

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0044750 Facility Name: Community Nrsing & Rehab Ctr Address: 1136 North Mill St Naperville 60563 County: DuPage Telephone Number: (630) 355-3300 Fax # (630) 355-1417 HFS ID Number: Date of Initial License for Current Owners: 04/01/2000 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Amanda Springborn Telephone Number: (314) 925-3838 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) (Title) Paid Preparer (Signed) (Print Name and Title) (Firm Name & Address) (Telephone) MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number Community Nrsing & Rehab Ctr

0044750 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>153</u>	Skilled (SNF)	<u>153</u>	<u>55,998</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>153</u>	TOTALS	<u>153</u>	<u>55,998</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>15,873</u>	<u>3,275</u>	<u>11,644</u>	<u>30,792</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>15,873</u>	<u>3,275</u>	<u>11,644</u>	<u>30,792</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 54.99%

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 ☐ Note : Non-allowable costs have been
eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 04/01/2000

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 04/01/2000 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 153 and days of care provided 3,801

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 Community Nrsing & Rehab Ctr # 0044750 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	429,772	61,332		491,104		491,104		491,104			1
2	Food Purchase		215,165		215,165		215,165	(19,550)	195,615			2
3	Housekeeping	221,880	35,764		257,644		257,644		257,644			3
4	Laundry	77,823	16,324		94,147		94,147		94,147			4
5	Heat and Other Utilities			214,146	214,146		214,146		214,146			5
6	Maintenance	75,880	53,628	100,678	230,186		230,186		230,186			6
7	Other (specify):*											7
8	TOTAL General Services	805,355	382,213	314,824	1,502,392		1,502,392	(19,550)	1,482,842			8
	B. Health Care and Programs											
9	Medical Director			43,850	43,850		43,850		43,850			9
10	Nursing and Medical Records	3,151,400	175,011	66,587	3,392,998		3,392,998	40,919	3,433,917			10
10a	Therapy											10a
11	Activities	148,014	3,321	3,895	155,230		155,230		155,230			11
12	Social Services	168,782		945	169,727		169,727		169,727			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,468,196	178,332	115,277	3,761,805		3,761,805	40,919	3,802,724			16
	C. General Administration											
17	Administrative	155,847		360,000	515,847		515,847		515,847			17
18	Directors Fees											18
19	Professional Services			182,325	182,325		182,325	(36,694)	145,631			19
20	Dues, Fees, Subscriptions & Promotions			29,004	29,004		29,004	3,942	32,946			20
21	Clerical & General Office Expenses	188,601	19,335	97,103	305,039		305,039	(19,497)	285,542			21
22	Employee Benefits & Payroll Taxes			759,327	759,327		759,327	15,096	774,423			22
23	Inservice Training & Education			1,484	1,484		1,484		1,484			23
24	Travel and Seminar			2,692	2,692		2,692		2,692			24
25	Other Admin. Staff Transportation			4,158	4,158		4,158		4,158			25
26	Insurance-Prop.Liab.Malpractice			283,376	283,376		283,376	16,011	299,387			26
27	Other (specify):*											27
28	TOTAL General Administration	344,448	19,335	1,719,469	2,083,252		2,083,252	(21,142)	2,062,110			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,617,999	579,880	2,149,570	7,347,449		7,347,449	227	7,347,676			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			191,477	191,477		191,477	218,817	410,294			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,792	43,792		43,792	287,143	330,935			32
33	Real Estate Taxes							89,742	89,742			33
34	Rent-Facility & Grounds			663,984	663,984		663,984	(663,984)				34
35	Rent-Equipment & Vehicles			89,091	89,091		89,091		89,091			35
36	Other (specify):* Mortgage Insurance							38,432	38,432			36
37	TOTAL Ownership			988,344	988,344		988,344	(29,850)	958,494			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	18,079	508,403	1,067,432	1,593,914		1,593,914		1,593,914			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			247,031	247,031		247,031		247,031			42
43	Other (specify):* Non-Allowable Cos	35,353		295,323	330,676		330,676	(330,676)				43
44	TOTAL Special Cost Centers	53,432	508,403	1,609,786	2,171,621		2,171,621	(330,676)	1,840,945			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,671,431	1,088,283	4,747,700	10,507,414		10,507,414	(360,299)	10,147,115			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	(4,454)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,040)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	66,590	30		9
10	Interest and Other Investment Income	(2,916)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,600)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,100)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(240,000)	43		24
25	Fund Raising, Advertising and Promotional	(50,014)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(50,516)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (299,050)		\$	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)	(61,249)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (61,249)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (360,299)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (5,559)	43	1
2	Chamber of Commerce Dues	(495)	20	2
3	NH X Ray	(16,690)	43	3
4	Miscellaneous Income	(6,506)	21	4
5	Cable TV	(15,813)	43	5
6	Non-Allowable Lobbying Expense	(5,453)	20	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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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	(50,516)		49

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
Mark Weldler	29.50	Pine Acres Rehab & Living Center, LLC	DeKalb	Community Nursing & Rehab Realty, LLC	Naperville	Real Estate
Steve Jeremias	29.50					
Malka Mermelstein	.50	The Springs at Crystal Lake, LLC	Crystal Lake			
Herman Mermelstein Decl of Trust 27-610789	.50			Pine Acres Realty, LLC	DeKalb	Real Estate
Estate of Hirsch Wolf	40					
				TS Realty, LLC	Crystal Lake	Real Estate

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Accounting	\$	Community Nursing & Rehab Realty, LLC	100	\$ 15,975	\$ 15,975	1
2	V	20	Licenses		Community Nursing & Rehab Realty, LLC	100	250	250	2
3	V	26	Insurance		Community Nursing & Rehab Realty, LLC	100	54,443	54,443	3
4	V	30	Depreciation		Community Nursing & Rehab Realty, LLC	100	152,227	152,227	4
5	V	32	Interest	409	Community Nursing & Rehab Realty, LLC	100	290,468	290,059	5
6	V	33	Real Estate Tax		Community Nursing & Rehab Realty, LLC	100	89,742	89,742	6
7	V	34	Building Rent	663,984	Community Nursing & Rehab Realty, LLC	100		(663,984)	7
8	V	43	State Replacement Tax		Community Nursing & Rehab Realty, LLC	100	39	39	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 664,393			\$ 603,144	\$ * (61,249)	14

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

Facility Name & ID Number Community Nrsing & Rehab Ctr # 0044750 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Steve Jeremias	Manager	Administrative	29.50	See Sch 7A	35	70.00	Guar Pmts	\$ 180,000	L17, C3	1
2	Mark Weldler	Manager	Finance	29.50	See Sch 7A	35	70.00	Guar Pmts	180,000	L17, C3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 360,000		13

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

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

Facility Name & ID Number Community Nrsing & Rehab Ctr # 0044750 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
Street Address N/A _____
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		N/A								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	Ally - CNRC GMC Sierra		X	Facility Vehicle	789.28	10/1/11	\$ 43,628	\$	10/1/16	0.0324	\$ 891	1	
2	Marlin - Dish Machine & Booste		X	Facility Equipment	247.10	04/15/11	13,954		04/15/16	0.0625		2	
3	2015 Subaru		X	Facility Vehicle	651.00	04/30/15	37,666	25,850	04/30/20	0.0190	566	3	
4												4	
5	See Sch 9A		X	See Sch 9A	\$54,498.70	See Sch 9A	7,306,521	6,954,963	See Sch 9A	See Sch 9A	292,911	5	
	Working Capital												
6	Lake Forest Bank		X	Working Capital	Varies	9/15/11	1,000,000	1,000,000	9/1/2017	0.0500	31,687	6	
7	Member Loan	X		Working Capital	Varies	8/29/2016	1,000,000	600,000	Demand	0.0550	8,205	7	
8												8	
9	TOTAL Facility Related				\$56,186.08		\$ 9,401,769	\$ 8,580,813			\$ 334,260	9	
	B. Non-Facility Related*												
10												10	
11							Nonallowable Related Party Interest				(2,611)	11	
12							Interest Income				(714)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (3,325)	14	
15	TOTALS (line 9+line14)						\$ 9,401,769	\$ 8,580,813			\$ 330,935	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 38,432 Line # 36

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

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

Facility Name: Community Nrsing & Rehab Ctr
IDPH License ID Number: 0044750
Fiscal Year End: 12/31/2016

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

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	Midland States Bank f/k/a Heartland	X		Mortgage	\$52,698.00	6/27/14	\$ 7,247,900	\$ 6,938,339	7/1/44	0.0415	\$ 290,468	1	
2	Lenovo		X	Computer Equipment	\$1,672.72	9/22/14	54,350	15,097	10/22/17	0.0900	2,240	2	
3	Lenovo		X	Computer Equipment	\$127.98	10/15/14	4,271	1,527	12/15/17	0.0900	203	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$54,498.70		\$ 7,306,521	\$ 6,954,963			\$ 292,911	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related				\$0.00		\$ 0	\$ 0			\$ 0	14	

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.	2015	\$	103,400		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.)		\$	98,542		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(4,858)		3	
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	94,600		4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	89,742		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2011		99,814	8		
	2012		101,323	9		
	2013		101,891	10		
	2014		102,627	11		
	2015		98,542	12		
Real estate tax accrual based on 96% of 2015 tax bill 98,542 X 0.96 = 94,600.						

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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Community Nursing & Rehabilitation Center, LLC COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0044750

CONTACT PERSON REGARDING THIS REPORT Mark Weldler

TELEPHONE (630) 355-3300 FAX #: (630) 355-1417

A. **Summary of Real Estate Tax Cost**

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>07-12-403-042</u>	<u>Nursing Home</u>	\$ <u>98,542.26</u>	\$ <u>98,542.26</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>98,542.26</u></u>	\$ <u><u>98,542.26</u></u>

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

A. Square Feet:62,087

B. General Construction Type:ExteriorBrickFrameSteelNumber of StoriesTwo

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:N/A

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

3. Current Period Amortization:N/A

4. Dates Incurred:N/A

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	Resident Use	164,335	2000	\$ 453,622	1
2					2
3	TOTALS	164,335		\$ 453,622	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	153		2000	1986	\$ 4,184,589	\$	40	\$ 104,615	\$ 104,615	\$ 1,752,307
5										
6										
7										
8										
	Improvement Type**									
9	CABLE		2000		4,305	108	40	108		1,809
10	ELEVATOR DOOR		2000		4,389	110	40	110		1,833
11	PARKING LOT		2000		38,200	955	40	955		15,917
12	LANDSCAPING		2000		8,736	218	40	218		3,615
13	SIGN		2000		4,541	114	40	114		1,890
14	ARCHITECT FEES		2000		3,060	77	40	77		1,287
15	DOOR LOCK		2000		2,248	56	40	56		929
16	CLOSETS		2000		7,729	193	40	193		3,168
17	COVE BASE		2000		4,459	111	40	111		1,804
18	HANDRAILS AND KICKPLATES		2000		15,146	379	40	379		6,159
19	LIGHTING		2000		65,796	1,645	40	1,645		26,731
20	TILE		2000		2,317	58	40	58		942
21	FLOORING		2000		16,378	409	40	409		6,597
22	EXIT DOORS		2000		1,598	40	40	40		650
23	WINDOW AND CUBICLE TREATMENTS		2000		34,021	851	40	851		13,829
24	LIGHTING		2000		1,729	43	40	43		699
25	CARPETING		2000		27,139	678	40	678		11,018
26	FIRE PANEL		2000		4,500	113	40	113		1,836
27	NURSE'S STATION		2000		8,913	223	40	223		3,605
28	DOOR HANDLES		2000		1,644	41	40	41		663
29	CUBICLE TRACK		2000		915	23	40	23		370
30	MOTOR		2000		13,276	332	40	332		5,478
31	STOVE HOODS		2000		1,429	36	40	36		579
32	COVER BASE - RESIDENTS' ROOMS		2001		865		10			865
33	CERAMIC TILES		2001		10,930		10			10,930
34	CEILING & LIGHTING		2001		9,063		10			9,063
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Community Nrsing & Rehab Ctr

0044750

Report Period Beginning:

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	RENOVATIONS - THERAPY ROOM	2001	\$ 10,558	\$	10	\$	\$	\$ 10,558	37
38	TILE & COVE BASE - BASEMENT	2001	2,327		10			2,327	38
39	SHAMPOO STATION	2001	5,431		10			5,431	39
40	COVE BASE - SECOND FLOOR	2001	1,699		10			1,699	40
41	WALLPAPER/COVEBASE/CARPETING/LIGHTING	2001	1,403		10			1,403	41
42	ABS PUMP	2001	11,908		10			11,908	42
43	CARPETING	2001	14,572		10			14,572	43
44	FLOORING	2001	1,320		10			1,320	44
45	2ND FLOOR RENOVATIONS	2001	38,875		10			38,875	45
46	AVERY	2001	2,419		10			2,419	46
47	KITCHEN - COOLING AIR UNIT	2001	2,275		10			2,275	47
48	WALLCOVERINGS	2001	12,289		10			12,289	48
49	SIGNAGE/ELECTRIC BALLAST (ADMISSIONS OFFICE)	2001	3,131		10			3,131	49
50	ROOM CURTAIN DIVIDER	2001	2,003		10			2,003	50
51	HANDRAILS & BUMPER GUARDS	2001	17,855		10			17,855	51
52	FIRE ALARM TRANSFORMER	2001	1,715		10			1,715	52
53	TEMP CONTROL ON AIR HANDLER	2001	9,519		10			9,519	53
54	COVEBASE/LANDSCAPING/LIGHTING/FLOORING	2001	2,642		10			2,642	54
55	LIGHTING - CORRIDORS & RESIDENT ROOMS	2001	20,544		10			20,544	55
56	NEW BEARING & SHAFT	2001	1,402		10			1,402	56
57	DIALYSIS ROOM RENOVATIONS	2001	23,351		10			23,351	57
58	ASPHALT SEALCOATING & STRIPING	2001	1,405		10			1,405	58
59	KITCHEN TILE	2001	930		10			930	59
60	SEPTIC TANK PUMPS	2001	13,862		10			13,862	60
61	CARPETING	2001	5,729		10			5,729	61
62	PAINTING & WALLPAPER	2001	20,440		10			20,440	62
63	PAINTING & WALLPAPER	2001	11,875		10			11,875	63
64	PAINTING & WALLPAPER	2001	4,500		10			4,500	64
65	NEW DOORS	2002	1,731		10			1,731	65
66	MURAL FOR SECOND FLOOR DINING ROOM	2002	7,000		10			7,000	66
67	NEW TROUGH IN LAUNDRY ROOM	2002	6,300		10			6,300	67
68	WINDOW MOLDINGS	2002	210		10			210	68
69	NEW THRESHHOLDS	2002	205		10			205	69
70	TOTAL (lines 4 thru 69)		\$ 4,739,340	\$ 6,813		\$ 111,428	\$ 104,615	\$ 2,145,998	70

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

Facility Name & ID Number Community Nrsing & Rehab Ctr

0044750

Report Period Beginning:

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,739,340	\$ 6,813		\$ 111,428	\$ 104,615	\$ 2,145,998	1
2	NEW PVC PIPING IN KITCHEN	2002	1,320		10			1,320	2
3	UPGRADE BACKFLOW SYSTEM	2002	1,695		10			1,695	3
4	ALARM FOR RAMP EXIT	2002	1,443		10			1,443	4
5	FLOORING IN ELEVATOR	2002	856		10			856	5
6	CORNER GUARDS/WATER SOFTENER	2002	1,328		10			1,328	6
7	NEW DRAINAGE PIPES - DISPOSAL	2002	9,985		10			9,985	7
8	CORNER GUARDS	2003	276		10			276	8
9	UPGRADE DIALYSIS ROOM	2003	28,103		10			28,103	9
10	NEW AWNINGS FOR PATIO	2003	3,940		10			3,940	10
11	INSTALL GREASE TRAP IN KITCHEN	2003	3,250		10			3,250	11
12	NEW COIL FOR AIR HANDLER	2003	3,493		10			3,493	12
13	INSTALL LASER EYE ON ELEVATOR	2003	1,590		10			1,590	13
14	UPGRADE DIALYSIS ROOM	2004	30,778		10			30,778	14
15	NEW ROOF	2004	8,600		10			8,600	15
16	REMODEL VESTIBULE, NEW FLOORING	2004	10,044		10			10,044	16
17	INSTALL NEW SMOKE DETECTORS	2004	4,911		10			4,911	17
18	NEW OXYGEN ROOM	2004	5,688		10			5,688	18
19	NEW ELEVATOR TANK, PUMP AND MOTOR	2004	11,960		10			11,960	19
20	ROOF REPLACEMENT	2005	5,800		10			5,800	20
21	WIRE GLASS FOR RECEPTION WINDOW	2005	1,348		10			1,348	21
22	NEW CEMENT WALKWAYS	2005	2,400		10			2,400	22
23	NEW WALL HUNG SINK	2006	3,410	341	10	341		3,409	23
24	MOTOR FOR A/C	2006	664	66	10	66		660	24
25	NEW PUMP SYSTEM	2006	5,108	510	10	510		5,108	25
26	NEW HOT WATER HEATER	2006	7,998	798	10	798		7,998	26
27	SOLID STATE STARTER	2006	3,900	390	10	390		3,900	27
28	PUMP	2006	1,553	155	10	155		1,549	28
29	NEW FIRE ALARM	2006	6,800	680	10	680		6,800	29
30	NEW PUMP FOR BASEMENT A/C	2006	988	98	10	98		988	30
31	PAVE PARKING LOT	2006	3,500	350	10	350		3,500	31
32	NEW TIME CLOCK	2006	4,345	431	10	431		4,345	32
33	REPLACE HVAC ROOF TOP UNIT	2007	3,511	351	10	351		3,335	33
34	TOTAL (lines 1 thru 33)		\$ 4,919,925	\$ 10,983		\$ 115,598	\$ 104,615	\$ 2,326,398	34

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

Facility Name & ID Number Community Nrsing & Rehab Ctr

0044750

Report Period Beginning:

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,919,925	\$ 10,983		\$ 115,598	\$ 104,615	\$ 2,326,398	1
2	BALANCE OF TIME CLOCK	2007	4,345	434	10	434		4,123	2
3	HOT WATER HEATER	2007	9,212	921	10	921		8,750	3
4	SECURITY CAMERAS	2008	5,458	546	10	546		4,641	4
5	RELOCATE GAS LINE	2008	21,900	2,190	10	2,190		18,615	5
6	FRONT & BACK LANDSCAPING	2008	33,000	3,300	10	3,300		28,050	6
7									7
8	Architect Services	2009	29,257	2,926	10	2,926		21,944	8
9	Roof	2009	230,100	23,010	10	23,010		172,575	9
10	Construction Period Interest	2009	32,240	3,224	10	3,224		24,180	10
11	1st floor resident room baths - remove existing vinyl floor,								11
12	floor prep, installation of sheet vinyl, ceramic tile	2009	22,546	2,255	10	2,255		16,910	12
13	1st floor dining room - remove existing cove base and sheet								13
14	vinyl, floor prep, pvt install, pvt wallcovering	2009	32,001	3,200	10	3,200		24,001	14
15	Activity room - wall covering, remove cove base, install pvt &								15
16	cove base, cornices, custom built in computer work station,								16
17	remove existing ceiling tile, furnish & install new acoustic								17
18	ceiling tile, furnish & install new can lights	2009	20,443	2,044	10	2,044		15,332	18
19	Shower room - install 4 shower stalls, remove existing cove								19
20	base & sheet vinyl, install new ceramic tile	2009	43,873	4,387	10	4,387		32,905	20
21	Basement corridor - cove base, flooring, paint doors & frames,								21
22	wallpaper purchase & installation	2009	46,436	4,644	10	4,644		34,828	22
23	Therapy room - wallcovering, remove existing cove base and								23
24	vct installation of pvt, glue down carpet, remove cinder-								24
25	block wall and office separating OT & PT rooms, demo of								25
26	old and installation of new acoustical ceiling	2009	30,482	3,048	10	3,048		22,861	26
27	Foyer - remove old flooring, install new ceramic flooring &								27
28	pedimat, wallcovering	2009	12,181	1,218	10	1,218		9,136	28
29	Lobby - remove old cove base and flooring, install new ceramic								29
30	tile and cove base, wallcovering, built in reception desk,								30
31	remove mirror, door, frame & glass. Install new moldings,								31
32	remove existing receptionist wall and rebuild wall, re-								32
33	install door 3 feet from current location	2009	34,706	3,471	10	3,471		26,030	33
34	TOTAL (lines 1 thru 33)		\$ 5,528,105	\$ 71,801		\$ 176,416	\$ 104,615	\$ 2,791,277	34

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

Facility Name & ID Number Community Nrsing & Rehab Ctr

0044750

Report Period Beginning:

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,528,105	\$ 71,801		\$ 176,416	\$ 104,615	\$ 2,791,277	1
2	Building Facade & Renovation								2
3	- General requirements	2009	19,795	1,981	10	1,981		14,854	3
4	- Permits	2009	5,000	500	10	500		3,750	4
5	- Excavation and site demolition	2009	22,626	2,263	10	2,263		16,971	5
6	- Asphalt Patching	2009	5,928	593	10	593		4,447	6
7	- Mansard and patio canopy demolition	2009	9,300	930	10	930		6,975	7
8	- Concrete work	2009	23,807	2,381	10	2,381		17,856	8
9	- Brick pavers	2009	13,440	1,344	10	1,344		10,080	9
10	- Masonry columns & Screen wall	2009	16,190	1,619	10	1,619		12,143	10
11	- Steel	2009	9,700	970	10	970		7,275	11
12	- Wood fencing	2009	1,580	158	10	158		1,185	12
13	- Pylon Sign	2009	8,000	800	10	800		6,000	13
14	- Room framing and sheathing	2009	81,769	8,177	10	8,177		61,327	14
15	- Cut and patch existing roofing for new construction	2009	17,310	1,731	10	1,731		12,983	15
16	- Roofing and sheetmetal	2009	40,835	4,084	10	4,084		30,629	16
17	- Electrical	2009	4,150	415	10	415		3,113	17
18	- Dry fire sprinkler system	2009	7,000	700	10	700		5,250	18
19	- Duct demolition	2009	2,160	216	10	216		1,620	19
20	- Homosote sheathing	2009	7,549	755	10	755		5,662	20
21	- Eifs	2009	13,350	1,335	10	1,335		10,013	21
22	- Fypon Moldings	2009	6,790	679	10	679		5,093	22
23	- Painting	2009	3,400	340	10	340		2,550	23
24	- Main extrace roof tower	2009	47,588	4,759	10	4,759		35,692	24
25	- Asphalt sidewalk on north side of bldg	2009	4,920	492	10	492		3,690	25
26	- Landscaping	2009	18,000	1,800	10	1,800		13,500	26
27	- Landscape demo	2009	5,566	557	10	557		4,176	27
28	- Insurance	2009	3,562	357	10	357		2,675	28
29	- General contractor fee	2009	13,685	1,369	10	1,369		10,266	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,941,105	\$ 113,106		\$ 217,721	\$ 104,615	\$ 3,101,052	34

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

Facility Name & ID Number Community Nrsing & Rehab Ctr

0044750

Report Period Beginning:

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

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 5,941,105	\$ 113,106		\$ 217,721	\$ 104,615	\$ 3,101,052	1
2	1st floor elevator lobby - remove old flooring and install new								2
3	pvt tile, wallcovering	2009	2,699	270	10	270		2,024	3
4	1st floor corridor - corner guard, remove old and install new								4
5	wood look pvt flooring and carpet, wallcovering	2009	55,531	5,553	10	5,553		41,648	5
6	1st floor wallcovering and paint	2009	38,491	3,849	10	3,849		28,868	6
7	2nd floor shower rooms - remove existing ceramic tile, furnish								7
8	and install new ceramic tile	2009	7,067	707	10	707		5,301	8
9	1st floor resident rooms - cove base, built in double wardrobe,								9
10	remove old wallpaper and glue, paint ceilings, walls, doors								10
11	and radiators, custom built in wardrobes, cornices and								11
12	cubicle curtains	2009	159,255	15,926	10	15,926		119,445	12
13									13
14									14
15	Landmark-building façade renovation	2009	9,419	942	10	942		7,065	15
16	Satellite TV-Installation and wiring	2009	9,000	900	10	900		6,750	16
17	Architect Fees	2009	713	71	10	71		534	17
18	Sprinkler System	2009	134,000	13,400	10	13,400		100,500	18
19	Window Treatments	2009	44,355	4,436	10	4,436		33,269	19
20	Alzheimers Nurses Station Remodel	2009	18,328	1,833	10	1,833		13,747	20
21	Adjust for accounts payable invoice	2009	(23,592)						21
22									22
23	Pump Motor	2010	7,004	700	10	700		4,550	23
24	Telephone Paging System	2010	7,047	176	40	176		1,144	24
25	Wanderguard	2010	12,289	308	40	308		2,002	25
26	2nd Floor Common Area Flooring	2010	6,860	686	10	686		4,459	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,429,571	\$ 162,863		\$ 267,478	\$ 104,615	\$ 3,472,357	34

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

Facility Name & ID Number Community Nrsing & Rehab Ctr

0044750

Report Period Beginning:

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 6,429,571	\$ 162,863		\$ 267,478	\$ 104,615	\$ 3,472,357	1
2	Compressor Replacement	2011	9,763	976	10	976		5,368	2
3	Sprinkler system	2011	9,933	497	20	497		2,733	3
4	Patio	2011	3,708	185	20	185		1,018	4
5	Business office thermostat	2011	5,988	597	5	597		5,988	5
6	Transformer	2011	13,500	675	20	675		3,713	6
7	Rehab corridor(Flooring, wallcovering)	2011	40,509	5,787	7	5,787		31,829	7
8	Rehab corridor(Handrails, Door & Frame)	2011	43,724	2,186	20	2,186		12,023	8
9	Nursing home (Relaminate)	2011	13,483	1,348	10	1,348		7,414	9
10									10
11	3 Broan fans, sheet metal work - Entire Facility	2012	4,300	430	10	430		1,935	11
12	Roof Chiller - Roof of Main Building	2012	4,455	446	10	446		2,006	12
13	Automatic Door - Homeward Bound Unit	2012	4,200	420	10	420		1,890	13
14									14
15	Resurface parking lot	2013	8,033	803	10	803		2,812	15
16	Condensor fan & water heater	2013	5,932	593	10	593		2,076	16
17	Rod floor drains, install new drains	2013	3,000	300	10	300		1,050	17
18	Replace door	2013	3,000	300	10	300		1,050	18
19									19
20	Mechanical door restrictor device-Elevators	2014	2,910	291	10	291		728	20
21	Repair 5 leaks in cold water supply throughout facility	2014	4,712	471	10	471		1,178	21
22	Replace Wi-Fi & low voltage cabling & elec-Entire facility	2014	18,642	1,864	10	1,864		4,661	22
23	Replace concrete ramp	2014	3,900	390	10	390		975	23
24	Replace heat pump at nurses station	2014	4,195	420	10	420		1,049	24
25	175 KW Standby diesel generator-Entire facility	2014	72,800		40	1,820	1,820	4,550	25
26	Fire dampers-Entire facility	2014	36,960		40	924	924	2,310	26
27	Replace 25 bay windows-Homeward Bound Unit	2014	62,400		40	1,560	1,560	3,900	27
28	Recover canopy awning-Front Door	2014	16,866		40	422	422	1,054	28
29	Remodel Homeward Bound Unit: wall covering, wood trim,	2014	112,500		40	2,813	2,813	7,031	29
30	doors & hardware, flooring, carpentry, paint, electrical								30
31	Remodel Nurses Station - Homeward Bound Unit: wall covering,	2014	12,464		40	312	312	779	31
32	wood trim, countertop, carpentry, labor								32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,951,448	\$ 181,841		\$ 294,306	\$ 112,465	\$ 3,583,476	34

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

Facility Name & ID Number Community Nrsing & Rehab Ctr

0044750

Report Period Beginning:

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 6,951,448	\$ 181,841		\$ 294,306	\$ 112,465	\$ 3,583,476	1
2	Install Sewer Pit Pump - Back of building	2015	7,103	710	10	710		1,065	2
3	Electrical Work - Computer Room	2015	3,300	330	10	330		495	3
4	Add door to Wanderguard System - Resident Patio Smoking Door	2015	3,070	307	10	307		461	4
5	Evaporator chilled water coil pipe replacement - Entire Facility HVAC	2015	8,518	852	10	852		1,277	5
6									6
7	Gas piping drawing for Pulmonary Unit Project	2016	3,100	155	10	155		155	7
8	Pulmonary Wing-Electrical, install oxygen outlets, medical air	2016	180,997	9,050	10	9,050		9,050	8
9	outlets, medical vacuum inlets & vacuum slides								9
10	Electrical Work - Pulmonary Wing	2016	21,642	1,082	10	1,082		1,082	10
11	Medical Gas Enclosure - North Wing	2016	74,600	3,730	10	3,730		3,730	11
12	Interior Remodel-Doors & drywall, carpentry, trim, pre-stain & finish	2016	71,200	3,560	10	3,560		3,560	12
13	3 Doors in small dining room, 2 doors at soiled & clean utility room	2016	7,550	378	10	378		378	13
14	Architect Fees - North Wing	2016	15,289	764	10	764		764	14
15	Replace roof mounted exhaust fans - Roof	2016	2,972	149	10	149		149	15
16	Chilled water condenser-HVAC System	2016	9,977	499	10	499		499	16
17	Replaced 18 smoke detectors - throughout facility	2016	4,229	211	10	211		211	17
18	Sewer Pump	2016	5,522	276	10	276		276	18
19	Window Treatments - North Wing	2016	6,323	632	5	632		632	19
20	Recessed medicine cabinets - North Wing	2016	4,037	404	5	404		404	20
21	Wallpaper, countertop, lighting, electrical - Dining Room Remodel	2016	9,922	992	5	992		992	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30	Adjust book depreciation to financial statements			(98,316)			98,316		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,390,799	\$ 107,607		\$ 318,387	\$ 210,781	\$ 3,608,656	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	\$524,613	\$66,549	\$74,586	\$8,037	3-10	\$429,504	71
72	Current Year Purchases	54,596	5,460	5,460	-	5	5,460	72
73	Fully Depreciated Assets	1,023,462			-		1,023,462	73
74					-			74
75	TOTALS	\$1,602,671	\$72,009	\$80,046	\$8,037		\$1,458,426	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	Facility	GMC Truck	2011	\$44,128	\$4,411	\$4,411	\$-	5	\$44,128	76
77	Facility	Subaru	2015	37,246	7,450	7,450	-	5	11,175	77
78							-			78
79							-			79
80	TOTALS			\$81,374	\$11,861	\$11,861	\$-		\$55,303	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)	\$9,528,466	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$191,477	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$410,294	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$218,818	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$5,122,385	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

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?
If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.

9. Option to Buy: YES NO Terms:

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: \$89,091 Description: See Attached Schedule 14A
(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	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name:

Community Nrsing & Rehab Ctr

IDPH License ID Number:

0044750

Fiscal Year End:

12/31/2016

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	40,315
Office Equipment	754
Maintenance Equipment	774
Copier	47,248
Total - Line 16	89,091

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	3,803	\$ 273,839	\$	3,803	\$ 273,839	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,343	96,671		1,343	96,671	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		3,458	249,004		3,458	249,004	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				477,243		477,243	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): <u>Resp Ther/Oxygen</u>	39(1)(2)(3)	476	18,079	5,315	382,664	31,160	5,791	431,903	12
13	Other (specify): <u>Dialysis Services</u>	39(3)				63,905			63,905	13
14	TOTAL			\$ 18,079	13,919	\$ 1,066,083	\$ 508,403	14,395	\$ 1,592,565	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	\$ 5,815	\$ 5,815	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 333,617)	2,113,065	2,113,065	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	213,445	241,859	6
7	Other Prepaid Expenses	13,259	13,259	7
8	Accounts Receivable (owners or related parties)	768,019	724,143	8
9	Other(specify): See Schedule 17A	13,593	452,827	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,127,196	\$ 3,550,968	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		453,622	13
14	Buildings, at Historical Cost		4,184,589	14
15	Leasehold Improvements, at Historical Cost	1,956,819	3,206,210	15
16	Equipment, at Historical Cost	600,499	1,684,045	16
17	Accumulated Depreciation (book methods)	(1,543,465)	(5,122,385)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Mortgage Costs, Net		54,835	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,013,853	\$ 4,460,916	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,141,049	\$ 8,011,884	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,527,814	\$ 1,556,129	26
27	Officer's Accounts Payable	13,861	13,861	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	16,624	16,624	29
30	Accrued Salaries Payable	97,367	97,367	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,937	8,937	31
32	Accrued Real Estate Taxes(Sch.IX-B)		94,600	32
33	Accrued Interest Payable	7,927	31,922	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,164,466	1,164,466	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,836,996	\$ 2,983,906	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,625,850	1,625,850	39
40	Mortgage Payable		6,938,339	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,625,850	\$ 8,564,189	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,462,846	\$ 11,548,095	46
47	TOTAL EQUITY(page 18, line 24)	\$ (321,797)	\$ (3,536,211)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,141,049	\$ 8,011,884	48

*(See instructions.)

Facility Name: Community Nrsing & Rehab Ctr
IDPH License ID Number: 0044750
Fiscal Year End: 12/31/2016

Schedule 17A

XV. Balance Sheet

Line 9 Current Assets Other (specify):

	Description	Operating	After Consolidation
11500.000	Rent Receivable	-	6,714
14100.000	Escrow - MIP	-	18,584
14200.000	Escrow - Insurance	-	5,525
14300.000	Escrow - Real Estate Taxes	-	41,011
14400.000	Escrow - Replacement Reserve	-	367,400
20810.000	Due To/from AdminAstar	13,593	13,593
Total - Line 9		13,593	452,827

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

	Description	Operating	After Consolidation
20230.000	Accrued Management Fees	247,500	247,500
20260.000	Accrued Rent	6,714	6,714
20430.000	Accrued Assessment Fee	8	8
20435.000	Accrued Assessment Fee #2	27,692	27,692
20570.000	Insurance payable	213,399	213,399
20800.000	Due To State	302,863	302,863
20815.000	Resident Credit Balances	42,146	42,146
20820.000	Due To/From Insurance (BC-BS Etc)	11,762	11,762
20830.000	Due To/From BC-BS	29,429	29,429
20840.000	Due To/From Hospice	10,090	10,090
20905.000	Due To/From Pine Acres	(11,118)	(11,118)
20910.000	Due To/From The Springs	217,609	217,609
25145.000	Note Payable - State	66,372	66,372
Total - Line 36		1,164,466	1,164,466

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,739,755	1
2	Restatements (describe):		2
3	Prior period adjustment	9,496	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,749,251	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,071,048)	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)	\$ (2,071,048)	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)	\$ (321,797)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Community Nrsing & Rehab Ctr

0044750

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,324,651	1
2	Discounts and Allowances for all Levels	(945,779)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,378,872	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,429,310	6
7	Oxygen	19,360	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,448,670	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	3,326	12
13	Barber and Beauty Care	2,901	13
14	Non-Patient Meals	1,128	14
15	Telephone, Television and Radio	2,040	15
16	Rental of Facility Space		16
17	Sale of Drugs	435,500	17
18	Sale of Supplies to Non-Patients	46,031	18
19	Laboratory	85,314	19
20	Radiology and X-Ray	16,430	20
21	Other Medical Services	6,721	21
22	Laundry	2,472	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 601,863	23
	D. Non-Operating Revenue		
24	Contributions	150	24
25	Interest and Other Investment Income***	305	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 455	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	6,506	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,506	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,436,366	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,502,392	31
32	Health Care	3,761,805	32
33	General Administration	2,083,252	33
	B. Capital Expense		
34	Ownership	988,344	34
	C. Ancillary Expense		
35	Special Cost Centers	1,924,590	35
36	Provider Participation Fee	247,031	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,507,414	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,071,048)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,071,048)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,793,131	44
45	Private Pay - Net Inpatient Revenue	1,142,676	45
46	Medicare - Net Inpatient Revenue	934,223	46
47	Other-(specify) <u>Managed Care</u>	129,542	47
48	Other-(specify) <u>Hospice</u>	379,300	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,378,872	49

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

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

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

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

^ - This entity is a cash basis taxpayer

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	1,832	2,080	\$ 135,101	\$ 64.95	1
2	Assistant Director of Nursing	3,840	4,192	175,930	41.97	2
3	Registered Nurses	22,940	24,209	762,800	31.51	3
4	Licensed Practical Nurses	16,378	17,156	435,660	25.39	4
5	CNAs & Orderlies	78,586	84,384	1,262,276	14.96	5
6	CNA Trainees					6
7	Licensed Therapist	476	535	18,079	33.79	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,808	2,080	52,523	25.25	9
10	Activity Assistants	8,003	8,393	95,491	11.38	10
11	Social Service Workers	3,591	4,089	168,782	41.28	11
12	Dietician	1,660	1,820	49,934	27.44	12
13	Food Service Supervisor	2,575	3,073	68,904	22.42	13
14	Head Cook	8,142	8,656	120,799	13.96	14
15	Cook Helpers/Assistants	16,755	17,591	190,135	10.81	15
16	Dishwashers					16
17	Maintenance Workers	4,007	4,478	75,880	16.95	17
18	Housekeepers	17,816	19,386	221,880	11.45	18
19	Laundry	7,456	7,849	77,823	9.92	19
20	Administrator	1,600	1,968	155,847	79.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,459	10,337	188,601	18.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,733	1,931	39,943	20.69	31
32	Other Health C: SCH20A	10,799	11,622	339,690	29.23	32
33	Other(specify) <u>Mktg & Hosp Liai</u>	3,578	3,986	35,353	8.87	33
34	TOTAL (lines 1 - 33)	223,034	239,815	\$ 4,671,431 *	\$ 19.48	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		\$		35
36	Medical Director	Monthly	43,850	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	1,350	10(3,7)	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	161	41,249	10(3), 39(3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant	17	896	11(3)	44
45	Social Service Consultant	15	945	12(3)	45
46	Other(specify)				46
47	Infectious Disease Consultant	Monthly	24,996	10(3)	47
48	Psych Consultant	Monthly	1,691	10(3)	48
49	TOTAL (lines 35 - 48)	193	\$ 114,977		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		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

Facility Name: Community Nrsing & Rehab Ctr
IDPH License ID Number: 0044750
Fiscal Year End: 12/31/2016

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Restorative Nurses	4,117	4,396	97,779	\$ 22.24
MDS Coordinator	1,344	1,452	39,436	\$ 27.16
Treatment Nurse	3,346	3,515	110,956	\$ 31.57
Case Manager	1,992	2,259	91,519	\$ 40.51
Total - Line 32 Other Health Care (specify):	10,799	11,622	339,690	\$ 29.23

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	
Larry Banks	Administrator	0	\$ 155,847	Workers' Compensation Insurance		\$ 163,505	IDPH License Fee	\$	
				Unemployment Compensation Insurance			Advertising: Employee Recruitment	4,150	
				FICA Taxes		359,662	Health Care Worker Background Check		
				Employee Health Insurance		206,065	(Indicate # of checks performed 11)	154	
				Employee Meals		15,096	Patient Background Checks	3,046	
				Illinois Municipal Retirement Fund (IMRF)*			IL Council LTC Dues	16,524	
				Flowers		329	Naperville Chamber of Commerce	495	
				Other Employee Benefits		29,766	Miscellaneous Dues & Licenses	14,236	
							Allocated from RE Entity	289	
							Less: Lobbying Expense & Chamber	(5,948)	
							Less: Public Relations Expense	()	
							Non-allowable advertising	()	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 155,847	TOTAL (agree to Schedule V, line 22, col.8)		\$ 774,423	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 32,946
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Steve Jeremias-COO			\$ 180,000	N/A		\$	Out-of-State Travel	\$	
Mark Weldler-CFO			180,000						
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 360,000						
C. Professional Services									
Vendor/Payee	Type		Amount						
RSM US LLP	Accounting		\$ 44,331						
Paylocity	Payroll Services		13,232						
Will County Clerk	Notary		10						
MDI Achieve	Computer Consultant		39,569						
Innovative LTC Solutions	Software Company		4,182						
Allscripts	Data Processing		3,173						
Personnel Planners	U/E Consultant		1,569						
Meyer Magence	Legal		63				Seminar Expense 2,692		
See Schedule 21C	See Schedule 21C		76,196				Entertainment Expense ()		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 182,325	TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
							TOTAL 2,692		

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name: Community Nrsing & Rehab Ctr
IDPH License ID Number: 0044750
Fiscal Year End: 12/31/2016

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
From Page 21		106,129
Ability Network Inc	Computer Services	3,852
American Express	Computer Services	360
AT & T	Computer Services	54
CDW	Computer Services	2,713
Experian Health Inc	Computer Services	314
HCA	Computer Services	3,000
Information Controls, Inc.	Computer Services	1,613
Nebo Systems Inc	Computer Services	78
Red Eyed Moose Technologies	Computer Services	3,672
Singer Networks LLC	Computer Services	34,763
Telemedicine Solutions, LLC	Computer Services	8,424
Duane Morris LLP	Legal	9,859
Meyers & Flowers LLC	Legal	2,186
Much Shelist Attorneys At Law	Legal	4,828
Vanek, Larson & Kolb LLC	Legal	480
Total (agree to Schedule V, line 19, column 3)		182,325
Reclassified to appropriate line		(39,569)
Allocated from Management Company Professional Services		15,975
Less: Non-Allowable Legal Fees		(13,100)
Total (agree to Schedule V, line 19, column 8)		145,631

XX. GENERAL INFORMATION:

- (1)

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

No

(2)

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

Yes
Illinois Council -LTC - \$16,524

(3)

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

Yes
Yes

(4)

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

No
N/A

(5)

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

Yes
5 Yrs

(6)

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

\$ 1,390 Line 10(2)

(7)

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

Yes

(8)

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

No
N/A

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

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

N/A

(11)

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

\$ 247,031

(12)

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

No
- (13)

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

Yes

(14)

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

No

(15)

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

\$ 15,096
Yes
Indicate the amount. \$ 4454

(16)

Travel and Transportation

a.

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

No

b.

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

No
N/A

c.

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

None

d.

Have vehicle usage logs been maintained?

Adequate records have been maintained

e.

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

N/A

f.

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

N/A

g.

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

No
N/A

(17)

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

No
N/A

(18)

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

Yes

(19)

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

Yes