

		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>0046201</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																	
Facility Name: <u>Lemont Nrsg & Rehab Center</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>12450 Walker Road</u> <u>Lemont</u> <u>60539</u>																																																																																			
Number City Zip Code																																																																																			
County: <u>Cook</u>																																																																																			
Telephone Number: <u>(630) 243-0400</u> Fax # <u>(630) 243-5063</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></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____ *</td></tr><tr><td>* Subject to the attached Accountants Consulting Report (Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td colspan="2"></td><td colspan="2">(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>2/1/2003</u></td><td colspan="2" rowspan="5"> 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 </td></tr><tr><td colspan="2">Type of Ownership:</td></tr><tr><td colspan="2"><table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table></td></tr><tr><td colspan="2"></td></tr><tr><td colspan="2"></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td></tr><tr><td colspan="2">Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u></td></tr><tr><td colspan="2">Email Address: _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____		Paid Preparer	(Signed) _____ *	* Subject to the attached Accountants Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>			(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>		Date of Initial License for Current Owners: <u>2/1/2003</u>		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		Type of Ownership:		<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></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 _____							In the event there are further questions about this report, please contact:		Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u>		Email Address: _____	
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Facility Name & ID Number Lemont Nrsg & Rehab Center

0046201 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>158</u>	Skilled (SNF)	<u>158</u>	<u>57,828</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>158</u>	TOTALS	<u>158</u>	<u>57,828</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>24,905</u>	<u>9,283</u>	<u>15,922</u>	<u>50,110</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>24,905</u>	<u>9,283</u>	<u>15,922</u>	<u>50,110</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.65%

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES ☐ NO ☒

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

YES ☐ NO ☒

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

Date started 02/01/03

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

YES ☒ Date 02/01/03 NO ☐

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

YES ☒ NO ☐ If YES, enter number of beds certified 158 and days of care provided 14,246

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number **Lemont Nrsg & Rehab Center** # **0046201** 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	331,137	86,383	21,483	439,003		439,003	10,050	449,053			1
2	Food Purchase		363,695		363,695		363,695	(253)	363,442			2
3	Housekeeping	218,920	49,226		268,146		268,146	1,158	269,304			3
4	Laundry	60,984	29,129		90,113		90,113		90,113			4
5	Heat and Other Utilities			156,054	156,054		156,054	52	156,106			5
6	Maintenance	124,366		278,406	402,772		402,772	12,435	415,207			6
7	Other (specify):*							4,659	4,659			7
8	TOTAL General Services	735,407	528,433	455,943	1,719,783		1,719,783	28,101	1,747,884			8
	B. Health Care and Programs											
9	Medical Director			39,000	39,000		39,000		39,000			9
10	Nursing and Medical Records	3,232,128	274,852	577,460	4,084,440		4,084,440	38,045	4,122,485			10
10a	Therapy	266,068		1,822	267,890		267,890		267,890			10a
11	Activities	188,023	30,386		218,409		218,409		218,409			11
12	Social Services	254,850			254,850		254,850	23,879	278,729			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							8,966	8,966			15
16	TOTAL Health Care and Programs	3,941,069	305,238	618,282	4,864,589		4,864,589	70,890	4,935,479			16
	C. General Administration											
17	Administrative	160,879			160,879		160,879	100,299	261,178			17
18	Directors Fees											18
19	Professional Services			796,392	796,392	(1,036)	795,356	(689,974)	105,382			19
20	Dues, Fees, Subscriptions & Promotions			118,461	118,461		118,461	(51,420)	67,041			20
21	Clerical & General Office Expenses	177,243	44,825	391,760	613,828		613,828	(187,688)	426,140			21
22	Employee Benefits & Payroll Taxes			816,858	816,858		816,858	(5,742)	811,116			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,746	5,746		5,746	905	6,651			24
25	Other Admin. Staff Transportation			4,214	4,214		4,214	1,054	5,268			25
26	Insurance-Prop.Liab.Malpractice			226,849	226,849		226,849	2,450	229,299			26
27	Other (specify):*							35,760	35,760			27
28	TOTAL General Administration	338,122	44,825	2,360,280	2,743,227	(1,036)	2,742,191	(794,356)	1,947,835			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,014,598	878,496	3,434,505	9,327,599	(1,036)	9,326,563	(695,365)	8,631,198			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			142,317	142,317		142,317	150,518	292,835			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34	34		34	450,592	450,626			32
33	Real Estate Taxes			367,642	367,642	1,036	368,678	4,715	373,393			33
34	Rent-Facility & Grounds			1,860,000	1,860,000		1,860,000	(1,860,000)				34
35	Rent-Equipment & Vehicles			11,789	11,789		11,789	996	12,785			35
36	Other (specify):*			645	645		645	(645)				36
37	TOTAL Ownership			2,382,427	2,382,427	1,036	2,383,463	(1,253,824)	1,129,639			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		735,407	1,889,596	2,625,003		2,625,003	(37,875)	2,587,128			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			296,351	296,351		296,351		296,351			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		735,407	2,185,947	2,921,354		2,921,354	(37,875)	2,883,479			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,014,598	1,613,903	8,002,879	14,631,380		14,631,380	(1,987,064)	12,644,316			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,550)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(31,784)	30		9
10	Interest and Other Investment Income	(87,909)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(660)	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				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	(309,832)	21		24
25	Fund Raising, Advertising and Promotional	(47,421)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(86,950)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (566,106)		\$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,420,958)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,420,958)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,987,064)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Gain/Loss Disposal Assets	\$ (81)	30	1
2	Jury Duty Income	(25)	10	2
3	Resident Clothing	(557)	10	3
4	Theft Loss	(746)	21	4
5	Collection Expense	(8,115)	21	5
6	Amortization	(645)	36	6
7	PAC Dues	(6,123)	20	7
8	Non Allowable Legal Fees	(15,758)	19	8
9	Building Company - Management Fees	(7,900)	17	9
10	Building Company - Amortization	(46,730)	36	10
11	Building Company - Filing Fees	(250)	20	11
12	Website Fees	(20)	19	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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37				37
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(86,950)		49

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
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83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

Summary B

12/31/16

	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)	
	Depreciation	(31,865)	179,216	2,433		734							150,518	30
	Amortization of Pre-Op. & Org.													31
	Interest	(87,909)	529,457	8,833		211							450,592	32
	Real Estate Taxes			4,255		460							4,715	33
	Rent-Facility & Grounds		(1,860,000)										(1,860,000)	34
	Rent-Equipment & Vehicles			996									996	35
	Other (specify):*	(47,375)	46,730										(645)	36
	TOTAL Ownership	(167,149)	(1,104,597)	16,517		1,405							(1,253,824)	37
	Ancillary Expense													
	E. Special Cost Centers													
	Medically Necessary Transportation													38
	Ancillary Service Centers						(37,875)						(37,875)	39
	Barber and Beauty Shops													40
	Coffee and Gift Shops													41
	Provider Participation Fee													42
	Other (specify):*													43
	TOTAL Special Cost Centers						(37,875)						(37,875)	44
	GRAND TOTAL COST													
	(sum of lines 29, 37 & 44)	(566,106)	(1,096,447)	(468,806)	151,603	32,970	(39,131)		(1,069)	(77)			(1,987,064)	45

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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			189		9,861							10,050	1
2	Food Purchase	(660)		407									(253)	2
3	Housekeeping			1,045		113							1,158	3
4	Laundry													4
5	Heat and Other Utilities	(1,550)		1,458		144							52	5
6	Maintenance			3,046	9,125	267				(3)			12,435	6
7	Other (specify):*				3,297	1,362							4,659	7
8	TOTAL General Services	(2,210)		6,145	12,422	11,747				(3)			28,101	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(582)				41,027	(1,257)		(1,069)	(74)			38,045	10
10a	Therapy													10a
11	Activities													11
12	Social Services					23,879							23,879	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					8,966							8,966	15
16	TOTAL Health Care and Programs	(582)				73,872	(1,257)		(1,069)	(74)			70,890	16
	C. General Administration													
17	Administrative	(7,900)	7,900	3,048	17,354	79,897							100,299	17
18	Directors Fees													18
19	Professional Services	(15,778)		(504,682)		(169,514)							(689,974)	19
20	Fees, Subscriptions & Promotions	(53,794)	250	990		1,134							(51,420)	20
21	Clerical & General Office Expenses	(318,693)		6,142	105,161	19,702							(187,688)	21
22	Employee Benefits & Payroll Taxes				(5,742)								(5,742)	22
23	Inservice Training & Education													23
24	Travel and Seminar			155		750							905	24
25	Other Admin. Staff Transportation			1,054									1,054	25
26	Insurance-Prop.Liab.Malpractice			1,825		625							2,450	26
27	Other (specify):*				22,408	13,352							35,760	27
28	TOTAL General Administration	(396,165)	8,150	(491,468)	139,181	(54,054)							(794,356)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(398,957)	8,150	(485,323)	151,603	31,565	(1,257)		(1,069)	(77)			(695,365)	29

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.

[illegible]

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	\$ 1,860,000	Lemont Property, LLC	100.00%	\$	\$ (1,860,000)	1
2	V	33	Rent - Property Taxes	367,642	Lemont Property, LLC	100.00%		(367,642)	2
3	V	32	Interest	136,438	Lemont Property, LLC	100.00%	665,895	529,457	3
4	V	20	Filing Fees		Lemont Property, LLC	100.00%	250	250	4
5	V	30	Depreciation		Lemont Property, LLC	100.00%	179,216	179,216	5
6	V	36	Amortization		Lemont Property, LLC	100.00%	46,730	46,730	6
7	V	33	Real Estate Tax		Lemont Property, LLC	100.00%	367,642	367,642	7
8	V	17	Management Fees		Lemont Property, LLC	100.00%	7,900	7,900	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,364,080			\$ 1,267,633	\$ * (1,096,447)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 189	\$ 189	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	407	407	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,045	1,045	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,458	1,458	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,046	3,046	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,048	3,048	20
21	V	19	Professional Fees	510,768	Extended Care Consulting, LLC	100.00%	6,086	(504,682)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	990	990	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	6,142	6,142	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	155	155	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,054	1,054	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,825	1,825	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,433	2,433	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	8,833	8,833	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	4,255	4,255	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	996	996	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			\$ 510,768			\$ 41,962	\$ * (468,806)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	9,125	\$	9,125
16	V	06	Maintenance (Direct)	19,140	Extended Care Consulting, LLC	100.00%	19,140		
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	855		855
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	2,442		2,442
19	V								
20	V								
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	17,354		17,354
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	105,161		105,161
23	V	21	Office and Clerical (Direct)		Extended Care Consulting, LLC	100.00%			
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	22,408		22,408
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%			
26	V	22	Employee Benefits	5,742	Extended Care Consulting, LLC	100.00%			(5,742)
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 24,882			\$ 176,485	\$ *	151,603

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 113	\$	113 15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	144		144 16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	267		267 17
18	V	19	Professional Fees	170,256	Extended Care Clinical, LLC	100.00%	742	(169,514)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	1,134	1,134	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,948	2,948	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	750	750	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	625	625	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	734	734	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	211	211	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	460	460	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	9,861	9,861	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,362	1,362	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	41,027	41,027	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	23,879	23,879	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	8,966	8,966	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	79,897	79,897	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	16,754	16,754	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	13,352	13,352	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 170,256			\$ 203,226	\$ *	32,970 39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	\$ 17,449	MAC Rx, LLC	100.00%	\$ 16,192	\$ (1,257)	15
16	V	21	Clerical & General Office Expenses		MAC Rx, LLC	100.00%			16
17	V	22	Employee Benefits		MAC Rx, LLC	100.00%			17
18	V	39	Ancillary	525,882	MAC Rx, LLC	100.00%	488,007	(37,875)	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			\$ 543,330			\$ 504,199	\$ * (39,131)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 311,789	\$ 311,789	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	311,789	CCS Employee Benefits Group	100.00%		(311,789)	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			\$ 311,789			\$ 311,789	\$ *	39

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

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Various Equipment	18,370	Vent Lease LLC	100.00%	17,301	\$ (1,069)	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			\$ 18,370			\$ 17,301	\$ * (1,069)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing Equipment Rental	5,563	Reliable Medical of the Midwest, LLC	100.00%	5,488	\$ (74)	15
16	V	6	Nursing Minor Equipment Purchases	220	Reliable Medical of the Midwest, LLC	100.00%	217	(3)	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			\$ 5,783			\$ 5,705	\$ * (77)	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ROTHNER HEALTH VENTURES G II, LLC	100.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	LEMONT PROPERTY, LI	EVANSTON	BUILDING COMPANY	1
2			BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONS	EVANSTON	MGMT/BOOKKEEPIN	2
3			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINI	EVANSTON	CLINICAL	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDI	EVANSTON	BUILDING COMPANY	4
5			GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMEN	5
6			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7			MAJOR HOSPITAL DYER	DYER, IN	MAC RX	DES PLAINES	PHARMACY	7
8			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	RELIABLE MEDICAL SU	DES PLAINES	MEDICAL SUPPLIES	8
9			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				9
10			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				10
11			MAJOR HOSPITAL SEBOS	HOBART, IN				11
12			MCKINLEY HEALTH CARE CENTER	CANTON, OH				12
13			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				13
14			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				14
15			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				15
16			RAINBOW BEACH QOC, L.L.C.	CHICAGO				16
17			SHEFFIELD MANOR	DYER, IN				17
18			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				18
19			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				19
20			SPRING CREEK NURSING & REHAB CENTER	JOLIET				20
21			ST. JAMES WELLNESS REHAB VILLAS	CRETE				21
22			THE ESTATES OF HYDE PARK	CHICAGO				22
23			THE PARC AT JOLIET	JOLIET				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				25
26			WHEATON CARE CENTER	WHEATON				26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	Mark Steinberg	Relative	Administrative	0	See Attached	2.89	5.26%	Alloc Sal/Fee	\$ 10,478	17-07	1
2	Kimberly Rudolph	Relative	Clerical	0	See Attached	0.28	3.63%	Alloc Salary	85	21-07	2
3	Adam Vales	Relative	Clerical	0	See Attached	1.58	3.96%	Alloc Salary	2,905	22-07	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 13,468		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 Lemont Nrsg & Rehab Center # 0046201 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

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

Ending: 12/31/16

(847) 905-3030

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Extended Care Consulting, LLC
Street Address 2201 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	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	06	Maintenance (Pooled)	Patient Days	1,380,761	34	251,431	251,431	50,110	9,125	1
2	06	Maintenance (Direct)	Direct		20	373,682	373,682		19,140	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,380,761	34	23,565		50,110	855	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		20	46,748			2,442	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,380,761	34	478,172	478,172	50,110	17,354	7
8	21	Office and Clerical (Pooled)	Patient Days	1,380,761	34	2,897,656	2,897,656	50,110	105,161	8
9	21	Office and Clerical (Direct)	Direct		24	460,382	460,382			9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,380,761	34	617,434		50,110	22,408	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		24	73,413				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					\$ 5,222,483	\$ 4,461,323		\$ 176,485	25

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Extended Care Clinical, LLC
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	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	03	Housekeeping	Patient Days	818,091	19	\$ 1,844	\$	50,110	\$ 113	1
2	05	Utilities	Patient Days	818,091	19	2,355		50,110	144	2
3	06	Maintenance	Patient Days	818,091	19	4,352		50,110	267	3
4	19	Professional Fees	Patient Days	818,091	19	12,122		50,110	742	4
5	20	Dues and Subscriptions	Patient Days	818,091	19	18,512		50,110	1,134	5
6	21	Office & Clerical	Patient Days	818,091	19	48,124		50,110	2,948	6
7	24	Travel and Seminar	Patient Days	818,091	19	12,239		50,110	750	7
8	26	Insurance	Patient Days	818,091	19	10,196		50,110	625	8
9	30	Depreciation	Patient Days	818,091	19	11,978		50,110	734	9
10	32	Interest	Patient Days	818,091	19	3,446		50,110	211	10
11	33	Real Estate Taxes	Patient Days	818,091	19	7,506		50,110	460	11
12	01	Dietary Salary	Patient Days	818,091	19	160,997	160,997	50,110	9,861	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	818,091	19	22,241		50,110	1,362	13
14	10	Nursing Salary	Patient Days	818,091	19	669,803	669,803	50,110	41,027	14
15	12	Social Service Salary	Patient Days	818,091	19	389,842	389,842	50,110	23,879	15
16	15	Emp. Ben. - Healthcare	Patient Days	818,091	19	146,386		50,110	8,966	16
17	17	Administration Salary	Patient Days	818,091	19	1,304,395	1,304,395	50,110	79,897	17
18	21	Office Salary	Patient Days	818,091	19	273,525	273,525	50,110	16,754	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	818,091	19	217,984		50,110	13,352	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,317,844	\$ 2,798,561		\$ 203,226	25

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization MAC Rx, LLC
Street Address 2307 S. Mount Prospect Road
City / State / Zip Code Des Plaines, IL 60018
Phone Number (224)220-2700
Fax Number (224)220-2730

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	10	Nursing And Medical Records	Direct Allocation		\$	\$		\$ 16,192	1
	2	21	Clerical & General Office Expense	Direct Allocation						2
	3	22	Employee Benefits	Direct Allocation						3
	4	39	Ancillary	Direct Allocation					488,007	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				\$	\$		\$ 504,199	25

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CCS Employee Benefits Group, Inc.
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847)905-4000
Fax Number (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			\$	\$		\$ 311,789	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 311,789	25

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Vent Lease, LLC
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 674-1180
Fax Number (847) 673-7741

	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	10	Various Equipment	Direct Allocation						17,301	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 17,301	25

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Reliable Medical of the Midwest, LLC
Street Address 200 Howard Avenue
City / State / Zip Code Des Plaines, Illinois 60018-5909
Phone Number (847) 566-0800
Fax Number ()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing Equipment Rental	Direct Allocation						5,488	1
2	6	Nursing Minor Equipment Purcha	Direct Allocation						217	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 5,705	25

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

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

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	MB Financial (Cole Taylor)		X	Mortgage			\$	12,700,000			\$	665,895	1
2	MB Financial (Cole Taylor)		X	Construction				3,700,894					2
3													3
4													4
5					-								5
	Working Capital												
6													6
7													7
8					-								8
9	TOTAL Facility Related						\$	16,400,894			\$	665,895	9
	B. Non-Facility Related*												
10	Interest Income		X									(87,909)	10
11	Interest Expense		X									34	11
12	Interest Income - Bldg Co		X									(136,438)	12
13	See Supplemental Schedule				-							9,044	13
14	TOTAL Non-Facility Related						\$				\$	(215,269)	14
15	TOTALS (line 9+line14)						\$	16,400,894			\$	450,626	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$		\$			\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15	Alloc- Extended Care Clinical	X					\$		\$			\$ 211	15
16	Alloc - Extended Care Consultin	X										8,833	16
17													17
18													18
19													19
20	TOTAL Non-Facility Related											9,044	20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

FACILITY NAME	<u>Lemont Nrsg & Rehab Center</u>	COUNTY	<u>Cook</u>
---------------	---------------------------------------	--------	-------------

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

A. Summary of Real Estate Tax Cost

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

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

IMPORTANT NOTICE

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

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

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Lemont Nrsg & Rehab Center

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0046201

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

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</u> <u>Applicable to</u> <u>Nursing Home</u>
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

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 NO

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

55,000

B. General Construction Type:

Exterior

Brick

Frame

Masonry&Steel

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Facility			2003		\$ 823,094	
2	Allocated from Extended Care Clinical/Consulting					23,077	
3	TOTALS					\$ 846,171	

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	158		2003	1995	\$ 5,391,423	\$ 179,216	35	\$ 154,041	\$ (25,175)	\$ 3,757,494	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2003		48,664		20	2,045	2,045	35,065	9
10	Various		2004		35,166		20	1,266	1,266	25,458	10
11	Various		2005		7,375		20	369	369	4,394	11
12	Various		2007		30,675		20	1,809	1,809	17,565	12
13	Various		2008		46,456		20	2,323	2,323	19,828	13
14	Various		2010		120,716		20	6,301	6,301	38,621	14
15	Various		2011		280,159		20	14,336	14,336	81,917	15
16	Various		2012		169,979		20	18,285	18,285	87,170	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lemont Nrsg & Rehab Center

0046201

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		109,557	1,524		1,524		73,818	68
69	Financial Statement Depreciation			142,236			(142,236)		69
70	TOTAL (lines 4 thru 69)		\$ 6,240,170	\$ 322,976		\$ 202,298	\$ (120,678)	\$ 4,141,330	70

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

Facility Name & ID Number Lemont Nrsg & Rehab Center

0046201

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,240,170	\$ 322,976		\$ 202,298	\$ (120,678)	\$ 4,141,330	1
2	Removed Concrete Floor In Room 106 To Find Causing Of Sinkin	2013	3,400		20	170	170	680	2
3	Nurse Call System	2013	12,239		20	612	612	2,397	3
4	Patched Asphalt, Installed Concrete Slabs	2013	5,140		20	257	257	985	4
5	Pt Room: New Carpentry, Framing, Drywall, Doors & Frames, Pa	2013	13,350		20	668	668	2,559	5
6	1St & 2Nd Floor Elevators - Piping Skylights & Sprinklers	2013	6,440		20	322	322	1,234	6
7	Lobby Floor & Wallcovering, Dining Room Skylite & Crown Molk	2013	57,717		20	2,886	2,886	10,822	7
8	Toilet And Sewer Line Repairs; Slab Jacking	2013	3,350		20	168	168	600	8
9	Fire Damper Repairs	2013	2,575		20	515	515	1,845	9
10	Installed Backflow Preventer For Sprinkler System	2013	7,950		20	398	398	1,325	10
11	Front Site Lighting And Repair	2013	16,500		20	825	825	2,681	11
12	Sprinklers - Repaired Butterfly Valves From Sprinklers	2013	2,778		20	139	139	440	12
13	Sprinklers - Replaced Dry Valve, Installed New Trim, Accelerator	2013	5,023		20	251	251	837	13
14	Generator Repair - E-Stop Button And Wiring	2013	2,832		20	142	142	566	14
15	Door Replacment	2014	3,600		20	180	180	465	15
16	Resident Room Repair - Asbestos Survey, Sawcutting, New Floor,	2014	21,500		20	1,075	1,075	2,598	16
17	Signage	2014	13,365		20	891	891	2,005	17
18	Dementia Shower Room - Ceiling Replacement, Plumbing Revisio	2014	79,000		20	3,950	3,950	11,192	18
19	Repair Hot Water Tank # 3	2014	3,134		20	157	157	457	19
20	Replace Annunciator On 2Nd Floor Nurses Station	2014	3,539		20	177	177	428	20
21	Repack Fire Pump & Replace Pressure Switch	2014	4,371		20	219	219	637	21
22	Dry System Compressor Repair	2014	3,940		20	197	197	509	22
23	Sprinkler System Repair	2014	3,080		20	154	154	398	23
24	New Compressor For Sprinkler System	2014	4,533		20	227	227	567	24
25	Preferred Mechanical - Hot Water Tank Replacement (80 Gallon)	2015	16,795		20	840	840	1,680	25
26	Hugo'S Construction-Work On Lower Soffit Section Where Sprin	2015	11,600		20	580	580	1,160	26
27	Generator-Automatic Transfer Switch (Ats) Faceplate, Ats Ztg Se	2015	4,127		20	206	206	378	27
28	Install Expansion Joint Material At All Cracked Seams In Drywal	2015	12,000		20	600	600	1,050	28
29	12X12 Vct Comm Tile - Hardware, Roppe 4X4 Fawn Cove Base -	2015	4,571		20	914	914	1,371	29
30	1X 2-Ton Mitsubishi, Ductless Mini-Split System, 1X Wall Mount	2015	7,800		20	390	390	553	30
31	Hvac - Replace Compressor, Liquid Line Drier, And Contactor	2015	3,393		20	170	170	226	31
32	Installed Duct Detectors. Replaced And Tested 8 Detectors.	2015	10,332		20	517	517	560	32
33	4 Crimson King Maple Trees	2016	3,187		20	146	146	146	33
34	TOTAL (lines 1 thru 33)		\$ 6,593,331	\$ 322,976		\$ 221,237	\$ (101,739)	\$ 4,194,681	34

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

Facility Name & ID Number Lemont Nrsg & Rehab Center

0046201

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	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		\$ 6,593,331	\$ 322,976		\$ 221,237	\$ (101,739)	\$ 4,194,681	1
2 Relocate Emergency Circuits	2016	7,150		20	358	358	358	2
3 1 6-Ton Rooftop Unit	2016	11,480		20	335	335	335	3
4 1 7.5-Ton Rooftop Unit	2016	12,995		20	379	379	379	4
5 Clean Out & Replace Concrete	2016	5,500		20	115	115	115	5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 6,630,456	\$ 322,976		\$ 222,423	\$ (100,553)	\$ 4,195,867	34

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

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,630,456	\$ 322,976		\$ 222,423	\$ (100,553)	\$ 4,195,867	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,630,456	\$ 322,976		\$ 222,423	\$ (100,553)	\$ 4,195,867	34

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

Facility Name & ID Number Lemont Nrsg & Rehab Center

0046201

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,630,456	\$ 322,976		\$ 222,423	\$ (100,553)	\$ 4,195,867	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
20									20
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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)		\$ 6,630,456	\$ 322,976		\$ 222,423	\$ (100,553)	\$ 4,195,867	34

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

Facility Name & ID Number Lemont Nrsg & Rehab Center

0046201

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Lemont Nrsg & Rehab Center

0046201

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 2201 W. Main, LLC	2002	28,700	736	39	736		10,517	3
4	Allocated from Extended Care Consulting, LLC - Dyer Bldg	2016	8,710	193	39	193		1,833	4
5	Allocated from Extended Care Clinical, LLC	2002	3,101	80	39	80		1,137	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	167	8	20	8		83	9
10	Allocated from Extended Care Consulting, LLC	2009	100	5	20	5		40	10
11	Allocated from Extended Care Consulting, LLC	2010	979	49	20	49		343	11
12	Allocated from Extended Care Consulting, LLC	2011	352	18	20	18		106	12
13	Allocated from Extended Care Consulting, LLC	2012	116	6	20	6		29	13
14	Allocated from Extended Care Consulting, LLC	2014	1,610	80	20	80		241	14
15	Allocated from Extended Care Consulting, LLC	2016	1,930	96	20	96		96	15
16									16
17	Allocated from 2201 W. Main, LLC	2002	23,708		20			23,708	17
18	Allocated from 2201 W. Main, LLC	2003	27,939		20			27,939	18
19	Allocated from 2201 W. Main, LLC	2005	1,388	2	20	2		1,388	19
20	Allocated from 2201 W. Main, LLC	2009	250	13	20	13		100	20
21	Allocated from 2201 W. Main, LLC	2014	2,330	116	20	116		349	21
22	Allocated from 2201 W. Main, LLC	2015	395	20	20	20		39	22
23	Allocated from 2201 W. Main, LLC	2016	1,560	78	20	78		78	23
24									24
25	Allocated from Extended Care Clinical, LLC	2002	2,562		20			2,562	25
26	Allocated from Extended Care Clinical, LLC	2003	3,019		20			3,019	26
27	Allocated from Extended Care Clinical, LLC	2005	150		20			150	27
28	Allocated from Extended Care Clinical, LLC	2009	27	1	20	1		11	28
29	Allocated from Extended Care Clinical, LLC	2014	252	13	20	13		38	29
30	Allocated form Extended Care Clinical, LLC	2015	43	2	20	2		4	30
31	Allocated form Extended Care Clinical, LLC	2016	169	8	20	8		8	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 109,557	\$ 1,524		\$ 1,524	\$	\$ 73,818	34

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

Facility Name & ID Number Lemont Nrsg & Rehab Center

0046201

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 109,557	\$ 1,524		\$ 1,524	\$	\$ 73,818	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 109,557	\$ 1,524		\$ 1,524	\$	\$ 73,818	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	\$410,804	\$827	\$69,596	\$68,769	10	\$248,074	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	484,219				10	484,219	73
74								74
75	TOTALS	\$895,023	\$827	\$69,596	\$68,769		\$732,293	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 Clinical, L	2016	\$3,147	\$629	\$629		5	\$2,818	76
77		Alloc - Extended Care Consulting	2016	6,549	185	185		5	6,179	77
78										78
79										79
80	TOTALS			\$9,696	\$814	\$814			\$8,997	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)	\$8,381,346	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$324,617	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$292,833	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(31,784)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,937,157	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

YES

NO
- If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								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: \$ 12,786

Description: See Attached Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$ -	\$	21

10. Effective dates of current rental agreement:

Beginning

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

Fiscal Year Ending

Annual Rent

12. /2017\$

13. /2018\$

14. /2019\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

		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	\$		\$ 808,238	\$		\$ 808,238	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			108,953			108,953	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			955,954			955,954	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				534,403		534,403	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					16,451	201,004		217,455	13
14	TOTAL			\$		\$ 1,889,596	\$ 735,407		\$ 2,625,003	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	\$ 908,255	\$ 1,192,927	1
2	Cash-Patient Deposits	25,678	25,678	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,244,376	2,244,376	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	290,917	290,917	6
7	Other Prepaid Expenses	20,334	20,334	7
8	Accounts Receivable (owners or related parties)	4,369,727	17,493,065	8
9	Other(specify): <u>See Attached Schedule</u>	9,612,764	9,756,586	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 17,472,051	\$ 31,023,883	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		823,094	13
14	Buildings, at Historical Cost		5,590,504	14
15	Leasehold Improvements, at Historical Cost	1,015,052	1,015,052	15
16	Equipment, at Historical Cost	495,689	495,689	16
17	Accumulated Depreciation (book methods)	(956,319)	(4,592,390)	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): <u>See Attached Schedule</u>	2,673	4,308,363	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 557,095	\$ 7,640,312	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 18,029,146	\$ 38,664,195	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,451,937	\$ 1,451,937	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,464	20,464	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	185,112	185,112	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,984	7,984	31
32	Accrued Real Estate Taxes(Sch.IX-B)	389,943	389,943	32
33	Accrued Interest Payable		58,967	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	5,121	5,122,899	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,060,561	\$ 7,237,306	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		16,400,894	39
40	Mortgage Payable			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)	\$	\$ 16,400,894	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,060,561	\$ 23,638,200	46
47	TOTAL EQUITY(page 18, line 24)	\$ 15,968,585	\$ 15,025,995	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 18,029,146	\$ 38,664,195	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 14,702,769	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 14,702,769	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,517,816	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	(252,000)	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)	\$ 1,265,816	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)	\$ 15,968,585	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lemont Nrsg & Rehab Center

0046201

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	\$ 15,887,497	1
2	Discounts and Allowances for all Levels	(8,550,664)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,336,833	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,978,593	6
7	Oxygen	573	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,979,166	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	1,315	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	520,643	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	111,813	19
20	Radiology and X-Ray	36,990	20
21	Other Medical Services	61,241	21
22	Laundry	5,348	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 737,350	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	87,909	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 87,909	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,938	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,938	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,149,196	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,719,783	31
32	Health Care	4,864,589	32
33	General Administration	2,743,227	33
	B. Capital Expense		
34	Ownership	2,382,427	34
	C. Ancillary Expense		
35	Special Cost Centers	2,625,003	35
36	Provider Participation Fee	296,351	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,631,380	40
41	Income before Income Taxes (line 30 minus line 40)**	1,517,816	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,517,816	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,113,569	44
45	Private Pay - Net Inpatient Revenue	2,262,346	45
46	Medicare - Net Inpatient Revenue	647,202	46
47	Other-(specify) Hospice	351,112	47
48	Other-(specify) Insurance	(37,396)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,336,833	49

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,790	1,959	\$ 93,999	\$ 47.98	1
2	Assistant Director of Nursing	1,337	1,468	56,431	38.44	2
3	Registered Nurses	25,116	27,775	908,871	32.72	3
4	Licensed Practical Nurses	28,961	31,161	954,402	30.63	4
5	CNAs & Orderlies	80,666	86,126	1,152,449	13.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,923	13,205	266,068	20.15	8
9	Activity Director	1,798	2,069	48,423	23.40	9
10	Activity Assistants	13,352	14,353	139,600	9.73	10
11	Social Service Workers	9,685	10,793	254,850	23.61	11
12	Dietician					12
13	Food Service Supervisor	2,299	2,534	58,789	23.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,865	10,846	158,075	14.57	15
16	Dishwashers	11,163	12,164	114,273	9.39	16
17	Maintenance Workers	5,328	5,854	124,366	21.24	17
18	Housekeepers	21,200	22,902	218,920	9.56	18
19	Laundry	5,230	5,796	60,984	10.52	19
20	Administrator	1,982	2,104	105,827	50.30	20
21	Assistant Administrator	1,787	1,971	55,052	27.93	21
22	Other Administrative					22
23	Office Manager	1,975	2,171	32,761	15.09	23
24	Clerical	6,115	6,852	144,482	21.09	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	2,731	3,031	48,731	16.08	31
32	Other Health Care(specify)					32
33	Other(specify)	1,015	1,110	17,245	15.54	33
34	TOTAL (lines 1 - 33)	245,318	266,244	\$ 5,014,598 *	\$ 18.83	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	424	\$ 21,483	01-03	35
36	Medical Director	Monthly	39,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,675	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	36	1,822	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	460	\$ 72,980		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,258	\$ 82,933	10-03	50
51	Licensed Practical Nurses	3,795	161,701	10-03	51
52	Certified Nurse Assistants/Aides	12,509	322,151	10-03	52
53	TOTAL (lines 50 - 52)	17,562	\$ 566,785		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Lemont Nrsg & Rehab Center

0046201Report Period Beginning:01/01/16Ending:12/31/16Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Lisa Hardaman (Jan - Jul)

Administrator

0

\$ 66,671

Jomarie Silver (Jul - Dec)

Administrator

0

39,156

Mary Boulos

Assnt Administrator

0

3,303

Leigh Drew

Assnt Administrator

0

1,101

Elmelech Mayer

Assnt Administrator

0

50,648

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 160,879

B. Administrative - Other

Description

Amount

N/A

\$

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

Pro Payroll Solutions

Payroll Processing

\$ 28,132

E Health Data Solutions

MDS Software

1,590

Coburn Enterprises

Data Processing

20

Ability Network

Medicare Billing

5,558

National Data Corporation

Data Processing

1,002

Marcum

Accounting Services

24,826

Personal Planners

Unemployment Services

2,520

ECC Consulting

Home Office Allocation

510,768

ECC Clinical

Home Office Allocation

170,256

Legal Services

See Attachment

33,739

Allscripts

Data Processing

1,538

See Supplemental Schedule

16,440

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 796,389

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 125,341

Unemployment Compensation Insurance

124,964

FICA Taxes

376,222

Employee Health Insurance

171,438

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Employee Physicals

87

Other Employee Benefits

5,552

Holiday Expense

7,512

TOTAL (agree to Schedule V, line 22, col.8)

\$ 811,116

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 1,990

Advertising: Employee Recruitment

42,977

Health Care Worker Background Check

(Indicate # of checks performed 57)

1,310

Patient Background Checks

208

Dues & Subscriptions

13,870

Licenses and Fees

2,413

Secretary of State

277

Allocated from Extended Care Consulting

990

See Supplemental Schedule

1,134

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 67,041

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

5,746

Allocated from Extended Care Consulting

155

Allocated from Extended Care Clinical

750

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

\$ 6,651

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Lemont Nrsg & Rehab Center	STATE OF ILLINOIS # 0046201	Report Period Beginning: 01/01/16	Ending: 12/31/16	Page 22
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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? Yes
 If YES, give association name and amount. ICLTC \$18,556

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
 What was the average life used for new equipment added during this period? 10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 56,721 Line 10

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

(8) Are you presently operating under a sale and leaseback arrangement? No
 If YES, give effective date of lease. 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. \$ 296,351
 This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? None
 d. Have vehicle usage logs been maintained? N/A
 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? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
 Firm Name: 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. Yes
 Attach invoices and a summary of services for all architect and appraisal fees