

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0052712</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Kensington Place Nsg & Rehab</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>3405 S Michigan Ave</u> <u>Chicago</u> <u>60616</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(312) 791 - 0035</u> Fax # <u>(312) 791 - 0626</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Edward N. Slack, CPA</u> <u>Partner, Health and Human Services</u></td></tr><tr><td>(Firm Name & Address) <u>Plante & Moran, PLLC</u> <u>2155 Point Boulevard, Suite 200 Elgin, Illinois 60123</u></td></tr><tr><td>(Telephone) <u>(847) 628 - 8796</u> Fax # <u>(248) 327 - 8417</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) <u>Edward N. Slack, CPA</u> <u>Partner, Health and Human Services</u>	(Firm Name & Address) <u>Plante & Moran, PLLC</u> <u>2155 Point Boulevard, Suite 200 Elgin, Illinois 60123</u>	(Telephone) <u>(847) 628 - 8796</u> Fax # <u>(248) 327 - 8417</u>												
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Date of Initial License for Current Owners: <u>02/01/14</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
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	☒ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Edward N. Slack, CPA</u> Telephone Number: <u>(847) 628 - 8796</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Kensington Place Nsg & Rehab

#

0052712

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	155	Skilled (SNF)	155	56,730	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	155	TOTALS	155	56,730	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	16,303	85	34,312	50,700	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,303	85	34,312	50,700	14

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

89.37%

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

0

(Do not include bed-hold days in Section B.)

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

N/A

F. Does the facility maintain a daily midnight census?

Yes

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

YES

NO

X

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

YES

NO

X

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

Date started

05/01/87

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

YES

X

Date

05/01/87

NO

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

YES

X

NO

If YES, enter number of beds certified

155

and days of care provided

2,625

Medicare Intermediary

National Government Services, Inc.

IV. ACCOUNTING BASIS

MODIFIED

ACCRUAL

X

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/16

Fiscal Year:

12/31/16

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab # 0052712 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	240,822	42,746	15,697	299,265		299,265	225	299,490			1
2	Food Purchase		281,822		281,822		281,822	187	282,009			2
3	Housekeeping	149,383	33,086		182,469		182,469	1,245	183,714			3
4	Laundry	58,569	16,992		75,561		75,561		75,561			4
5	Heat and Other Utilities			116,363	116,363		116,363	1,736	118,099			5
6	Maintenance	103,626		132,500	236,126		236,126	14,495	250,621			6
7	Other (specify):* See Supplemental	27,700		50,965	78,665		78,665	1,019	79,684			7
8	TOTAL General Services	580,100	374,646	315,525	1,270,271		1,270,271	18,907	1,289,178			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	2,352,951	126,414	49,795	2,529,160		2,529,160	(400)	2,528,760			10
10a	Therapy	147,502			147,502		147,502		147,502			10a
11	Activities	93,181	11,509	2,779	107,469		107,469		107,469			11
12	Social Services	242,254	13,638	713	256,605		256,605		256,605			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	2,835,888	151,561	62,287	3,049,736		3,049,736	(400)	3,049,336			16
	C. General Administration											
17	Administrative	262,138			262,138		262,138	24,299	286,437			17
18	Directors Fees											18
19	Professional Services			238,423	238,423		238,423	(141,843)	96,580			19
20	Dues, Fees, Subscriptions & Promotions			60,090	60,090		60,090	(5,867)	54,223			20
21	Clerical & General Office Expenses	331,245	14,828	807,033	1,153,106		1,153,106	(636,532)	516,574			21
22	Employee Benefits & Payroll Taxes			741,384	741,384		741,384	(6,082)	735,302			22
23	Inservice Training & Education			4,991	4,991		4,991		4,991			23
24	Travel and Seminar			4,769	4,769		4,769	185	4,954			24
25	Other Admin. Staff Transportation			19,626	19,626		19,626	1,256	20,882			25
26	Insurance-Prop.Liab.Malpractice			197,283	197,283		197,283	2,174	199,457			26
27	Other (specify):* See Supplemental							28,532	28,532			27
28	TOTAL General Administration	593,383	14,828	2,073,599	2,681,810		2,681,810	(733,878)	1,947,932			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,009,371	541,035	2,451,411	7,001,817		7,001,817	(715,371)	6,286,446			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Kensington Place Nsg & Rehab
Medicaid Cost Report
01/01/16 - 12/31/16

Page 3 Supplemental Schedule

Description		Salaries		Supplies		Other		Total
Line 7 - Other General Services								
Security		27,700						27,700
Valet						50,965		50,965
								-
Alloc. - Extended Care Consulting, LLC								-
Gen. Services - Employee Benefits						1,019		1,019
								-
								-
Sub-Total		<u>27,700</u>		<u>-</u>		<u>51,984</u>		<u>79,684</u>
Line 15 - Other Health Care Services								
								-
								-
								-
								-
								-
								-
								-
Sub-Total		<u>-</u>		<u>-</u>		<u>-</u>		<u>-</u>
Line 27 - Other General Administration								
Alloc. - Extended Care Consulting, LLC								-
Gen. Admin. - Employee Benefits						28,532		28,532
								-
								-
								-
								-
								-
Sub-Total		<u>-</u>		<u>-</u>		<u>28,532</u>		<u>28,532</u>

Kensington Place Nsg & Rehab
Medicaid Cost Report
01/01/16 - 12/31/16

Page 3 Supplemental Schedule - Other Staff Administration Travel Expense

Employee	Travel Purpose	Travel Destination	Travel Date	Expenses			Total
				Travel	Accomodations	Meals	
Capitol One	Business Matters	Various	Various	8,360			8,360
Care Management Facility	Business Matters	Various	Various	5,806			5,806
Countryside Nursing & Rehab	Business Matters	Various	Various	747			747
David Mashiach	Business Matters	Various	Various	332			332
Lorena Robledo-Sommerfield	Business Matters	Various	Various	946			946
Shoaib Zaidi	Business Matters	Various	Various	3,394			3,394
Sonia Navar	Business Matters	Various	Various	41			41
							-
							-
							-
							-
							-
							-
							-
							-
Alloc. - Extended Care Consulting, LLC				1,256			1,256
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
Total				20,882	-	-	20,882

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			63,692	63,692		63,692	95,861	159,553			30
31	Amortization of Pre-Op. & Org.			1,600	1,600		1,600		1,600			31
32	Interest			13,621	13,621		13,621	127,567	141,188			32
33	Real Estate Taxes			256,581	256,581		256,581	5,067	261,648			33
34	Rent-Facility & Grounds			926,417	926,417		926,417	(926,417)				34
35	Rent-Equipment & Vehicles			23,864	23,864		23,864	1,187	25,051			35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			1,285,775	1,285,775		1,285,775	(696,735)	589,040			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		62,420	369,463	431,883		431,883		431,883			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			362,154	362,154		362,154		362,154			42
43	Other (specify):* See Supplemental											43
44	TOTAL Special Cost Centers		62,420	731,617	794,037		794,037		794,037			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,009,371	603,455	4,468,803	9,081,629		9,081,629	(1,412,106)	7,669,523			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Description	Salaries		Supplies		Other		Total	
Line 36 - Other Capital Costs								
								-
								-
								-
								-
								-
								-
Sub-Total		== - ==		== - ==		== - ==		== - ==
Line 43 - Other Special Cost Centers								
								-
								-
								-
								-
								-
								-
Sub-Total		== - ==		== - ==		== - ==		== - ==

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,953)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(297)	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	(1,290)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(756,050)	21		24
25	Fund Raising, Advertising and Promotional	(7,046)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,118)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Supplemental Schedule	(74,442)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (851,196)		\$	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)	(560,910)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (560,910)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,412,106)		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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Other Income	\$ (5,747)	21	1
2	Jury Duty Income	(400)	10	2
3	Professional Fees - Collections	(2,448)	19	3
4	Professional Fees - Lobbying	(2,339)	19	4
5	Professional Fees - Line of Credit	(3,450)	19	5
6	Professional Fees - Legal	(3,454)	19	6
7	Professional Fees - Appraisal	(3,000)	19	7
8	Bank Charges	(3,454)	21	8
9				9
10				10
11				11
12				12
13	Boulevard Property, LLC			13
14	Professional Fees	(7,750)	19	14
15	License	(500)	21	15
16	Bank Charges	(189)	21	16
17	State Replacement Tax	(6,313)	21	17
18	Other	(30,069)	21	18
19	Amortization	(5,329)	31	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	(74,442)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Kensington Place Nsg & Rehab# 0052712

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	0	0	225	0	0	0	0	0	0	0	0	225	1
2	Food Purchase	(297)	0	484	0	0	0	0	0	0	0	0	187	2
3	Housekeeping	0	0	1,245	0	0	0	0	0	0	0	0	1,245	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,736	0	0	0	0	0	0	0	0	1,736	5
6	Maintenance	0	0	3,627	10,868	0	0	0	0	0	0	0	14,495	6
7	Other (specify):*	0	0	0	1,019	0	0	0	0	0	0	0	1,019	7
8	TOTAL General Services	(297)	0	7,317	11,887	0	0	0	0	0	0	0	18,907	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(400)	0	0	0	0	0	0	0	0	0	0	(400)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(400)	0	0	0	0	0	0	0	0	0	0	(400)	16
	C. General Administration													
17	Administrative	0	0	3,631	20,668	0	0	0	0	0	0	0	24,299	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(22,441)	7,750	(127,152)	0	0	0	0	0	0	0	0	(141,843)	19
20	Fees, Subscriptions & Promotions	(7,046)	0	1,179	0	0	0	0	0	0	0	0	(5,867)	20
21	Clerical & General Office Expenses	(808,730)	37,071	7,315	127,812	0	0	0	0	0	0	0	(636,532)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(6,082)	0	0	0	0	0	0	0	(6,082)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	185	0	0	0	0	0	0	0	0	185	24
25	Other Admin. Staff Transportation	0	0	1,256	0	0	0	0	0	0	0	0	1,256	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,174	0	0	0	0	0	0	0	0	2,174	26
27	Other (specify):*	0	0	0	28,532	0	0	0	0	0	0	0	28,532	27
28	TOTAL General Administration	(838,217)	44,821	(111,412)	170,930	0	0	0	0	0	0	0	(733,878)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(838,914)	44,821	(104,095)	182,817	0	0	0	0	0	0	0	(715,371)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Kensington Place Nsg & Rehab # 0052712 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	92,963	2,898	0	0	0	0	0	0	0	0	95,861	30
31	Amortization of Pre-Op. & Org.	(5,329)	5,329	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,953)	124,000	10,520	0	0	0	0	0	0	0	0	127,567	32
33	Real Estate Taxes	0	0	5,067	0	0	0	0	0	0	0	0	5,067	33
34	Rent-Facility & Grounds	0	(926,417)	0	0	0	0	0	0	0	0	0	(926,417)	34
35	Rent-Equipment & Vehicles	0	0	1,187	0	0	0	0	0	0	0	0	1,187	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(12,282)	(704,125)	19,672	0	0	0	0	0	0	0	0	(696,735)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(851,196)	(659,304)	(84,423)	182,817	0	0	0	0	0	0	0	(1,412,106)	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 - Supp		See Page 6 - Supp		See Page 6 - Supp		

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	\$ 926,417	Boulevard Property, LLC	100.00%	\$	\$ (926,417)	1
2	V	32	Interest	34,162	Boulevard Property, LLC	100.00%		(34,162)	2
3	V	19	Professional Fees		Boulevard Property, LLC	100.00%	7,750	7,750	3
4	V	21	Office		Boulevard Property, LLC	100.00%	37,071	37,071	4
5	V	26	Property Insurance		Boulevard Property, LLC	100.00%			5
6	V	30	Depreciation		Boulevard Property, LLC	100.00%	92,963	92,963	6
7	V	31	Amortization		Boulevard Property, LLC	100.00%	5,329	5,329	7
8	V	32	Interest		Boulevard Property, LLC	100.00%	158,162	158,162	8
9	V	33	Real Estate Taxes	256,581	Boulevard Property, LLC	100.00%	256,581		9
10	V	36	Mortgage Insurance Premiums		Boulevard Property, LLC	100.00%			10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,217,160			\$ 557,856	\$ * (659,304)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Kensington Place Nsg & Rehab

0052712

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	Yechiel Mashiach	15.20%	Beecher Manor Nursing and Rehab	Beecher, IL	Ex. Care Consulting	Evanston, IL	Home Office	1
2	Emilelch Ray	7.40%	Briar Place	Indian Head, IL	Ex. Care Clinical	Evanston, IL	Administrative	2
3	Chaim Ray	7.40%	Chateau Village Nursing and Rehab	Willowbrook, IL	2201 Main Street	Evanston, IL	Bldg. Company	3
4	Devorah Ray - Engel	7.40%	Grasmere Place	Chicago, IL	CCS VEBA	Evanston, IL	Health Insurance	4
5	Nechama Ray	7.40%	Lakewood Nursing and Rehab	Plainfield, IL	Vent Lease	Evanston, IL	Vent. Rental	5
6	Malkara Ray - Mashiach	15.20%	Lemont Nursing and Rehab	Lemont, IL	Mac RX, LLC	Des Plaines, IL	Pharmacy	6
7	Atied	40.00%	Prairie Manor Halth Care	Chicago Heights, IL	Reliable Medical	Des Plaines, IL	Medical Supply	7
8			Rainbow Beach Nursing Center	Chicago, IL				8
9			Sheridan Shores	Chicago, IL				9
10			South Suburban Rehabilitation Center	Chicago, IL				10
11			Tri-State Nursing and Rehab	Lansing, IL				11
12			Wheaton Care Center	Wheaton, IL	Boulevard			12
13			Kensington Place Nursing and Rehab	Chicago, IL	Property, LLC	Dolton, IL	Bldg. Company	13
14			Countryside Nursing and Rehab	Dolton, IL				14
15			Spring Creek Nursing and Rehab	Joliet, IL				15
16			Park House Nursing and Rehab	Chicago, IL				16
17			Timber Point Healthcare Center	Camp Point, IL				17
18			Prairie Village Healthcare Center	Jacksonville, IL				18
19			Major Hospital - Dyer	Dyer, IN				19
20			Major Hospital - Lake County	East Chicago, IN				20
21			Major Hospital - Sebo	Holbart, IN				21
22			Major Hospital - Lincolnshire	Merrillville, IN				22
23			Major Hospital - Munster	Munster, IN				23
24			McKinley Health Care Center	Canton, OH				24
25			St. James Manor	Crete, IL				25
26			St. James Manor - Assisted Living	Crete, IL				26
27			The Parc at Joliet	Joliet, IL				27
28			The Estates of Hyde Park	Chicago, IL				28
29			Rushville Nursing and Rehab	Rushville, IL				29
30			Paramount of Oak Park	Oak Park, IL				30

SEE ACCOUNTANTS' PREPARATION REPORT

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			Sheffield Manor Assisted Living	Dyer, IN				1
2			Kenosha Estates	Kenosha, WI				2
3			Milwaukee Estates	Milwaukee, WI				3
4			Appleton	Appleton, WI				4
5								5
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25								25
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27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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	1	Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 225	\$ 225	15
16	V	2	Food		Extended Care Consulting, LLC	100.00%	484	484	16
17	V	3	Housekeeping		Extended Care Consulting, LLC	100.00%	1,245	1,245	17
18	V	5	Utilities		Extended Care Consulting, LLC	100.00%	1,736	1,736	18
19	V	6	Maintenance		Extended Care Consulting, LLC	100.00%	3,627	3,627	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,631	3,631	20
21	V	19	Professional Fees	134,400	Extended Care Consulting, LLC	100.00%	7,248	(127,152)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,179	1,179	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	7,315	7,315	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	185	185	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,256	1,256	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	2,174	2,174	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,898	2,898	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	10,520	10,520	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	5,067	5,067	29
30	V	35	Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	1,187	1,187	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			\$ 134,400			\$ 49,977	\$ * (84,423)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	6	Maintenance (Pooled)	\$	Extended Care Consulting, LLC	100.00%	\$ 10,868	\$ 10,868	15
16	V	6	Maintenance (Direct)		Extended Care Consulting, LLC	100.00%	0		16
17	V	7	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,019	1,019	17
18	V	7	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	0		18
19	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	20,668	20,668	19
20	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	125,246	125,246	20
21	V	21	Office and Clerical (Direct)	17,706	Extended Care Consulting, LLC	100.00%	20,272	2,566	21
22	V	27	Emp. Gen. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	26,688	26,688	22
23	V	27	Emp. Gen. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,844	1,844	23
24	V	22	Employee Benefits	6,082	Extended Care Consulting, LLC	100.00%		(6,082)	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			\$ 23,788			\$ 206,605	\$ * 182,817	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	22	Employee Benefits	\$ 168,693	CCS VEBA	100.00%	\$ 168,693	\$	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			\$ 168,693			\$ 168,693	\$ *	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab # 0052712 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Yechiel Mashiach	Owner	Administrator	15.20%	N/A	40.00	100.00%	Salary	\$ 130,670	17 - 01	1
2	Adam Vales	Relative	Clerical	0.00%	See Attached	0.86	2.14%	Alloc. Salary	1,572	22 - 07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 132,242		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

SEE ACCOUNTANTS' PREPARATION REPORT

Kensington Place Nsg & Rehab
Medicaid Cost Report
01/01/16 - 12/31/16

Page 7 Supplemental Schedule

Description	Alloc. Hours	Total Hours	Alloc. Percentage	Total Compensation			Alloc. Compensation	
				Salary	Mgmt. Fees		Salary	Mgmt. Fees
Owners / Director Compensation								
Adam Vales							-	-
Prairie Village Healthcare Center	0.42	40.00	1.04%	73,410	-		762	-
Timber Point Healthcare Center	0.85	40.00	2.12%	73,410	-		1,556	-
Rushville Nursing & Rehab Center	0.51	40.00	1.27%	73,410	-		935	-
Countryside Nursing & Rehab Center	1.29	40.00	3.21%	73,410	-		2,360	-
Kensington Nursing & Rehab Center	0.86	40.00	2.14%	73,410	-		1,572	-
Park House Nursing & Rehab Center	0.63	40.00	1.57%	73,410	-		1,151	-
Other Insured Entities	35.46	40.00	88.65%	73,410	-		65,075	-
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Ending: 12/31/16

7

Ending: 12/31/16

(847) 491 - 9565

Ending: 12/31/16

(847) 941 - 9565

Ending: 12/31/16

(847) 491 - 9565

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	Private Bank		X	Mortgage			\$	5,300,000			\$	158,162	1
2													2
3													3
4													4
5													5
	Working Capital												
6	HFG		X	Line of Credit				750,000				13,621	6
7	Alloc. - Extended Care		X									10,520	7
8													8
9	TOTAL Facility Related						\$	6,050,000			\$	182,303	9
	B. Non-Facility Related*												
10													10
11													11
12	Int. Income - Operating		X									(6,953)	12
13	Int. Income - Building		X									(34,162)	13
14	TOTAL Non-Facility Related						\$				\$	(41,115)	14
15	TOTALS (line 9+line14)						\$	6,050,000			\$	141,188	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' PREPARATION 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.		\$	202,926		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.)		\$	229,216		2
3. Under or (over) accrual (line 2 minus line 1).		\$	26,290		3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	235,358		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.		\$	261,648		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	177,238	8	
		2012	186,917	9	
		2013	189,446	10	
		2014	193,263	11	
		2015	224,149	12	
2016 Real Estate Tax Accrual = \$224,149 * 1.05 = \$235,358					
Alloc. - Extended Care Consulting, LLC = \$5,067					

	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	Kensington Place Nsg & Rehab	COUNTY	Cook
---------------	------------------------------	--------	------

FACILITY IDPH LICENSE NUMBER 0052712

CONTACT PERSON REGARDING THIS REPORT Edward N. Slack, CPA

TELEPHONE (847) 628 - 8796 FAX #: (248) 327 - 8417

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 17 - 34 - 119 - 001 - 0000	Long Term Care Facility	\$ 66,255.70	\$ 66,255.70
2. 17 - 34 - 119 - 002 - 0000	Long Term Care Facility	\$ 11,207.15	\$ 11,207.15
3. 17 - 34 - 119 - 003 - 0000	Long Term Care Facility	\$ 110,591.25	\$ 110,591.25
4. 17 - 34 - 119 - 004 - 0000	Long Term Care Facility	\$ 10,712.38	\$ 10,712.38
5. 17 - 34 - 119 - 005 - 0000	Long Term Care Facility	\$ 12,691.45	\$ 12,691.45
6. 17 - 34 - 119 - 006 - 0000	Long Term Care Facility	\$ 12,691.45	\$ 12,691.45
7. Alloc. - Ext. Care Consulting	Long Term Care Facility	\$ 167,518.13	\$ 4,304.69
8. Alloc. - Ext. Care Consulting	Long Term Care Facility	\$ 36,794.68	\$ 945.51
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ 428,462.19	\$ 229,399.58

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 providecopies of their original **second installment** tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,293

B. General Construction Type: Exterior BrickFrame Steel

Number of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	51,000	1995	\$ 100,000	1
2	Alloc. - Ext. Care			21,071	2
3	TOTALS	51,000		\$ 121,071	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1989		\$ 1,209,350	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	8,296						9
10	Various			1988	11,646						10
11	Various			1989	5,250						11
12	Various			1990	7,780						12
13	Various			1991	16,578						13
14	Various			1992	17,269						14
15	Various			1993	21,968						15
16	Various			1994	13,356						16
17	Various			1995	12,270						17
18	Various			1996	15,797						18
19	Various			1997	7,187						19
20	Various			1998	17,815						20
21	Various			1999	6,043						21
22	Various			2000	235,020						22
23	Various			2001	61,023						23
24	Various			2002	236,588						24
25	Various			2003	110,588						25
26	Various			2004	98,820						26
27	Various			2005	1,500						27
28	Various			2006	18,167						28
29	Various			2007	7,963						29
30	Various			2008	12,185						30
31	Various			2009	10,849						31
32	Various			2010	87,696						32
33	Various			2011	66,198						33
34	Various			2012	162,288						34
35	Elevator - GAL Door Restrictors			2013	5,665						35
36	Elevator - GAL Door Restrictors			2013	4,216						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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

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	
37	Hot Water Heater - 80 Gallon 199,000 BTU	2013	\$ 8,400	\$		\$	\$	\$	37
38	New 30 Circuit Panelboard	2013	6,500						38
39	Fire Alarm System Devises	2013	3,161						39
40	Elevator - 3D Infrared Detector Edge	2013	3,200						40
41	Elevator - Valve Replacement	2013	5,308						41
42	Parking Lot - Asphalt and Striping	2013	13,863						42
43	Roof Drain	2013	5,635						43
44	Hallway Doors - Egress Locks	2014	14,894						44
45	Canopy - Main Entrance	2014	9,620						45
46	Hot Water / Cold Water Riser	2014	10,370						46
47	Electrical Outlets - Nurses Stations	2014	2,893						47
48	Elevator - Vale	2014	8,910						48
49	Sprinkler System - Grounds	2014	3,800						49
50	Elevator - Remove and Replace Casings	2016	27,200						50
51	Elevator - Control System Board	2016	4,488						51
52	Painting - Group, Therapy, Dishwasher, Basement, Dining,								52
53	Recreation, Kitchen, Storage, 2nd and 3rd Floors	2016	22,845						53
54	Nurse Call System	2016	12,094						54
55	Elevator - Two Door Opener	2016	9,500						55
56	Elevator - Hydraulic Cylindar	2016	33,000						56
57	Flooring - Dishwashing Room	2016	4,590						57
58	Facility Renovations								58
59	Structural Engineering, Permits, and Project Management	2016	12,239						59
60	Guest Bathroom - New Tile, Cove Base, Drywall, and Fixture	2016	2,569						60
61	Vestibule - Electric Doors, Electric Signs, Fire Alarm Switch,								61
62	Carpet Tile, Millwork, and Painting	2016	18,977						62
63	Therapy Room - Cornices	2016	317						63
64	Offices - Carpet Tile, Cove Base, Window Treatments, Painting	2016	8,828						64
65	Elevator - Wallcovering, Handrail, Bumper, and Flooring	2016	10,990						65
66	Dayroom - Fireplace, Cove Base, Wallcoverinig, and Window Tr	2016	18,259						66
67	Conference Room - Carpet Tile, Cove Base, Wallcoverings,								67
68	Lighting, and Painting	2016	10,091						68
69	Corridors - Cove Base, Signage, Lights, Wallcoverings, and Han	2016	55,317						69
70	TOTAL (lines 4 thru 69)		\$ 2,837,231	\$		\$	\$	\$	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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 12A, Carried Forward		\$ 2,837,231	\$		\$	\$	\$	1
2									2
3	Facility Renovations (Continued)								3
4	Administrator Bathroom - Tile, Drywall, Lights, and Fixtures	2016	3,062						4
5	Lobby - Cove Base, New Wall, Drop Ceiling, Wallcoverings,								5
6	Electrical Fixtures, Double Doors and Framing, Signs,								6
7	Cornices, and Sheers	2016	29,625						7
8	Resident Rooms - Cove Base, Overbed Lights, Cubicle								8
9	Curtains, Window Treatments, Bumper Guards and								9
10	End Caps, and Painting	2016	52,481						10
11	1st Floor Corridors, Dining Room, and Lobby - Ceiling Tiles	2016	18,557						11
12	1st Floor - New Doors, Hardward, and Installation	2016	34,496						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)		\$ 2,975,452	\$		\$	\$	\$	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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 12B, Carried Forward		\$ 2,975,452	\$		\$	\$	\$	1
2								2
3 Related Party Allocations - See Supplemental Schedules								3
4								4
5 Allocations - Extended Care Consulting, LLC	2007	169						5
6 Allocations - Extended Care Consulting, LLC	2009	101						6
7 Allocations - Extended Care Consulting, LLC	2010	991						7
8 Allocations - Extended Care Consulting, LLC	2011	357						8
9 Allocations - Extended Care Consulting, LLC	2013	116						9
10 Allocations - Extended Care Consulting, LLC	2014	1,629						10
11 Allocations - Extended Care Consulting, LLC	2016	1,953						11
12								12
13 Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	29,037						13
14 Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	23,987						14
15 Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2003	28,268						15
16 Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2005	1,404						16
17 Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2009	253						17
18 Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2014	2,357						18
19 Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2015	400						19
20 Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2016	1,579						20
21								21
22 Allocations - Extended Care Consulting, LLC / Dyer Building	2007	8,813						22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30 Depreciation - Kensington Place Nursing & Rehabilitation			63,692		63,692		90,878	30
31 Depreciation - Boulevard Property, LLC			92,963		92,963		3,530,631	31
32 Depreciation - Extended Care Consulting, LLC			2,898		2,898		71,809	32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,076,866	\$ 159,553		\$ 159,553	\$	\$ 3,693,318	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$93,485	\$	\$	\$		\$	71
72	Current Year Purchases	68,812						72
73	Fully Depreciated Assets							73
74	See Supplemental	275,488						74
75	TOTALS	\$437,785	\$	\$	\$		\$	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	Alloc. - Extended Care			\$6,627	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$6,627	\$	\$	\$		\$	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)	\$3,642,349	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$159,553	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$159,553	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,693,318	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Kensington Place Nsg & Rehab
Medicaid Cost Report
01/01/16 - 12/31/16

Page 13 - Related Party Furniture and Equipment Allocations

[illegible]

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	See Suppl				0			5
6								6
7	TOTAL				\$			7

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	\$

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: \$ 14,973 Description: See Supplemental 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	Lexus	\$	\$ 10,078	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 10,078	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Kensington Place Nsg & Rehab
Medicaid Cost Report
01/01/16 - 12/31/16

Page 14 Supplemental Schedule

Description		Amount		Total
Building Rental				
				-
N/A				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		-	-	
Equipment Rental				
Toshiba		39		39
Pitney Bowes		441		441
US Bank Equipment Finance		5,429		5,429
Lenova Financial Services		7,137		7,137
Chicago Office Technology		740		740
				-
				-
Alloc. - Extended Care Consulting, LLC		1,187		1,187
				-
				-
				-
				-
				-
				-
Total		14,973	14,973	

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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 - 03	hrs	\$		\$	162,224	\$		\$	162,224	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				36,771				36,771	2	
3	Licensed Recreational Therapist		hrs				157,360				157,360	3	
4	Licensed Physical Therapist	39 - 03	hrs									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					62,351			62,351	9	
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)												
10			hrs									10	
11	Academic Education		hrs									11	
12	Other (specify): See Supplemental	39 - 02						69			69	12	
13	Other (specify): See Supplemental	39 - 03					13,108				13,108	13	
14	TOTAL				\$		\$	369,463	\$	62,420	\$	431,883	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 163,733	\$ 465,536	1
2	Cash-Patient Deposits	44,617	44,617	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,144,918)	1,652,934	1,652,934	3
4	Supply Inventory (priced at Cost - FIFO)			4
5	Short-Term Investments			5
6	Prepaid Insurance	272,547	272,547	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	2,360	2,360	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,136,191	\$ 2,437,994	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		3,624,354	14
15	Leasehold Improvements, at Historical Cost	499,055	499,055	15
16	Equipment, at Historical Cost	146,923	301,923	16
17	Accumulated Depreciation (book methods)	(90,878)	(3,621,509)	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): See Supplemental Schedule	656,182	2,967,938	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,211,282	\$ 3,871,761	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,347,473	\$ 6,309,755	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 609,093	\$ 609,093	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,617	44,617	28
29	Short-Term Notes Payable	750,000	750,000	29
30	Accrued Salaries Payable	285,315	285,315	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,067	11,067	31
32	Accrued Real Estate Taxes(Sch.IX-B)		235,358	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	1,219,120		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,919,212	\$ 1,935,450	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	15,187	15,187	39
40	Mortgage Payable		5,300,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 15,187	\$ 5,315,187	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,934,399	\$ 7,250,637	46
47	TOTAL EQUITY(page 18, line 24)	\$ 413,074	\$ (940,882)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,347,473	\$ 6,309,755	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Kensington Place Nsg & Rehab
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Page 17 Supplemental Schedule

Description		Operating		Building		Total
Line 9 - Other Current Assets						
Security Deposits		2,360				2,360
						-
						-
						-
						-
Sub-Total		2,360		-		2,360
Line 23 - Long Term Assets						
Option Deposit		650,000		(650,000)		-
Organization Costs (Net Amortization)		4,800				4,800
State Replacement Tax Benefit		1,382				1,382
Due from Affiliated Entities				2,961,756		2,961,756
						-
Sub-Total		656,182		2,311,756		2,967,938
Line 36 - Other Current Liability						
Due to Boulevard Property, LLC		522,299		(522,299)		-
Due to Affiliated Entities		696,821		(696,821)		-
						-
						-
						-
Sub-Total		1,219,120		(1,219,120)		-
Line 43 - Long term Liabilities						
						-
						-
						-
						-
						-
Sub-Total		-		-		-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 580,829	1
2	Restatements (describe):		2
3	Rounding	6	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 580,835	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	387,239	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	(555,000)	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)	\$ (167,761)	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)	\$ 413,074	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	\$ 9,381,340	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,381,340	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	74,428	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 74,428	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,953	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,953	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	6,147	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,147	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,468,868	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,270,271	31
32	Health Care	3,049,736	32
33	General Administration	2,681,810	33
	B. Capital Expense		
34	Ownership	1,285,775	34
	C. Ancillary Expense		
35	Special Cost Centers	431,883	35
36	Provider Participation Fee	362,154	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,081,629	40
41	Income before Income Taxes (line 30 minus line 40)**	387,239	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 387,239	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,552,228	44
45	Private Pay - Net Inpatient Revenue	11,644	45
46	Medicare - Net Inpatient Revenue	1,444,573	46
47	Other-(specify) <u>Insurance - Net Patient Revenue</u>	208,592	47
48	Other-(specify) <u>Hospice - Net Patient Revenue</u>	164,303	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,381,340	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Final 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Kensington Place Nsg & Rehab
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Page 19 Supplemental Schedule

[illegible]

Facility Name & ID Number Kensington Place Nsg & Rehab# 0052712

Report Period Beginning:

01/01/16

Ending:

12/31/16

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,041	2,211	\$ 103,603	\$ 46.86	1
2	Assistant Director of Nursing	2,041	2,211	85,113	38.50	2
3	Registered Nurses	7,884	8,510	247,072	29.03	3
4	Licensed Practical Nurses	29,521	32,227	823,280	25.55	4
5	CNAs & Orderlies	67,700	74,193	812,647	10.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,341	8,258	147,502	17.86	8
9	Activity Director	1,918	2,120	33,494	15.80	9
10	Activity Assistants	5,295	5,729	59,687	10.42	10
11	Social Service Workers	12,740	14,065	242,254	17.22	11
12	Dietician					12
13	Food Service Supervisor	1,873	2,113	47,161	22.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,418	18,438	193,661	10.50	15
16	Dishwashers					16
17	Maintenance Workers	5,485	6,067	103,626	17.08	17
18	Housekeepers	13,356	14,494	149,383	10.31	18
19	Laundry	4,854	5,443	58,569	10.76	19
20	Administrator	2,041	2,207	130,670	59.21	20
21	Assistant Administrator	2,041	2,211	93,218	42.16	21
22	Other Administrative	908	1,020	38,250	37.50	22
23	Office Manager					23
24	Clerical	11,540	12,461	331,245	26.58	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	2,268	2,588	33,644	13.00	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	8,798	9,410	275,292	29.26	33
34	TOTAL (lines 1 - 33)	206,063	225,976	\$ 4,009,371 *	\$ 17.74	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		\$ 15,697	01 - 03	35
36	Medical Director		9,000	09 - 03	36
37	Medical Records Consultant		2,731	10 - 03	37
38	Nurse Consultant		32,230	10 - 03	38
39	Pharmacist Consultant		14,617	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		217	10 - 03	42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,779	11 - 03	44
45	Social Service Consultant		713	12 - 03	45
46	Other(specify)				46
47	<u>See Supplemental Schedule</u>				47
48					48
49	TOTAL (lines 35 - 48)		\$ 77,984		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				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Kensington Place Nsg & Rehab
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Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Security	07	2,389	2,589	27,700	10.70		
MDS / Care Plan Coordinator	10	3,832	4,146	135,234	32.62		
Quality Assurance	10	2,577	2,675	112,358	42.00		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		8,798	9,410	275,292	29.26		

Contracted Services							
Total						-	-

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	
Yechiel Mashlach	Administrator	0	\$ 130,670	Workers' Compensation Insurance		\$ 123,311	IDPH License Fee	\$ 1,990	
Cynthia Staine	Asst. Admin.	0	93,218	Unemployment Compensation Insurance		58,122	Advertising: Employee Recruitment	20,356	
Lorena Sommerfield	Administration	0	38,250	FICA Taxes		301,336	Health Care Worker Background Check (Indicate # of checks performed _____)	6,445	
				Employee Health Insurance		204,487	Patient Background Checks		
				Employee Meals			Dues - ICLTC	18,299	
				Illinois Municipal Retirement Fund (IMRF)*			Dues and Subscriptions	691	
				Retirement Contributions		41,855	Licenses and Fees	5,263	
				Other Employee Benefits		12,273	Advertising and Promotion	7,046	
				Page 6B - Employee Benefit Offset		(6,082)	Alloc. - Extended Care Consulting	1,179	
							Less: Public Relations Expense	()	
							Non-allowable advertising	(7,046)	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 262,138	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 54,223
B. Administrative - Other							G. Schedule of Travel and Seminar**		
Description			Amount	Description			Amount		
			\$						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 735,302		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
Vendor/Payee	Type		Amount	Description	Line #	Amount			
Extended Care Consulting	Management Fee		\$ 134,400			\$	Out-of-State Travel		
Plante & Moran, PLLC	Accounting		15,975						
Personnel Planners	Unemployment Consultant		1,470						
Matrixcare	Data Processing / IT		19,836				In-State Travel		
Ability Network	Data Processing / IT		5,120						
National Data Corporation	Data Processing / IT		5,376						
Paycor Payroll Services	Data Processing / IT		22,781						
E Health Data Solutions	Data Processing / IT		1,698				Seminar Expense		
Other	Data Processing / IT		5,579				Alloc. - Extended Care Consulting		
Generation Law	Legal		500						
Holly Turner, Esq	Legal		2,858						
See Supplemental Schedule			22,830				Entertainment Expense		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 238,423	TOTAL			\$		
							(agree to Sch. V, line 24, col. 8)		
							TOTAL		
							\$ 4,954		

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

Kensington Place Nsg & Rehab
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Page 21 Supplemental Schedule - Other Professional Fees

[illegible]

Kensington Place Nsg & Rehab
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Page 21 Supplemental Schedule - Legal Invoice Detail

Vendor	Service Description	Invoice Date		Amount	Non-Allowable	Allowable
Generation Law	Resident Guardianship	09/08/16		500		500
Holly Turner, Esq	Non - Allowable	N/A		238	238	-
Holly Turner, Esq	Non - Allowable	N/A		238	238	-
Holly Turner, Esq	Non - Allowable	N/A		238	238	-
Holly Turner, Esq	Non - Allowable	N/A		238	238	-
Holly Turner, Esq	Non - Allowable	N/A		238	238	-
Holly Turner, Esq	Non - Allowable	N/A		238	238	-
Holly Turner, Esq	Non - Allowable	N/A		296	296	-
Holly Turner, Esq	Non - Allowable	N/A		238	238	-
Holly Turner, Esq	Non - Allowable	N/A		153	153	-
Holly Turner, Esq	Non - Allowable	N/A		743	743	-
Michael Margolies	Non - Allowable	N/A		596	596	-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
Total				3,954	3,454	500

XX. GENERAL INFORMATION:

- (1)

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

Yes
- (2)

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

Yes
ICLTC - \$18,299
- (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?

No
N/A
- (4)

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

No
N/A
- (5)

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

Yes
5 - 10 Yrs
- (6)

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

\$
Line 10 - 02
- (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.

\$ 362,154
- (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 benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 0
No
Indicate the amount. \$ 0
- (16)

Travel and Transportation

a.

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

No

b.

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

No
N/A

c.

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

N/A

d.

Have vehicle usage logs been maintained?

Yes

e.

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

Yes

f.

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

Yes

g.

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

No
N/A

(17)

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

No
N/A

(18)

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

Yes

(19)

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

N/A

SEE ACCOUNTANTS' PREPARATION REPORT