

		FOR BHF USE					

LL1

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: 0053843 Facility Name: Chalet Living & Rehab Address: 7350 N Sheridan Road Chicago 60626 County: Cook Telephone Number: (773) 274-1000 Fax #: (773) 274-2353 HFS ID Number: Date of Initial License for Current Owners: 10/1/2011 Type of Ownership: ☐ VOLUNTARY,NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other

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

Name: Steven N. Lavenda Telephone Number: (847) 282-6300

Email Address:

Facility Name & ID Number Chalet Living & Rehab

0053843 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

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>219</u>	Skilled (SNF)	<u>219</u>	<u>80,154</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>219</u>	TOTALS	<u>219</u>	<u>80,154</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>61,051</u>	<u>3,605</u>	<u>5,271</u>	<u>69,927</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>61,051</u>	<u>3,605</u>	<u>5,271</u>	<u>69,927</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.24%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

☐

NO

☒

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 10/01/2011

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

YES

☒

Date 10/01/2011

NO

☐

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

YES

☒

NO

☐

If YES, enter number

of beds certified

219

and days of care provided

4,423

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 Chalet Living & Rehab # 0053843 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	379,038	25,635	9,816	414,489		414,489		414,489			1
2	Food Purchase		386,906		386,906		386,906	(7,095)	379,811			2
3	Housekeeping	243,093	61,335		304,428		304,428	153	304,581			3
4	Laundry	64,240	20,164		84,404		84,404		84,404			4
5	Heat and Other Utilities			259,496	259,496		259,496	(12,462)	247,034			5
6	Maintenance	128,871	9,646	190,050	328,567		328,567	55,504	384,071			6
7	Other (specify):*											7
8	TOTAL General Services	815,242	503,686	459,362	1,778,290		1,778,290	36,100	1,814,390			8
	B. Health Care and Programs											
9	Medical Director			31,378	31,378		31,378		31,378			9
10	Nursing and Medical Records	3,643,393	80,171	87,503	3,811,067		3,811,067	56,901	3,867,968			10
10a	Therapy	184,995			184,995		184,995	(12,574)	172,421			10a
11	Activities	135,219	11,399	848	147,466		147,466		147,466			11
12	Social Services	173,801		2,770	176,571		176,571	152,302	328,873			12
13	CNA Training											13
14	Program Transportation			6,875	6,875		6,875	9	6,884			14
15	Other (specify):*							16,347	16,347			15
16	TOTAL Health Care and Programs	4,137,408	91,570	129,374	4,358,352		4,358,352	212,985	4,571,337			16
	C. General Administration											
17	Administrative	167,949		9,838	177,787		177,787	162,268	340,055			17
18	Directors Fees											18
19	Professional Services			101,249	101,249	(980)	100,269	26,431	126,700			19
20	Dues, Fees, Subscriptions & Promotions			68,648	68,648		68,648	(14,399)	54,249			20
21	Clerical & General Office Expenses	258,296	7,132	467,765	733,193		733,193	(51,004)	682,189			21
22	Employee Benefits & Payroll Taxes			920,983	920,983		920,983		920,983			22
23	Inservice Training & Education			38,939	38,939		38,939		38,939			23
24	Travel and Seminar			7,476	7,476		7,476	3,013	10,489			24
25	Other Admin. Staff Transportation			3,592	3,592		3,592		3,592			25
26	Insurance-Prop.Liab.Malpractice			200,665	200,665		200,665	6,282	206,947			26
27	Other (specify):*							65,515	65,515			27
28	TOTAL General Administration	426,245	7,132	1,819,155	2,252,532	(980)	2,251,552	198,107	2,449,658			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,378,895	602,388	2,407,891	8,389,174	(980)	8,388,194	447,191	8,835,385			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							701,251	701,251			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,654	42,654		42,654	1,551,938	1,594,592			32
33	Real Estate Taxes			195,000	195,000	980	195,980	2,385	198,365			33
34	Rent-Facility & Grounds			3,553,258	3,553,258		3,553,258	(3,553,128)	130			34
35	Rent-Equipment & Vehicles			11,677	11,677		11,677	81	11,758			35
36	Other (specify):*											36
37	TOTAL Ownership			3,802,589	3,802,589	980	3,803,569	(1,297,472)	2,506,097			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		273,896	677,076	950,972		950,972		950,972			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			521,130	521,130		521,130		521,130			42
43	Other (specify):*			743,644	743,644		743,644	(743,644)	0			43
44	TOTAL Special Cost Centers		273,896	1,941,850	2,215,746		2,215,746	(743,644)	1,472,102			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,378,895	876,284	8,152,330	14,407,509		14,407,509	(1,593,925)	12,813,584			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	(15,477)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(85,423)	30		9
10	Interest and Other Investment Income	(5,176)	32		10
11	Discounts, Allowances, Rebates & Refunds	(7,871)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(199)	02		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	(499)	21		18
19	Entertainment	(2,032)	21		19
20	Contributions	(1,402)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(239,692)	21		24
25	Fund Raising, Advertising and Promotional	(9,635)	20		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	(1,684,522)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,051,928)		\$	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)	458,003		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 458,003		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,593,925)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Chalet Living & Rehab

	ID#	0053843
Report Period Beginning:		01/01/16
Ending:		12/31/16

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Additional R&M	\$ 31,367	06	1
2	Non-Allowable Legal	(8,387)	19	2
3	Miscellaneous Income	(150)	21	3
4	Patient Personal Items	(1,334)	10	4
5	Marketing	(12,250)	43	5
6	Bank Charges	(2,959)	21	6
7	Sequestration	(50,040)	21	7
8	Therapy Discounts	(12,574)	10A	8
9	Pharmacy Discounts	(11,678)	10	9
10	Building Co - Title Fees	(4,683)	20	10
11	Building Co - Loan Fee	(82,389)	26	11
12	Building Co - Accounting Fee	(7,694)	19	12
13	Building Co - Legal	(17,207)	19	13
14	Building Co - Tax Extension Fee	(2,800)	19	14
15	Building Co - Management Fee	(761,015)	21	15
16	PAC Dues	(6,717)	20	16
17	Capitalized R&M	(2,618)	06	17
18	Non-Allowable Expense	(731,394)	43	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	(1,684,522)		49

ID#

0053843

Report Period Beginning:

01/01/16

Ending:

12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chalet Living & Rehab # 0053843 Report Period Beginning: 01/01/16 Ending: 12/31/16

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													1
2	Food Purchase	(8,070)		214		761							(7,095)	2
3	Housekeeping			153									153	3
4	Laundry													4
5	Heat and Other Utilities	(15,477)		670			2,345						(12,462)	5
6	Maintenance	28,749		8,893		15,236	2,627						55,504	6
7	Other (specify):*													7
8	TOTAL General Services	5,202		9,929		15,997	4,972						36,100	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(13,012)				69,913							56,901	10
10a	Therapy	(12,574)											(12,574)	10a
11	Activities													11
12	Social Services					152,302							152,302	12
13	CNA Training													13
14	Program Transportation					9							9	14
15	Other (specify):*					16,347							16,347	15
16	TOTAL Health Care and Programs	(25,586)				238,570							212,985	16
	C. General Administration													
17	Administrative			13,822		148,446							162,268	17
18	Directors Fees													18
19	Professional Services	(36,088)	27,701	31,420	91	2,245	1,061						26,431	19
20	Fees, Subscriptions & Promotions	(22,437)	4,683	2,724		627	4						(14,399)	20
21	Clerical & General Office Expenses	(1,056,387)	761,015	242,062		2,273	33						(51,004)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,810		1,203							3,013	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(82,389)	82,389	1,562		4,249	471						6,282	26
27	Other (specify):*			52,364		13,152							65,515	27
28	TOTAL General Administration	(1,197,301)	875,788	345,765	91	172,194	1,570						198,107	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,217,685)	875,788	355,694	91	426,761	6,542						447,191	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chalet Living & Rehab # 0053843 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(85,423)	783,487	718	2,469								701,251	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,176)	1,550,954	12	894		5,255						1,551,938	32
33	Real Estate Taxes			1,270			1,115						2,385	33
34	Rent-Facility & Grounds		(3,553,258)	67,279		51	(67,200)						(3,553,128)	34
35	Rent-Equipment & Vehicles			81									81	35
36	Other (specify):*													36
37	TOTAL Ownership	(90,599)	(1,218,817)	69,360	3,363	51	(60,830)						(1,297,472)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(743,644)											(743,644)	43
44	TOTAL Special Cost Centers	(743,644)											(743,644)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,051,928)	(343,029)	425,054	3,454	426,812	(54,288)						(1,593,925)	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		See Page 6-Supplemental		See Page 6-Supplemental		

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 3,553,258	Chalet Real Property LLC	100.00%	\$	\$(3,553,258)	1
2	V	20	Title Fee		Chalet Real Property LLC	100.00%	4,683	4,683	2
3	V	32	Interest		Chalet Real Property LLC	100.00%	1,550,954	1,550,954	3
4	V	21	Management Fee		Chalet Real Property LLC	100.00%	761,015	761,015	4
5	V	26	Loan Fee		Chalet Real Property LLC	100.00%	82,389	82,389	5
6	V	19	Accounting		Chalet Real Property LLC	100.00%	7,694	7,694	6
7	V	19	Legal		Chalet Real Property LLC	100.00%	17,207	17,207	7
8	V	19	Tax Extension Fee		Chalet Real Property LLC	100.00%	2,800	2,800	8
9	V	30	Depreciation		Chalet Real Property LLC	100.00%	783,487	783,487	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 3,553,258			\$ 3,210,229	\$ * (343,029)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	\$	Legacy Healthcare Financial Services	100.00%	\$ 214	\$ 214	15
16	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	153	153	16
17	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	670	670	17
18	V	6	GROUPS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	6,684	6,684	18
19	V	6	MAINTENANCE SALARY		Legacy Healthcare Financial Services	100.00%	2,208	2,208	19
20	V	17	CFO SALARY		Legacy Healthcare Financial Services	100.00%	13,822	13,822	20
21	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	31,420	31,420	21
22	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	2,724	2,724	22
23	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	209,640	209,640	23
24	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	32,422	32,422	24
25	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	1,810	1,810	25
26	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	1,562	1,562	26
27	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	52,364	52,364	27
28	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%	718	718	28
29	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	12	12	29
30	V	33	REAL ESTATE TAXES		Legacy Healthcare Financial Services	100.00%	1,270	1,270	30
31	V	34	RENT		Legacy Healthcare Financial Services	100.00%	67,200	67,200	31
32	V	34	STORAGE		Legacy Healthcare Financial Services	100.00%	79	79	32
33	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	81	81	33
34	V								34
35	V								35
36	V	17	MANAGEMENT FEES	9,838	Legacy Healthcare Financial Services	100.00%		(9,838)	36
37	V	17	MANAGEMENT FEES - YAIR ZUCKERMAN		Legacy Healthcare Financial Services	100.00%	9,838	9,838	37
38	V								38
39	Total			\$ 9,838			\$ 434,892	\$ * 425,054	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	19	PROFESSIONAL FEES	\$	Legacy Real Properties	100.00%	\$ 91	\$	91
16	V	30	DEPRECIATION		Legacy Real Properties	100.00%	2,469		2,469
17	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	894		894
18	V								
19	V								
20	V								
21	V								
22	V								
23	V								
24	V								
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$			\$ 3,454	\$ *	3,454

* 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.

☒ X

 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	2	FOOD	\$	Progressive Healthcare Consulting	100.00%	\$ 761	\$ 761	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	14,712	14,712	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	523	523	17
18	V	10	MEDICAL AND NURSING SUPPLIES		Progressive Healthcare Consulting	100.00%	203	203	18
19	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	146,373	146,373	19
20	V	12	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	183	183	20
21	V	12	CLERGY SALARY		Progressive Healthcare Consulting	100.00%	2,657	2,657	21
22	V	12	ADMISSIONS SALARY		Progressive Healthcare Consulting	100.00%	149,462	149,462	22
23	V	14	PATIENT TRANSPORTATION		Progressive Healthcare Consulting	100.00%	9	9	23
24	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	21,914	21,914	24
25	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	153,759	153,759	25
26	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	2,245	2,245	26
27	V	20	FEES, SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%	627	627	27
28	V	21	CLERICAL & GENERAL		Progressive Healthcare Consulting	100.00%	2,273	2,273	28
29	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	1,203	1,203	29
30	V	27	EMP. BEN.-NON-NURSING		Progressive Healthcare Consulting	100.00%	45,396	45,396	30
31	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	4,249	4,249	31
32	V	34	STORAGE RENTAL		Progressive Healthcare Consulting	100.00%	51	51	32
33	V								33
34	V	10	NURSING	76,663	Progressive Healthcare Consulting	100.00%		(76,663)	34
35	V	17	ADMINISTRATIVE	5,313	Progressive Healthcare Consulting	100.00%		(5,313)	35
36	V	15	PAYROLL TAXES - NURSING	5,567	Progressive Healthcare Consulting	100.00%		(5,567)	36
37	V	27	PAYROLL TAXES - NON-NURSING	32,244	Progressive Healthcare Consulting	100.00%		(32,244)	37
38	V								38
39	Total			\$ 119,787			\$ 546,599	\$ * 426,812	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	5	UTILITIES	\$	CF ST. LOUIS, LLC	100.00%	\$ 2,345	\$ 2,345	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	2,627	2,627	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	1,061	1,061	17
18	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	4	4	18
19	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100.00%	33	33	19
20	V	26	INSURANCE		CF ST. LOUIS, LLC	100.00%	471	471	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	5,255	5,255	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	1,115	1,115	22
23	V								23
24	V	34	RENT	67,200	CF ST. LOUIS, LLC	100.00%		(67,200)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 67,200			\$ 12,912	\$ * (54,288)	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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

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	YAIR ZUCKERMAN	0.90%	ASTORIA PLACE SKILLED NURSING FACILITY LLC	CHICAGO	CHALET PROPERTIES		BUILDING COMPANY	1
2	DINA ZUCKERMAN	0.10%	BETHANY TERRACE	MORTON GROVE	LEGACY REAL PROPERTIES	LINCOLNWOOD	BUILDING CO	2
3	10 PACK TENANT, LLC	99.00%	CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BOOKKEEPING	3
4			ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	4
5			EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	5
6			GROVE OF FOX VALLEY	AURORA	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	6
7			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	7
8			GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	8
9			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO	LINCOLNSHIRE ASSISTED LIVING	LINCOLNSHIRE	ASSISTED LIVING	9
10			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO	CF ST. LOUIS LLC	SKOKIE	BUILDING COMPANY	10
11			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				11
12			AVANTARA LONG GROVE	LONG GROVE				12
13			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				13
14			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				14
15			WARREN BARR NORTH SHORE	HIGHLAND PARK				15
16			AVANTARA PARK RIDGE	PARK RIDGE				16
17			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				17
18			WARREN BARR SOUTH LOOP	CHICAGO				18
19			WARREN BARR LIVING AND REHAB	CHICAGO				19
20			CEDAR SKILLED NURSING FACILITY	CEDAR CITY, UT				20
21			ST. GEORGE SKILLED NURSING FACILITY	ST. GEORGE, UT				21
22			CLARK SKILLED NURSING FACILITY	CHICAGO				22
23			PARKER SKILLED NURSING FACILITY LLC	PARKER, CO				23
24			AZRIA MONTCLAIR	OMAHA, NE				24
25			AZRIA OLATHE	OLATHE, KS				25
26								26
27								27
28								28
29								29
30								30

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								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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	Yair Zuckerman	Owner	Administrative	0.90%	See Attached	2.46	4.92%	Mgmt Fee	\$ 9,838	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 9,838		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

Ending: 12/31/16

Fax Number

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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

Ending: 12/31/16

(847) 683-2900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	AVAIL. BED DAYS	1,629,488	29	\$ 4,354	\$	80,154	\$ 214	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,629,488	29	3,107		80,154	153	2
3	5	UTILITIES	AVAIL. BED DAYS	1,629,488	29	13,622		80,154	670	3
4	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,629,488	29	135,883		80,154	6,684	4
5	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,629,488	29	44,897	44,897	80,154	2,208	5
6	17	CFO SALARY	AVAIL. BED DAYS	1,629,488	29	281,003	281,003	80,154	13,822	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,629,488	29	638,760		80,154	31,420	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,629,488	29	55,387		80,154	2,724	8
9	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,629,488	29	4,261,866	4,261,866	80,154	209,640	9
10	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,629,488	29	659,124		80,154	32,422	10
11	24	SEMINARS	AVAIL. BED DAYS	1,629,488	29	36,800		80,154	1,810	11
12	26	INSURANCE	AVAIL. BED DAYS	1,629,488	29	31,752		80,154	1,562	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,629,488	29	1,064,526		80,154	52,364	13
14	30	DEPRECIATION	AVAIL. BED DAYS	1,629,488	29	14,600		80,154	718	14
15	32	INTEREST	AVAIL. BED DAYS	1,629,488	29	234		80,154	12	15
16	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,629,488	29	25,813		80,154	1,270	16
17	34	RENT	AVAIL. BED DAYS	1,629,488	29	1,366,146		80,154	67,200	17
18	34	STORAGE	AVAIL. BED DAYS	1,629,488	29	1,600		80,154	79	18
19	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,629,488	29	1,654		80,154	81	19
20										20
21	17	MANAGEMENT FEES- Y. ZUC	AVG HOURS WKD	50	29	200,000		3.19	9,838	21
22										22
23										23
24										24
25	TOTALS					\$ 8,841,129	\$ 4,587,766		\$ 434,892	25

Facility Name & ID Number Chalet Living & Rehab # 0053843 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Legacy Real Properties
Street Address 3450 Oakton Street
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 679-9797
Fax Number (847) 683-2900

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,629,488	29	\$ 1,852	\$	80,154	\$ 91	1
2	30	DEPRECIATION	AVAIL. BED DAYS	1,629,488	29	50,196		80,154	2,469	2
3	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,629,488	29	18,179		80,154	894	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					\$ 70,227	\$		\$ 3,454	25

Ending: 12/31/16

(847) 683-2900

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	2	FOOD	AVAIL. BED DAYS	1,167,679	21	\$ 11,123	\$ 79,935	\$ 761	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,167,679	21	214,912	79,935	14,712	2
3	6	BUILDING MAINTENANCE A	AVAIL. BED DAYS	1,167,679	21	7,646	79,935	523	3
4	10	MEDICAL AND NURSING SUP	AVAIL. BED DAYS	1,167,679	21	2,971	79,935	203	4
5	10	NURSING SALARIES	AVAIL. BED DAYS	1,167,679	21	2,138,189	79,935	146,373	5
6	12	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,167,679	21	2,679	79,935	183	6
7	12	CLERGY SALARY	AVAIL. BED DAYS	1,167,679	21	38,812	79,935	2,657	7
8	12	ADMISSIONS SALARY	AVAIL. BED DAYS	1,167,679	21	2,183,313	79,935	149,462	8
9	14	PATIENT TRANSPORTATION	AVAIL. BED DAYS	1,167,679	21	128	79,935	9	9
10	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,167,679	21	320,111	79,935	21,914	10
11	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,167,679	21	2,246,090	79,935	153,759	11
12	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,167,679	21	32,793	79,935	2,245	12
13	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,167,679	21	9,154	79,935	627	13
14	21	CLERICAL & GENERAL	AVAIL. BED DAYS	1,167,679	21	33,203	79,935	2,273	14
15	24	SEMINARS	AVAIL. BED DAYS	1,167,679	21	17,580	79,935	1,203	15
16	27	EMP. BEN.-NON-NURSING	AVAIL. BED DAYS	1,167,679	21	663,131	79,935	45,396	16
17	26	INSURANCE	AVAIL. BED DAYS	1,167,679	21	62,063	79,935	4,249	17
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,167,679	21	750	79,935	51	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 7,984,649	\$ 6,821,317	\$ 546,599	25

Facility Name & ID Number Chalet Living & Rehab # 0053843 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 CF St. Louis LLC
Street Address 3450 Oakton Street
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 676-5300
Fax Number (847) 676-5348

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	5	UTILITIES	AVAIL. BED DAYS	1,629,488	29	\$ 47,675	\$ 80,154	\$ 2,345	1
	2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,629,488	29	53,400	80,154	2,627	2
	3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,629,488	29	21,572	80,154	1,061	3
	4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,629,488	29	76	80,154	4	4
	5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,629,488	29	678	80,154	33	5
	6	26	INSURANCE	AVAIL. BED DAYS	1,629,488	29	9,585	80,154	471	6
	7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,629,488	29	106,824	80,154	5,255	7
	8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,629,488	29	22,674	80,154	1,115	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				\$ 262,484	\$		\$ 12,912	25

Ending: 12/31/16

Fax Number

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

Facility Name & ID Number Chalet Living & Rehab # 0053843 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

Ending: 12/31/16

Fax Number

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

Facility Name & ID Number Chalet Living & Rehab # 0053843 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

Ending: 12/31/16

Fax Number

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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	The Private Bank		X	Mortgage			\$	32,228,498			\$	1,550,954	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	The Private Bank		X					1,545,173				42,654	6
7	Allocated from Legacy HC	X										12	7
8	See Supplemental Schedule				-							6,149	8
9	TOTAL Facility Related						\$	33,773,671			\$	1,599,769	9
	B. Non-Facility Related*												
10	Interest Income		X									(5,176)	10
11													11
12													12
13					-								13
14	TOTAL Non-Facility Related						\$				\$	(5,176)	14
15	TOTALS (line 9+line14)						\$	33,773,671			\$	1,594,593	15

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

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8	Alloc from Legacy Real Propert	X					\$	\$			\$ 894	8	
9	Allocated from CF St. Louis	X									5,255	9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital										6,149	14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.			\$	322,869	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	222,899	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(99,970)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	297,355	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	980	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	198,365	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	193,231	8	
		2012	188,105	9	
		2013	189,529	10	
		2014	183,129	11	
		2015	220,514	12	
Beginning Accrual Adjusted					
2016 Accrual: \$220,514 x 1.35 = \$297,355					
Allocated from Legacy HC: \$1,270					
Allocated from CF St. Louis LLC: \$1,115					
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

FACILITY NAME	<u>Chalet Living & Rehab</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0053843</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	<u>(847) 236-6300</u>	FAX #:	<u>(847) 236-6301</u>

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

B. Real Estate Tax Cost Allocations

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? X YES 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 provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

FACILITY NAME	<u>Chalet Living & Rehab</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0053843</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	<u>(847) 236-6300</u>	FAX #:	<u>(847) 236-6301</u>

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

B. Real Estate Tax Cost Allocations

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

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

Page 10B

A. Square Feet: 76,920

B. General Construction Type: Exterior Masonry Frame

Number of Stories 4

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2014	\$ 1,752,000	1
2	Allocated from Legacy Real Properties			4,024	2
3	TOTALS			\$ 1,756,024	3

Facility Name & ID Number Chalet Living & Rehab

0053843

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	219		2014	1979	\$ 14,673,000	\$ 783,487	35	\$ 419,229	\$ (364,258)	\$ 1,038,545	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2012		858,803		20	42,940	42,940	85,880	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		113,466	1,806		5,100	3,294	21,073	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 15,645,269	\$ 785,293		\$ 467,269	\$ (318,024)	\$ 1,145,498	70

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

Facility Name & ID Number Chalet Living & Rehab

0053843

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	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	
1	Totals from Page 12A, Carried Forward		\$ 15,645,269	\$ 785,293		\$ 467,269	\$ (318,024)	\$ 1,145,498	1
2	1St Floor Renovation: Demo,Framing,Drywall	2013			20				2
3	Doors,Hardware,Glass,Handrail,Hvac	2013			20				3
4	Accoustical Ceiling, Archtectureal Fees/Permits	2013	231,066		20	11,553	11,553	23,107	4
5	Therapy Room,Computer Room,Admin Office,Part	2013			20				5
6	Of Hallway 1St Floor-Install The Tiles And Carpet	2013	24,262		20	1,213	1,213	2,426	6
7	Two Staff Bathrooms,Hallways,Beauty Salon	2013			20				7
8	Install New Toilets,Ceramic Tiles,Lights Fixtures,Crown Molding	2013	15,778		20	789	789	1,578	8
9	Shower Room Renovation-Replace Light Fixtures,Drop Ceiling,In	2013			20				9
10	Ceramic Tiles, Toilets, Sink,Paint Entire Shower Room	2013	28,801		20	1,440	1,440	2,880	10
11	1St Floor Rehab Project:Painting Of The New	2013			20				11
12	Installed Soffits,Crown Molding, Vinyl Wallcovering	2013			20				12
13	Additional Patching And Skimming,	2013	57,334		20	2,867	2,867	5,733	13
14	Ceiling Fixture,Ceiling Decorative Circle	2013			20				14
15	Electrical Demolition Work:Install Exit Lights	2013			20				15
16	Outlets,Recessed Fixtures With Trim And Bulbs;	2013			20				16
17	Ceramic Tiles, Plumbing, Millwork	2013	41,871		20	2,094	2,094	4,187	17
18	4Th Floor: Guest Rooms & Baths,Corridors,Patient Bathrooms,D	2013			20				18
19	Entry Doors,Stripped And Waxed All Floors,Install Baseboard,	2013			20				19
20	Vinyl Wallcovering, Painting	2013	100,350		20	5,018	5,018	10,035	20
21	Kitchen Cabinets Installation,Drop Ceiling In Living Room	2013	11,650		20	583	583	1,165	21
22	Elevator-Replaced Submersible Pump Motor	2013	5,716		20	286	286	572	22
23	Installation Of Fire Alarm System Devices,Smoke Detectors	2013	12,392		20	620	620	1,239	23
24	Hot Water Heater Replacement	2013	10,898		20	545	545	1,090	24
25	Fire Dampers Replacement	2013	5,967		20	298	298	597	25
26	Reworked Existing Sprinklers On 1St Floor And Lobby Area	2013			20				26
27	Repair Anti-Freeze System In Connection With Renovation	2013	20,542		20	1,027	1,027	2,054	27
28	Architectureal Fees And Permits, Materials And Shop Drawings	2013	14,000		20	700	700	1,400	28
29	4Th Floor Rooms Renovation-Install New Electrical Outlets	2013			20				29
30	And Cable Wiring For Tvs,Install New Curtains,Install Tv, Replac	2013			20				30
31	All Necessary Electrical Outlets,Switches,And Plates	2013			20				31
32	Bathrooms Paper And Soap Dispenser Installation	2013	18,000		20	900	900	1,800	32
33	Electric -First Floor Entrance	2013	6,175		20	309	309	618	33
34	TOTAL (lines 1 thru 33)		\$ 16,250,071	\$ 785,293		\$ 497,509	\$ (287,784)	\$ 1,205,978	34

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

Facility Name & ID Number Chalet Living & Rehab

0053843

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	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	
1	Totals from Page 12B, Carried Forward		\$ 16,250,071	\$ 785,293		\$ 497,509	\$ (287,784)	\$ 1,205,978	1
2	<u>Tiling</u>	2013	3,317		20	166	166	332	2
3	<u>Pcc Wire/Wireless Installed</u>	2013	48,016		20	2,401	2,401	4,802	3
4	<u>Cubicle Curtains And Design Fee For Basement</u>	2013	39,905		20	1,995	1,995	3,991	4
5	<u>Fire Pump Repairs And Fire Dampers Installed</u>	2013	15,360		20	768	768	1,536	5
6	<u>Basement Rehab-Demo,Carpentry,Dumpsters</u>	2013			20				6
7	<u>Drywall,Door,Ceiling Tiles,Bath Accessor,</u>	2013			20				7
8	<u>Clean Up,Project Management,Profit Overhead</u>	2013	28,264		20	1,413	1,413	2,826	8
9	<u>New Flooring/Tiling</u>	2013	41,430		20	2,072	2,072	4,143	9
10	<u>New Therapy Room Ac Installation</u>	2013	17,268		20	863	863	1,727	10
11	<u>Basement Work-Two Staff Bathrooms,Activity</u>	2013			20				11
12	<u>Room Bathroom And Electric Work In The Basement</u>	2013	17,010		20	851	851	1,701	12
13	<u>Electric Work On Fourth Floor</u>	2013	16,602		20	830	830	1,660	13
14	<u>Installation Renovation Of Therapy Room,</u>	2013			20				14
15	<u>Library And Beauty Salon, Conference Room</u>	2013			20				15
16	<u>Hallway And Other Work</u>	2013	42,550		20	2,128	2,128	4,255	16
17	<u>Plumbing And Vct Floor In Basement</u>	2013	13,950		20	698	698	1,395	17
18	<u>Furnish And Install Automatic Door</u>	2013	4,300		20	215	215	430	18
19	<u>Secruity-Egressable Mag Lock With Rest</u>	2013			20				19
20	<u>Switch,Exit Pad Pressure Sensitive</u>	2013	10,970		20	549	549	1,097	20
21	<u>Install New Tv On The Ceiling, Repair Wall In The</u>	2013			20				21
22	<u>Kitchen, Install Door Closers, Install Wet</u>	2013			20				22
23	<u>Chair For Beauty Shop</u>	2013	5,650		20	283	283	565	23
24	<u>New Pump For Chiller</u>	2013	8,699		20	435	435	870	24
25	<u>Basement Light Fixture</u>	2013	3,360		20	168	168	336	25
26	<u>Tiling In The Elevators</u>	2013	5,509		20	275	275	551	26
27	<u>Cubicle Curtains</u>	2013	19,443		20	972	972	1,944	27
28	<u>Painting In The Lower Level</u>	2013	10,685		20	534	534	1,069	28
29	<u>Locker Double Tier 6 Door Assembled</u>	2014	1,671		20	84	84	251	29
30	<u>Install Delayed Egress Locks And Associated Components</u>	2014	11,900		20	595	595	1,785	30
31	<u>Build & Install Wall Decorating Panel-Remove Wallpaper & Pain</u>	2014	18,650		20	933	933	2,798	31
32	<u>Wall, Install New Led Lights Strip & Outlets, Build & Stall New</u>	2014			20				32
33	<u>Kitchen Cabinets With Sink In The Basement, Build & Install</u>	2014			20				33
34	TOTAL (lines 1 thru 33)		\$ 16,634,580	\$ 785,293		\$ 516,734	\$ (268,559)	\$ 1,246,040	34

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

Facility Name & ID Number Chalet Living & Rehab

0053843

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	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	
1	Totals from Page 12C, Carried Forward		\$ 16,634,580	\$ 785,293		\$ 516,734	\$ (268,559)	\$ 1,246,040	1
2	Tv Panel; Remove Hallway By The Kitchen; Staff Launch Rooms	2014			20				2
3	Patio Ceiling And Wallcovering	2014	4,940		20	247	247	741	3
4	One Lot Of Signage	2014	4,947		20	247	247	742	4
5	Renovate Room 200 & 227; Repair Countertop By Nurses	2014	14,650		20	733	733	2,198	5
6	Station On 2Nd Floor;Renovate Two Elevators;Demo Floors & Ce	2014			20				6
7	Install New Cement Baord On The Walls; Install New Vct Floor T	2014			20				7
8	Install New Stainless Steel Ceiling Panels; Install New Led Lightin	2014			20				8
9	Install New Realigns; Seat Esprsd	2014	3,787		20	189	189	568	9
10	Install Owner Supplied Crossville Laminam Col Sketch Avorio Th	2014	5,857		20	293	293	879	10
11	Porcelain Panels On The Walls Of Two Elevators Of Compost	2014			20				11
12	Provide Electrical Outlets And Install New Computers And	2014	5,950		20	298	298	893	12
13	Other Repairing Work	2014			20				13
14	Replacement Of Valve Tamper Panel & Fire Alarm System Device	2014	5,233		20	262	262	785	14
15	Flashcan Address Monitor Module; Labor & Materials Fire Alarm	2014	3,831		20	192	192	575	15
16	Fire Pump Repairs & Fire Pump Power Monitor	2014	1,511		20	76	76	227	16
17	Condensor Tube Cleaning; Oil Filter;Filter Replacement Labor	2014	4,746		20	237	237	712	17
18	Install Summer Annuals To 5 Pots And All Flower Beds	2014	4,250		20	213	213	638	18
19	Amend Soil With 2 Cubic Yards	2014			20				19
20	Painting - Exterior Railings And Gate	2015	6,876		20	344	344	688	20
21	Elevator Handrails	2015	3,618		20	181	181	362	21
22	Pavement Repairs - Wheelstops/Milling/Priming/Striping	2015	43,290		20	2,165	2,165	4,329	22
23	32 Fire Rated Drop Ceiling Light Fixtures-4Th Floor	2015	9,280		20	464	464	928	23
24	Plumbing - Faucet/Levers/Valves/Drains	2015	4,950		20	248	248	495	24
25	Concrete Work On Smoking Deck	2015	2,500		20	125	125	250	25
26	Repaired Chiller	2015	9,436		20	472	472	944	26
27	Installed Water Heater In Kitchen	2015	3,400		20	170	170	340	27
28	Shower Room - Remove Wall Tiles/Framing/Valves	2016	11,950		20	598	598	598	28
29	Installed Ceiling Tile Boxes Firelight Fixtures	2016	9,680		20	484	484	484	29
30	Upgrade Elevator Doors & Sector	2016	11,655		20	583	583	583	30
31	Installed 4Th Floor Tamper/Fire Alarm System	2016	5,033		20	252	252	252	31
32	Repaired Deck - Permits/Gate Handle/Elecrical Switch	2016	12,550		20	1,255	1,255	1,255	32
33	Repaired 3Rd/4Th Floor Bathrooms - Tiles/Shower Heads/Pipes	2016	4,630		20	463	463	463	33
34	TOTAL (lines 1 thru 33)		\$ 16,833,129	\$ 785,293		\$ 527,521	\$ (257,772)	\$ 1,266,964	34

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

Facility Name & ID Number Chalet Living & Rehab

0053843

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 16,833,129	\$ 785,293		\$ 527,521	\$ (257,772)	\$ 1,266,964	1
2	Installation For Door Security On 6 Doors	2016	6,546		20	327	327	327	2
3	Repaired 4Th Floor Main Line/Ac Condensation	2016	2,775		20	139	139	139	3
4	Architect Fees - Shower Room	2016	2,500		20	125	125	125	4
5	Installed New Insulation And Drywall/Prime/Paint - Back Loading	2016	7,945		20	397	397	397	5
6	Installed New Garbage Disposal	2016	3,250		20	163	163	163	6
7	Repaired Elevator	2016	2,511		20	126	126	126	7
8	Installed Ceiling Tile/Hvac Film Tape/Fire Barriers	2016	2,618		20	131	131	131	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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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)		\$ 16,861,274	\$ 785,293		\$ 528,928	\$ (256,365)	\$ 1,268,371	34

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

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	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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)		\$	\$		\$	\$	\$	34

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

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	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

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	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Legacy Real Properties	2009	31,179	1,157	30	1,039	(118)	7,795	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Legacy Healthcare & Financial Services	2012	1,403	31	20	70	39	351	9
10	Allocated from Legacy Healthcare & Financial Services	2013	4,486	98	20	224	126	897	10
11	Allocated from Legacy Healthcare & Financial Services	2014	438	10	20	22	12	66	11
12	Allocated from Legacy Healthcare & Financial Services	2015	604	13	20	30	17	60	12
13									13
14	Allocated from Legacy Real Properties	2009	17,706	286	20	885	599	5,976	14
15	Allocated from Legacy Real Properties	2010	5,384	87	20	216	129	1,401	15
16	Allocated from Legacy Real Properties	2011	7,653	124	20	383	259	2,296	16
17									17
18	Allocated from CF St. Louis LLC	2016	44,613		20	2,231	2,231	2,231	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)		\$ 113,466	\$ 1,806		\$ 5,100	\$ 3,294	\$ 21,073	34

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

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 12H, Carried Forward		\$113,466	\$1,806		\$5,100	\$3,294	\$21,073	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$113,466	\$1,806		\$5,100	\$3,294	\$21,073	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	\$1,679,650	\$1,241	\$167,965	\$166,724	10	\$340,985	71
72	Current Year Purchases	43,585	140	4,358	4,218	10	4,358	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,723,234	\$1,381	\$172,323	\$170,942		\$345,343	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$20,340,533	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$786,674	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$701,251	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(85,423)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,613,715	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
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

YES

NO
- If NO, see instructions.

		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	Allocated from Legacy HC				79			5
6	Allocated from Progressive HC				51			6
7	TOTAL				\$130			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease
-

9. Option to Buy:

YES

NO

Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES

NO
16. Rental Amount for movable equipment: \$7,488Description: 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	2014 Jeep Grand Cherokee	\$854	\$4,270	17
18					18
19					19
20					20
21	TOTAL		\$854	\$4,270	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

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.)

12345678										
	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 - 03	hrs	\$		\$ 238,415	\$		\$ 238,415	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			116,062			116,062	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			263,771			263,771	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				140,689		140,689	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					58,828	133,207		192,035	13
14	TOTAL			\$		\$ 677,076	\$ 273,896		\$ 950,972	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	19,503	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,263,054	3,263,054	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	182,472	182,472	6
7	Other Prepaid Expenses	64,372	148,285	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	134,823	134,823	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,644,721	\$ 3,748,137	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,752,000	13
14	Buildings, at Historical Cost		11,891,700	14
15	Leasehold Improvements, at Historical Cost	39,681	1,947,497	15
16	Equipment, at Historical Cost	104,894	1,188,767	16
17	Accumulated Depreciation (book methods)	(72)	(2,547,055)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	841,736	6,527,262	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 986,239	\$ 20,760,171	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,630,960	\$ 24,508,308	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 859,512	\$ 864,262	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,545,173	1,545,173	29
30	Accrued Salaries Payable	244,667	244,667	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	9,139	9,139	31
32	Accrued Real Estate Taxes(Sch.IX-B)		297,355	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	13,659	30,836	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,672,150	\$ 2,991,432	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		32,228,498	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	1,630,424	1,630,424	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,630,424	\$ 33,858,922	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,302,574	\$ 36,850,354	46
47	TOTAL EQUITY(page 18, line 24)	\$ 328,386	\$ (12,342,046)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,630,960	\$ 24,508,308	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (126,020)	1
2	Restatements (describe):		2
3	Prior Year Depreciation	(4,715)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (130,735)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	459,121	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)	\$ 459,121	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)	\$ 328,386	24 *

* This must agree with page 17, line 47.

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	\$ 21,426,211	1
2	Discounts and Allowances for all Levels	(9,879,131)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,547,080	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,033,991	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,033,991	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	217,482	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,041	19
20	Radiology and X-Ray	3,145	20
21	Other Medical Services	11,442	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 248,110	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,176	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,176	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	32,273	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 32,273	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,866,630	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,778,290	31
32	Health Care	4,358,352	32
33	General Administration	2,252,532	33
	B. Capital Expense		
34	Ownership	3,802,589	34
	C. Ancillary Expense		
35	Special Cost Centers	1,694,616	35
36	Provider Participation Fee	521,130	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,407,509	40
41	Income before Income Taxes (line 30 minus line 40)**	459,121	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 459,121	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 10,699,596	44
45	Private Pay - Net Inpatient Revenue	734,710	45
46	Medicare - Net Inpatient Revenue	258,246	46
47	Other-(specify) Insurance	(145,472)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,547,080	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.
****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,756	1,909	\$ 91,280	\$ 47.82	1
2	Assistant Director of Nursing	1,361	1,480	57,544	38.88	2
3	Registered Nurses	23,654	25,710	844,054	32.83	3
4	Licensed Practical Nurses	41,675	45,299	1,320,924	29.16	4
5	CNAs & Orderlies	99,133	107,753	1,301,498	12.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,453	11,362	184,995	16.28	8
9	Activity Director	3,472	3,774	68,318	18.10	9
10	Activity Assistants	5,982	6,502	66,901	10.29	10
11	Social Service Workers	7,333	7,971	173,801	21.80	11
12	Dietician					12
13	Food Service Supervisor	3,934	4,276	84,911	19.86	13
14	Head Cook	3,775	4,103	56,616	13.80	14
15	Cook Helpers/Assistants	20,218	21,976	237,511	10.81	15
16	Dishwashers					16
17	Maintenance Workers	6,681	7,262	128,871	17.75	17
18	Housekeepers	21,257	23,105	243,093	10.52	18
19	Laundry	5,576	6,061	64,240	10.60	19
20	Administrator	2,565	2,788	145,895	52.33	20
21	Assistant Administrator	591	643	22,054	34.30	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,336	15,583	258,296	16.58	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	854	928	16,008	17.25	31
32	Other Health Care(specify)					32
33	Other(specify)	897	975	12,085	12.39	33
34	TOTAL (lines 1 - 33)	275,503	299,460	\$ 5,378,895 *	\$ 17.96	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	\$ 9,816	01-03	35
36	Medical Director	Monthly	31,378	09-03	36
37	Medical Records Consultant	Monthly	800	10-03	37
38	Nurse Consultant	Monthly	69,166	10-03	38
39	Pharmacist Consultant	Monthly	17,082	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	848	11-03	44
45	Social Service Consultant	Monthly	2,770	12-03	45
46	Other(specify)				46
47	Memory Support	Monthly	375	10-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 132,235		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	3	80	10-03	52
53	TOTAL (lines 50 - 52)	3	\$ 80		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	
Anthony Carbonari	Administrator	0.00%	\$ 76,154	Workers' Compensation Insurance	\$	135,095	IDPH License Fee	\$	
Mordechai Polstein	Administrator	0.00%	42,138	Unemployment Compensation Insurance		82,509	Advertising: Employee Recruitment	562	
Raphael Zimmerman	Administrator	0.00%	27,603	FICA Taxes		407,065	Health Care Worker Background Check	11,102	
Angela Pfamatter	Assistant Admin	0.00%	22,054	Employee Health Insurance		207,477	(Indicate # of checks performed 1110)		
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Dues and Subscriptions	24,677	
				Union Pension		34,825	Licenses and Permits	14,553	
TOTAL (agree to Schedule V, line 17, col. 1)				401K Expense		12,405	Allocated from Legacy HC	2,724	
(List each licensed administrator separately.)			\$ 167,949	Employee Physical Exams		17,710	Allocated from Progressive HC	627	
B. Administrative - Other				Other Employee Benefits		23,898	Allocated from CF St. Louis LLC	4	
Description			Amount				Less: Public Relations Expense	()	
Management Fees - Yair Zuckerman			\$ 9,838				Non-allowable advertising	()	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 9,838	TOTAL (agree to Schedule V, line 22, col.8)			\$ 920,985	TOTAL (agree to Sch. V, line 20, col. 8)	
(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**		
C. Professional Services				Description			Description		
Vendor/Payee	Type		Amount	Line #			Amount		
Marcum LLP	Accounting		\$ 12,070				\$		
KBKB	Accounting		13,232						
Achieve Accreditation	Joint Commission Consultant		8,162						
IIT/Source Tech	Data Processing		1,870				In-State Travel		
IL Rytes Corp	Compliance		11,255						
Lexis Nexis	Data Processing		476						
ProPay HR LLC	Payroll Processing		29,098						
Personnel Planners	Unemployment Tax Consult		1,764				Seminar Expense		
2401 Inc.	Architectural Services		2,780				7,476		
Documentation Solutions	Compliance Audit		4,096				Allocated from Legacy HC		
See Attached	Legal		12,311				1,810		
See Supplemental Schedule			4,135				Allocated from Progressive HC		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL					
(For legal fee disclosure, see page 39 of instructions)			\$ 101,249						
							Entertainment Expense		
							()		
							(agree to Sch. V, line 24, col. 8)		
							TOTAL		
							\$ 10,489		

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number		Chalet Living & Rehab		STATE OF ILLINOIS	#	0053843	Report Period Beginning:	01/01/16	Ending:	12/31/16	Page 22
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>No</u>							
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.			<u>Yes</u> <u>IL Council on LTC \$20,356</u>							
(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?			<u>Yes</u> <u>Yes</u>							
(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?			<u>No</u> <u>N/A</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?			<u>Yes</u> <u>10 Years</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>46,017</u> Line <u>10</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.			<u>Yes</u>							
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.			<u>No</u> <u>N/A</u>							
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>X</u> NO <u> </u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			<u>Chalet Living & Rehab Center, IDPH #0051615</u>							
(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.			\$ <u>521,130</u>							
(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.			<u>No</u>							
(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?			<u>Yes</u>							
(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.			<u>No</u>							
(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?			\$ <u>No</u> Indicate the amount. \$ <u>N/A</u>							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel? If YES, attach a complete explanation.			<u>No</u>							
	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.			<u>No</u> \$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>100% Ln 14</u>							
	d. Have vehicle usage logs been maintained?			<u>No</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>No</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>Yes</u>							
	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.			<u>No</u> \$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:			<u>No</u> <u>N/A</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(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			<u>Yes</u>							