703	2
3	TOTALS			\$ 1,450,403	3

Facility Name & ID Number **BRIA OF PALOS HILLS**

0051136

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	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	203		2012		\$ 1,636,707	\$ 41,967	27.5	\$ 41,967	\$	\$ 166,119
5			2016		18,665,735	311,096	27.5	311,096		311,096
6										
7										
8										
	Improvement Type**									
9	ROOF TOP AIR CONDITION			2010	9,124		5			9,124
10	LOBBY: MILLWORK,CROWN MOLDING,REPLACE OUTLETS,									
11	WALLCOVERING									
12	CORRIDOR #1:CEILING TILE,HANDRAILS,PAINTING WALLS,									
13	MILLWORK									
14	CORRIDOR #2:CEILING TILE,HANDRAILS,MILLWORK,LIGHT									
15	FIXTURE									
16	THERAPY AND RESIDENT ROOMS;CEILING TILE,WINDOW									
17	TREATMENTS,FLOORING,WALLCOVERING, LIGHT FIXTURES,									
18	INSTALL NEW VCT AND COVE BASE			2010	60,347	2,194	27.5	2,194		13,528
19	SOUTH HALL, NORTH/DINING, BEATY SHOP-PAINTING			2011	12,000	692	5	692		12,000
20	PHONE ROOM AREA-INSTALL NEW WIREGLASS WINDOW;									
21	DINING ROOM-CEILING TILE,WALLCOVERING,CHAIR RAIL'									
22	BUILD TWO NEW WALLS;									
23	THERAPY ROOM-INSTALL NEW DOOR,PAINT WALLS;									
24	RESIDENT BATHROOMS-PAINT,CEILINGS, COVE BASE;									
25	RECETTION AREA-DEMOLISH TWO WALLS,INSTALL NEW									
26	COUNTERTOP, PAINT;									
27	ADMISSION OFFICE-BUID NEW WALL,WALLCOVERING ,PAINT									
28	INSTALLATION OF WINDOW TREATMENTS,ROLLER SHADES,									
29	CUBICLE CURTAINS			2011	35,514	1,291	27.5	1,291		7,477
30	NORTH HALL, FRONT HALL-PAINTING			2011	13,350	769	5	769		13,350
31	INSTALL ANTI-FREEZE SYSTEM BELOW CANOPY			2011	5,135	187	27.5	187		1,114
32	INSTALL INTELLIGENT PHOTO DETECTOR			2011	7,998	291	27.5	291		1,734
33	LOBBY-INSTALL NEW CERAMIC TILE, MILLWORK, GROUT			2011	8,537	310	27.5	310		1,718
34	PARKING LOT-PAVED WITH 1.5" OF NEW ASPHALT			2011	29,850	1,990	15	1,990		10,779
35	INSTALL FIVE DELAYED EGRESS LOCKS-DOUBLE & SINGLE			2011	8,368	304	27.5	304		1,609
36				2011	2,622	95	27.5	95		487

*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 **BRIA OF PALOS HILLS**# **0051136**

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	2	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	REEROOFED PROPERTY USING SINGLE PLY MODIFIED		\$	\$		\$	\$	\$	37
38	BITUMEN; INSTALL 6 NEW RETRO FIT DRAINS	2011	35,700	1,298	27.5	1,298		6,544	38
39	INSTALLATION AND WIRING FOR WAP'S	2012	4,730	172	27.5	172		839	39
40	CORRIDOR-HANDRAILS, CORNER GUARDS	2012	5,225	190	27.5	190		910	40
41	REPLACEMENT OF A/C SOUTHEAST UNIT COMPRESSOR	2012	2,618	151	5	151		2,543	41
42	APPLIED A PATCH TO THE FIELD OR WALL FLASHINGS	2012	2,800	102	27.5	102		438	42
43	NURSES STATION; 2 BATHROOMS; NOTRH, WEST, SOUTH								43
44	CORRIDORS; CAFETERIA-INSTALL NEW CERAMIC TILE,								44
45	VCT AND MILLWORK	2013	36,893	1,342	27.5	1,342		5,312	45
46	APPLIED A PATCH TO THE FIELD USING SPMB OR WALL								46
47	FLASHING-EAST, SOUTH WING	2013	3,650	133	27.5	133		460	47
48	TUB ROOM; TRAINING TOILET; 2 SMALL SHOWER ROOMS								48
49	INSTALLATION OF CERAMIC FLOOR TILE	2013	18,583	676	27.5	676		2,225	49
50	FIRE SPRINKLER SYSTEM REPAIR-LABOT AND MATERIAL								50
51	TO COMPLETE WORK	2013	10,120	368	27.5	368		1,211	51
52	ALZHEIMERS DINING ROOM; SOUTH CORRIDOR; NORTH								52
53	SHOWER ROOM-INSTALL NEW VCT & MILLWORK	2013	26,867	977	27.5	977		3,135	53
54	REEROOFED PROPERTY USING SINGLE PLY MODIFIED								54
55	BITUMEN ON FRONT PORTION OF THE CENTER AND								55
56	SOUTH WING	2013	79,040	2,874	27.5	2,874		9,221	56
57	REPLACEMENT OF A/C UNIT IN NORTH DIALYSIS ROOM	2013	8,602	313	27.5	313		1,004	57
58	INSTALL NEW FIRE ALARM SYSTEM; SMOKE DETECTOR								58
59	BASE	2013	24,108	877	27.5	877		2,814	59
60	REPLACE WITH NEW PIPE AND FITTINGS OF THE SEWER								60
61	LINE' TWO SEPARATE TRENCH EXCAVATIONS	2013	8,425	306	27.5	306		956	61
62	INSTALLED NEW WHITE GRANULATED SPMB FLASHING								62
63	AND GRAVEL STOP-REMOVED EXISTING ROOF	2014	10,150	369	27.5	369		1,030	63
64	NORTHEAST DINING ROOM-INSTALLATION OF BUMPER								64
65	GUARD & CHAIR RAIL	2014	3,428	125	27.5	125		349	65
66	INSTALL CONCRETE PAD DEMO; SPOT TUCKPOINT AND								66
67	RESET SILLS AROUD BLDG	2014	16,636	1,109	15	1,109		3,050	67
68	REMODEL 5 SHOWERS ROOMS: NEW TILE, WALLS,								68
69	LIGHT FIXTURES, PAINT CEILINGS, NEW FIRE DOOR	2014	44,975	1,635	27.5	1,635		4,292	69
70	TOTAL (lines 4 thru 69)		\$ 20,837,837	\$ 374,203		\$ 374,203	\$	\$ 596,468	70

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

Facility Name & ID Number BRIA OF PALOS HILLS

0051136

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 20,837,837	\$ 374,203		\$ 374,203	\$	\$ 596,468	1
2 INSTALLED NEW CONDENSING UNIT ON ROOF	2014	6,300	229	27.5	229		563	2
3 INSTALL ACCUTECH DEPARTURE ALERT SYSTEM FOR								3
4 FRONT & BACK DOOR; DELAY LOCKS ON DOUBLE DOOR	2014	11,599	422	27.5	422		967	4
5 WIRE UP 10 ROOMS	2015	3,500	127	27.5	127		238	5
6 INSTALLATION OF THE FIRE DOORS COMING FROM								6
7 THE KITCHEN	2015	3,835	139	27.5	139		203	7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 20,863,071	\$ 375,120		\$ 375,120	\$	\$ 598,439	34

**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	\$ 243,217	\$ 14,095	\$ 31,709	\$ 17,614	3-10	\$ 131,866	71
72	Current Year Purchases	40,522	24,313	2,127	(22,186)	8-10	2,127	72
73	Fully Depreciated Assets							73
74	RELATED PARTY SL DEPRECIATION		352,281	352,281				74
75	TOTALS	\$ 283,739	\$ 390,689	\$ 386,117	\$ (4,572)		\$ 133,993	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 22,597,213	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 765,809	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 761,237	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,572)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 732,432	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
9. Option to Buy: ☐ YES ☒ NO Terms: *

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.		\$
13.		\$
14.		\$

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: \$ 33,144 Description: SEE ATTACHED SCHEDULE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2016 FORD TRANSIT	\$ #####	\$ 8,003	17
18					18
19					19
20					20
21	TOTAL		\$ #####	\$ 8,003	21

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

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

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	\$		\$ 423,708	\$		\$ 423,708	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			126,360			126,360	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			472,538			472,538	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				352,959		352,959	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): RADIOLOGY, LAB	39-2					46,295		46,295	12
13	MEDICAL SUPPLIES, RENTALS, Other (specify): I.V.THERAPY	39-2					48,947		48,947	13
14	TOTAL			\$		\$ 1,022,606	\$ 448,201		\$ 1,470,807	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	\$ 244,622	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 240,000)	5,014,693		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	241,049		6
7	Other Prepaid Expenses	74,764		7
8	Accounts Receivable (owners or related parties)	47,533		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,622,661	\$	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	560,630		15
16	Equipment, at Historical Cost	283,739		16
17	Accumulated Depreciation (book methods)	(372,533)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 471,836	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,094,497	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,694,710	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	637,604		29
30	Accrued Salaries Payable	386,513		30
31	Accrued Taxes Payable (excluding real estate taxes)	38,947		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	<u>DUE TO D. WEISS</u>	595,000		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,352,774	\$	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	<u>DUE TO PM NURSING & REHAB</u>	821,255		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 821,255	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,174,029	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 920,468	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,094,497	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,935,258	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,935,258	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,014,790)	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)	\$ (1,014,790)	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)	\$ 920,468	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BRIA OF PALOS HILLS

0051136

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	\$ 11,695,570	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,695,570	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	959	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 959	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)	\$ 11,696,529	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,303,555	31
32	Health Care	4,985,119	32
33	General Administration	2,731,732	33
	B. Capital Expense		
34	Ownership	857,056	34
	C. Ancillary Expense		
35	Special Cost Centers	1,470,807	35
36	Provider Participation Fee	363,050	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,711,319	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,014,790)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,014,790)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 6,023,331	44
45	Private Pay - Net Inpatient Revenue	354,130	45
46	Medicare - Net Inpatient Revenue	4,173,834	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>	379,673	47
48	Other-(specify) <u>MANAGED CARE</u>	764,602	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,695,570	49

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

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

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

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

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	3,608	3,680	\$ 149,919	\$ 40.74	1
2	Assistant Director of Nursing	4,520	4,544	160,904	35.41	2
3	Registered Nurses	22,175	22,523	910,451	40.42	3
4	Licensed Practical Nurses	33,625	34,571	927,595	26.83	4
5	CNAs & Orderlies	114,538	118,405	1,608,380	13.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,507	10,174	126,650	12.45	10
11	Social Service Workers	6,878	7,130	138,139	19.37	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	9,537	9,875	144,582	14.64	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,880	2,960	165,536	55.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,832	22,390	526,380	23.51	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	3,426	3,521	49,952	14.19	31
32	Other Health Care Care Plan Coord	4,503	4,801	166,416	34.66	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	237,029	244,574	\$ 5,074,904 *	\$ 20.75	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 0	1-3	35
36	Medical Director	O	47,500	9-3	36
37	Medical Records Consultant	N	720	10-3	37
38	Nurse Consultant	T	42,899	10-3	38
39	Pharmacist Consultant	H	16,153	10-3	39
40	Physical Therapy Consultant	L	45,270	10a-3	40
41	Occupational Therapy Consultant	Y	34,339	10a-3	41
42	Respiratory Therapy Consultant		57,349	10a-3	42
43	Speech Therapy Consultant	F	13,872	10a-3	43
44	Activity Consultant	E	2,992	11-3	44
45	Social Service Consultant	E	624	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 261,718		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	640	\$ 41,626	10-3	50
51	Licensed Practical Nurses	286	13,931	10-3	51
52	Certified Nurse Assistants/Aides	238	6,690	10-3	52
53	TOTAL (lines 50 - 52)	1,164	\$ 62,247		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
MATTHEW GIDLEY	ADMINISTRATOR	0	\$ 134,767
ISSAC PURE	ADMINISTRATOR	0	30,769
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 165,536
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
ALPHA DATA SERVICES	DATA PROCESSING	\$	10,769
NATIONAL DATACARE	DATA PROCESSING		2,797
KBKB, LTD	ACCOUNTING FEES		17,700
RICHARD PEELO & ASSOCIAT.	MEDICARE CONSULTANT		4,500
PERSONNEL PLANNERS	UC CONSULTANT		2,856
IMPG RISK MGMT SERVICES	LIABILITY/REGULATORY		3,333
EARTHWISE ENVIRONMENTAL	LEGIONELLA TESTING		4,500
LEGAL FEES	SEE SCHEDULE		85,805
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$	132,260
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	156,891
Unemployment Compensation Insurance			111,630
FICA Taxes			376,101
Employee Health Insurance			64,752
Employee Meals			0
Illinois Municipal Retirement Fund (IMRF)*			
EMPLOYEE BENEFITS - OTHER			18,271
EMPLOYEE PHYSICAL EXAMS			0
PENSION/PROFIT SHARING PLANS			0
INSURANCE - EXECUTIVE LIFE			0
CHICAGO BULLS TICKETS			(1,959)
INSURANCE - EXECUTIVE LIFE VI 21			0
TOTAL (agree to Schedule V, line 22, col.8)		\$	725,686
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		\$	1,980
Advertising: Employee Recruitment			29,443
Health Care Worker Background Check (Indicate # of checks performed 110)			1,100
Patient Background Checks 237			3,835
TRUST/FRANCHISE/CONTRIB/ETC			6,699
MARKETING/ADV/PROMO			394,914
LICENSES/DUES/SUBSCRIPTIONS			18,741
TRUST/FRANCHISE/CONTRIB/ETC			(6,699)
Less: Public Relations Expense		(	0)
Non-allowable advertising			(394,914)
Yellow page advertising		(	0)
TOTAL (agree to Sch. V, line 20, col. 8)		\$	55,099
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
			10,524
Seminar Expense			
			0
Entertainment Expense		(	)
TOTAL (agree to Sch. V, line 24, col. 8)		\$	10,524

*** Attach copy of IMRF notifications**

****See instructions.**

BRIA OF PALOS HILLS
SCHEDULE-LEGAL
12/31/2016

DATE	FIRM NAME	DESCRIPTION OF SERVICES	AMOUNT
1/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	428
2/29/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	614
3/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	688
4/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,459
5/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	448
6/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	2,078
7/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,024
8/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,021
9/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	808
10/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	821
11/30/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	821
12/31/2016	STONE , MCGUIRE & SIEGEL	COMPLIANCE LEGAL	623
2/2/2016	GARY A. WEINTRAUB,P.C.	CONSULTATION REGARDING COMPLIANCE	354
2/19/2016	GARY A. WEINTRAUB,P.C.	CONSULTATION REGARDING LINE OF CREDIT	1,641
5/2/2016	GARY A. WEINTRAUB,P.C.	GENERAL COUNSELING	590
6/2/2016	GARY A. WEINTRAUB,P.C.	CONSULTATION REGARDING COMPLIANCE	384
9/2/2016	GARY A. WEINTRAUB,P.C.	CONSULTATION REGARDING COMPLIANCE	472
10/2/2016	GARY A. WEINTRAUB,P.C.	CONSULTATION REGARDING COMPLIANCE	590
11/2/2016	GARY A. WEINTRAUB,P.C.	CONSULTATION REGARDING COMPLIANCE	384
12/2/2016	GARY A. WEINTRAUB,P.C.	CONSULTATION REGARDING COMPLIANCE	354
12/31/2016	GARY A. WEINTRAUB,P.C.	CONSULTATION REGARDING COMPLIANCE	455
2/20/2016	HALL PRANGLE & SCHOONVELD,L.L.C.	RESIDENT ESTATE	4,281
2/22/2016	HALL PRANGLE & SCHOONVELD,L.L.C.	RESIDENT ESTATE	218
3/15/2016	HALL PRANGLE & SCHOONVELD,L.L.C.	RESIDENT ESTATE	2,992
5/2/2016	HALL PRANGLE & SCHOONVELD,L.L.C.	RESIDENT ESTATE	745
5/23/2016	HALL PRANGLE & SCHOONVELD,L.L.C.	RESIDENT ESTATE	316
6/29/2016	HALL PRANGLE & SCHOONVELD,L.L.C.	RESIDENT ESTATE	1,258
7/29/2016	HALL PRANGLE & SCHOONVELD,L.L.C.	RESIDENT ESTATE	1,237
3/17/2016	SEYFARTH ATTORNEYS SHAW LLP	OPERATOR LOAN	2,153
8/19/2016	SEYFARTH ATTORNEYS SHAW LLP	CONSTRUCTION LOAN	6,299
9/9/2016	DUANE MORRIS	HFSRB EVALUATION	2,279
8/2/2016	CAN DEDUCTIBLE RECOVERY GROUP	SETTLEMENT	50,000
5/23/2016	SPIELBERGER LAW GROUP	SETTLEMENT	1,800
1/25/2016	FEDERAL INSURANCE COMPANY	DEFENSE COSTS	911
5/11/2016	FEDERAL INSURANCE COMPANY	DEFENSE COSTS	215
4/4/2016	HEPLERBROOM	RESIDENT ESTATE	(4,951)
TOTAL			<u><u>85,805</u></u>

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. IL COUNCIL ON LONG TERM CARE \$13,601

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

(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. \$ 36,022 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 X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
PALOS HILLS EXTENDED CARE LLC, IDPH #0046029 07/01/2010

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 363,050
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? 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