

		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>0048942</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>SKOKIE MEADOWS NRSG CTR #2</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</u> to <u>12/31/2016</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>4600 WEST GOLF ROAD</u> <u>SKOKIE</u> <u>60076</u>			
NumberCityZip Code			
County: <u>COOK</u>			
Telephone Number: <u>(847) 679-1157</u> Fax # <u>(847) 626-0432</u>			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>11/1/07</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____ ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other _____ ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other _____			
In the event there are further questions about this report, please contact:			
Name: <u>SANFORD BOKOR</u> Telephone Number: <u>(847) 675-3585</u>		(Signed) _____ (Date) _____ (Type or Print Name) <u>MARK APPEL</u> (Title) <u>OWNER</u> (Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u> (Firm Name & Address) <u>KBKB, LTD</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u> 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	
Email Address: _____			

Facility Name & ID Number SKOKIE MEADOWS NRSG CTR #2 # 0048942 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	137,501	17,617	10,327	165,445		165,445		165,445			1
2	Food Purchase		177,115		177,115	(5,505)	171,610		171,610			2
3	Housekeeping	96,180	25,015		121,195		121,195		121,195			3
4	Laundry		11,276		11,276		11,276		11,276			4
5	Heat and Other Utilities			31,365	31,365		31,365		31,365			5
6	Maintenance	30,092	17,790	38,579	86,461		86,461		86,461			6
7	Other (specify):*			8,455	8,455		8,455		8,455			7
8	TOTAL General Services	263,773	248,813	88,726	601,312	(5,505)	595,807		595,807			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,084,999	177,893	58,466	1,321,358		1,321,358		1,321,358			10
10a	Therapy											10a
11	Activities	68,815	5,661	1,260	75,736		75,736		75,736			11
12	Social Services	124,324		3,512	127,836		127,836		127,836			12
13	CNA Training											13
14	Program Transportation			266	266		266		266			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,278,138	183,554	75,504	1,537,196		1,537,196		1,537,196			16
	C. General Administration											
17	Administrative	73,377		120,000	193,377		193,377		193,377			17
18	Directors Fees											18
19	Professional Services			9,950	9,950		9,950		9,950			19
20	Dues, Fees, Subscriptions & Promotions			68,848	68,848		68,848	(34,038)	34,810			20
21	Clerical & General Office Expenses	29,834	5,198	12,825	47,857		47,857		47,857			21
22	Employee Benefits & Payroll Taxes			332,551	332,551	5,505	338,056		338,056			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,670	5,670		5,670		5,670			24
25	Other Admin. Staff Transportation			6,839	6,839		6,839		6,839			25
26	Insurance-Prop.Liab.Malpractice			75,145	75,145		75,145		75,145			26
27	Other (specify):*											27
28	TOTAL General Administration	103,211	5,198	631,828	740,237	5,505	745,742	(34,038)	711,704			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,645,122	437,565	796,058	2,878,745		2,878,745	(34,038)	2,844,707			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.

Facility Name & ID Number SKOKIE MEADOWS NRSG CTR #2

0048942 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>111</u>	Intermediate (ICF)	<u>111</u>	<u>40,626</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>111</u>	TOTALS	<u>111</u>	<u>40,626</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					8
9	SNF/PED					9
10	ICF	<u>20,104</u>	<u>732</u>	<u>9,566</u>	<u>30,402</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,104</u>	<u>732</u>	<u>9,566</u>	<u>30,402</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.83%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

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 11/1/07

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date 11/1/07 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided 0

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016
* All facilities other than governmental must report on the accrual basis.

V.COST CENTER EXPENSES				PAGE 3 COLUMN 3 OTHER			
LINE		SCHED REF	TOTAL	LINE		SCHED REF	TOTAL
1	DIETARY			10	NURSING		
	DIETITIAN CONSULTANT	XVIII B 35-2	8,351		CONTRACT NURSING	XVIII C 53-2	
	REPAIRS & MAINTENANCE		1,976		LABORATORY & XRAY EXPENSE		3,714
			10,327		PURCHASED SERVICES		23,070
3	HOUSEKEEPING				PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
			0		RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
			0		MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,600
4	LAUNDRY				PHARMACY CONSULTANT	XVIII B 39-2	6,082
	EQUIPMENT REPAIRS & MAINTENANCE		0		UTILIZATION REVIEW FEES	XVIII B __-2	0
			0		PHYSICIANS	XVIII B __-2	0
5	HEAT & OTHER UTILITIES				PSYCHIATRIC	XVIII B __-2	24,000
	GAS HEAT		18,349		RN CONSULTANT	XVIII B 38-2	0
	ELECTRICITY		0				
	WATER		11,099				58,466
	CABLE TV - LOBBY		1,917	10a	THERAPY		
			31,365		PHYSICAL THERAPY SERVICES		0
6	MAINTENANCE				SPEECH THERAPY SERVICES		0
	GROUNDS MAINTENANCE		732		OCCUPATIONAL THERAPY SERVICES		0
	PAINTING & DECORATING		0		REHABILITATION CONSULTANT	XVIII B __-2	0
	BUILDING REPAIRS		14,133		PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	MAINTENANCE TRAVEL		0		OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0
	EQUIPMENT MAINTENANCE & REPAIR		9,539		RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0
	ELEVATOR MAINTENANCE & REPAIR		2,887		SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
	OUTSIDE LABOR		0				
	EXTERMINATING SERVICE		563				0
	FIRE SERVICE		7,777	11	ACTIVITIES		
	CONTRACTED BUILDING MAINT.		2,948		CABLE TV - PATIENT ROOMS		0
					ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,260
			38,579				1,260
7	OTHER			12	SOCIAL SERVICES		
	SCAVENGER		8,455		SOCIAL REHABILITATION SERVICES		0
	SECURITY SERVICE		0		SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0
					SOCIAL WORKER	XVIII B 45-2	3,512
			8,455				3,512
9	MEDICAL DIRECTOR			13	NURSE AIDE TRAINING		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000		NURSE AIDE TRAINING COSTS	XIII	0
			12,000				0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	266	
			266
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 120,000	120,000
	DIRECTORS FEES		
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 0	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 9,950	
			9,950
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 27,054	
	EMPLOYEE WANT ADS	XIX F 0	
	CONTRIBUTIONS	VI 20 XIX F 0	
	DUES & SUBSCRIPTIONS	XIX F 34,839	
	LICENSES & PERMITS	XIX F 6,955	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 0	
	PATIENT BACKGROUND CHECKS	XIX F 0	
			68,848
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	30	
	EQUIPMENT REPAIR & MAINTENANCE	0	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 18 0	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	12,795	
	MESSENGER SERVICE	0	
			12,825

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 124,063	
	UNEMPLOYMENT COMPENSATION	XIX D 8,595	
	WORKERS COMPENSATION INSURANCE	XIX D 27,375	
	HOSPITALIZATION INSURANCE	XIX D 149,119	
	EMPLOYEE BENEFITS - OTHER	XIX D 2,841	
	EMPLOYEE PHYSICAL EXAMS	XIX D 250	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 20,308	
			332,551
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	0	
			0
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 5,670	
	TRAVEL	XIX G 0	
			5,670
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	6,839	
			6,839
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	75,145	
			75,145
27	OTHER		
	BAD DEBTS	VI 24 0	
			0

GRAND TOTAL COLUMN 3 OTHER

796,058

SKOKIE MEADOWS NRSG CTR #2
SCHEDULES
12/31/2016

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

TOTAL FOOD PURCHASE	177,115	
LESS SALES TAX	0	HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??
NET FOOD	<u>177,115</u>	
TOTAL PATIENT CENSUS	30,402	
TIMES 3 MEALS PER DAY	3	
TOTAL PATIENT MEALS	<u>91,206</u>	
ADD # EMPLOYEE MEALS/DAY	8	
TIMES # DAYS	366	
TOTAL EMPLOYEE MEALS	<u>2,928</u>	
PATIENT MEALS	91,206	
ADD EMPLOYEE MEALS	<u>2,928</u>	
TOTAL MEALS/YEAR	94,134	
NET FOOD	177,115	
DIVIDE TOTAL MEALS/YEAR	<u>94,134</u>	
COST PER MEAL	1.88	
TIMES EMPLOYEE MEALS	<u>2,928</u>	
EMPLOYEE MEAL RECLASSIFICATION	<u><u>5,505</u></u>	

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			6,707	6,707		6,707	78,032	84,739			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							163,875	163,875			32
33	Real Estate Taxes			223,920	223,920		223,920		223,920			33
34	Rent-Facility & Grounds			690,065	690,065		690,065	(690,065)				34
35	Rent-Equipment & Vehicles			6,470	6,470		6,470		6,470			35
36	Other (specify):*							36,440	36,440			36
37	TOTAL Ownership			927,162	927,162		927,162	(411,718)	515,444			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers											44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,645,122	437,565	1,723,220	3,805,907		3,805,907	(445,756)	3,360,151			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	17,385	30		9
10	Interest and Other Investment Income	(781)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(27,054)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(6,984)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (17,434)		\$	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)	(428,322)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (428,322)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (445,756)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	ALLIANCE FOR LIVING POLITICAL PORTION	\$ (6,984)	20	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(6,984)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SKOKIE MEADOWS NRSG CTR #2# 0048942

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(34,038)	0	0	0	0	0	0	0	0	0	0	(34,038)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(34,038)	0	0	0	0	0	0	0	0	0	0	(34,038)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(34,038)	0	0	0	0	0	0	0	0	0	0	(34,038)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SKOKIE MEADOWS NRSG CTR #2 # 0048942 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	17,385	60,647	0	0	0	0	0	0	0	0	0	78,032	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(781)	164,656	0	0	0	0	0	0	0	0	0	163,875	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(690,065)	0	0	0	0	0	0	0	0	0	(690,065)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	36,440	0	0	0	0	0	0	0	0	0	36,440	36
37	TOTAL Ownership	16,604	(428,322)	0	0	0	0	0	0	0	0	0	(411,718)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(17,434)	(428,322)	0	0	0	0	0	0	0	0	0	(445,756)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MARC APPEL	50	CAMBRIDGE NURSING REHAB CENTER	SKOKIE	SKOKIE CAMBRIDGE		REAL ESTATE
JOAN WILLEY	50			REALTY LLC	SKOKIE	

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	\$ 690,065	SKOKIE CAMBRIDGE REALTY, LLC		\$	(690,065)	1
2	V	30	DEPRECIATION				60,647	60,647	2
3	V	32	INTEREST				159,373	159,373	3
4	V	36	MIP INSURANCE				36,440	36,440	4
5	V	32	AMORT OF LOAN COST				5,283	5,283	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 690,065			\$ 261,743	\$ * (428,322)	14

* 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								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 SKOKIE MEADOWS NRSG CTR #2 # 0048942 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JOAN WILLEY	CEO	ADMINISTRATIVE	0.50		See	Attached	MGMT FEE	\$ 120,000	17-3	1
2											2
3											3
4	MARK APPEL	CEO	FINANCIAL	0.50	120,000	See	Attached				4
5											5
6					CAMBRIDGE NURSING & REHAB						6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 120,000		13

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

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

Facility Name & ID Number SKOKIE MEADOWS NRSRG CTR #2 # 0048942 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Skokie Cambridge						\$		\$			\$	1
2	Realty,LLC			MORTGAGE		12/21/12	7,239,800	6,557,538				159,373	2
3	LOAN COST			Amortized over life of loan			79,398	58,226				5,293	3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$ 7,319,198	\$ 6,615,764			\$ 164,666	9	
	B. Non-Facility Related*												
10	IRS,IDR,ETC		X	LATE FEES									10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 7,319,198	\$ 6,615,764			\$ 164,666	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 36,440 Line # 36

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SKOKIE MEADOWS NRSG CTR #2 COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0048942

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 10-10-304-042-0000	NURSING HOME	\$ 223,920.04	\$ 223,920.04
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 223,920.04	\$ 223,920.04

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet: 22,213

B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

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

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			2007	\$ 275,250	1
2					2
3	TOTALS			\$ 275,250	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	111		2007		\$ 2,365,250	\$ 60,647		\$ 60,647		\$ 495,284
5										
6										
7										
8										
	Improvement Type**									
9	WALL UNITS			2008	8,200	210	39	210		1,786
10	BASEMENT STAIRCASE			2008	4,895	126	39	126		1,070
11	INSTALLED REMOTE ANNAUNCIATOR PANEL			2008	6,850	176	39	176		1,496
12	INSTALL NEW GUIDES FOR ELEVATOR			2008	3,578	92	39	92		782
13	INSTALLED NEW TEKMAR CONTROL FOR BOILERS			2008	2,549	65	39	65		553
14	ELECTRICAL SERVICE			2008	2,650	68	39	68		578
15	ROOF TOP UNIT			2008	12,800	328	39	328		2,788
16	FIRE ALARM SYSTEM DEVICES			2009	29,065	745	39	745		5,926
17	SPRINKLER SYSTEM			2009	8,076	207	39	207		1,650
18	WALLCOVERING CORRIDOR AND LOBBY			2010	9,190	236	39	236		1,642
19	SHOWERS ROOMS FLOOR REPLACEMENT			2010	18,730	480	39	480		3,340
20	NORT DINING ROOM PARTITION			2010	4,650	119	39	119		828
21	MAIN DINING ROOM NEW CEILING			2010	7,385	189	39	189		1,315
22	DOCTOR OFFICE NEW WALL & CEILING			2010	3,072	79	39	79		550
23	NURSING OFFICE WALL COVERING			2010	3,188	82	39	82		570
24	BASEMENT FLOORING NEW TILES			2010	15,600	400	39	400		2,783
25	FRONT ENTRY WAY WALL COVERING			2010	15,600	400	39	400		2,783
26	PAINTING CEILING			2010	26,720	685	39	685		4,767
27	DOORS			2010	14,175	363	39	363		2,526
28	MOLDED TO RAIL FINISH BLACK PAINT			2010	6,000	154	39	154		1,072
29										
30	RESIDENT ROOM & PART OF HALLWAY FLOORING			2011	12,395	317	39	317		1,911
31	CONCRETE WORK			2011	11,880	305	39	305		1,835
32	HAT WATER SYSTEM			2011	20,433	524	39	524		3,156
33										
34	REMOVED EXISTING NURSING STATION, COUNTER TOP AND CABINETS									
35	REPLACE CABINETS AND COUNTERTOPS WITH A NEW DESIGN. TOP COUNTERTOP									
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 SKOKIE MEADOWS NRSG CTR #2

0048942

Report Period Beginning:

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	BUILT NEW CABINETS MADE FROM 3/4 INCH MELLAMI AND STANDAR		\$	\$		\$	\$	\$	37
38	GRADE LAMINATE. REMOVED EXISTING VINYL TILES FROM THE FLOOR								38
39	ALSO PREPARED THE FLOOR USING POWER GRINDER TO SMOOTH								39
40	THE SURFACE FOR THE NEW WOOD GRAIN 7 X 48 INCH VINYL								40
41	PLANKS. REMOVED EXISTING FORMICA COUNTERTOPS AND VINYL								41
42	TILES FROM THE FLOOR. REMOVED SOME DOOR FROM								42
43	EXISTING CABINETS. REPLACED WITH NEW LAMINATE LOOK.								43
44	BUILT NEW CABINETS FOR THE FAX MACHINE. INSTALLED								44
45	NEW WOOD GRAIN 7 X 48 INCH VINYL PLANK FLOORING,								45
46	TOPS AND NEW SINK. REMOVED AND REPLACED 30 X 80 INCH SOLID								46
47	CORE ENTRY DOOR TO MED ROOM. LAMINATED BOTH SIDES OF THE								47
48	DOOR WITH CHERRY LAMINATE LOOK AND DECORATIVE								48
49	TRIM. INSTALLED QUARTER INCH 12 X 12 CORK TILES BETWEEN								49
50	TOP CABINETS AND COUNTERTOP. INSTALLED 6 INCH C	2012	11,100	285	39	285		1,413	50
51	BASE TO FINISH.								51
52	HAND RAIL	2014	2,800	72	39	72		213	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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,626,831	\$ 67,354		\$ 67,354	\$	\$ 542,617	70

**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	\$173,854	\$	\$17,385	\$17,385		\$132,055	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$173,854	\$	\$17,385	\$17,385		\$132,055	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	3,075,935
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	67,354
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	84,739
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	17,385
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	674,672

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions				690,065			4
5								5
6								6
7	TOTAL				\$ 690,065			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?
16. Rental Amount for movable equipment: \$ 6,470 Description:
- ☐ YES☐ NO
- (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 EndingAnnual 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

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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)	\$			

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,207,528	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (112,077))	922,403		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,129,931	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	261,581		15
16	Equipment, at Historical Cost	266,541		16
17	Accumulated Depreciation (book methods)	(296,395)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 231,727	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,361,658	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 125,190	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	35,753		29
30	Accrued Salaries Payable	85,138		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	230,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>SKOKIE 1 & 2 ELIMINATION</u>	2,784,323		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,260,404	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,260,404	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (898,746)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,361,658	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (37,077)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (37,077)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(230,669)	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	(631,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (861,669)	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)	\$ (898,746)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number SKOKIE MEADOWS NRSNG CTR #2

0048942

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,570,780	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,570,780	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,677	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,677	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	781	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 781	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,575,238	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	601,312	31
32	Health Care	1,537,196	32
33	General Administration	740,237	33
	B. Capital Expense		
34	Ownership	927,162	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,805,907	40
41	Income before Income Taxes (line 30 minus line 40)**	(230,669)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (230,669)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,213,787	44
45	Private Pay - Net Inpatient Revenue	109,334	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>VETERAN</u>	1,247,659	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,570,780	49

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

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

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

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

Facility Name & ID Number SKOKIE MEADOWS NRSRG CTR #2# 0048942Report Period Beginning: 01/01/2016Ending: 12/31/2016

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	1,984	2,205	\$ 77,132	\$ 34.98	1
2	Assistant Director of Nursing	1,808	2,117	71,831	33.93	2
3	Registered Nurses	12,768	14,028	410,846	29.29	3
4	Licensed Practical Nurses	824	867	19,363	22.33	4
5	CNAs & Orderlies	32,063	35,029	423,056	12.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,960	2,080	27,290	13.12	9
10	Activity Assistants	2,305	2,649	41,525	15.68	10
11	Social Service Workers	5,680	6,211	124,324	20.02	11
12	Dietician					12
13	Food Service Supervisor	1,445	1,606	17,666	11.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,389	11,960	119,835	10.02	15
16	Dishwashers					16
17	Maintenance Workers	1,948	2,180	30,092	13.80	17
18	Housekeepers	7,165	8,566	96,180	11.23	18
19	Laundry					19
20	Administrator	1,984	2,080	73,377	35.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,940	2,140	29,834	13.94	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,526	1,606	16,006	9.97	31
32	Other Health Care <u>MDS</u>	1,768	2,125	66,765	31.42	32
33	Other(specify) _____					33
34	TOTAL (lines 1 - 33)	88,557	97,449	\$ 1,645,122 *	\$ 16.88	34

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

** See instructions.

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	54	\$ 8,351	1-3	35
36	Medical Director	250	12,000	9-3	36
37	Medical Records Consultant	50	1,600	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	55	6,082	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	62	1,260	11-3	44
45	Social Service Consultant	62	3,512	12-3	45
46	Other(specify) <u>PSYCHIATRIC</u>	250	24,000	10-3	46
47	_____				47
48	_____				48
49	TOTAL (lines 35 - 48)	783	\$ 56,805		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number		SKOKIE MEADOWS NRSRG CTR #2		STATE OF ILLINOIS		# 0048942		Report Period Beginning:		01/01/2016		Page 21		Ending: 12/31/2016	
XIX. SUPPORT SCHEDULES															
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions							
Name		Function		Ownership		Description		Amount		Description		Amount			
MARGARET O'BRIEN		ADMINISTRATOR		0		Workers' Compensation Insurance		\$ 27,375		IDPH License Fee		\$ 0			
		ASST ADMIN				Unemployment Compensation Insurance		8,595		Advertising: Employee Recruitment		0			
		OTHER ADMIN				FICA Taxes		124,063		Health Care Worker Background Check		0			
						Employee Health Insurance		149,119		(Indicate # of checks performed)					
						Employee Meals		5,505		Patient Background Checks		0			
						Illinois Municipal Retirement Fund (IMRF)*				TRUST/FRANCHISE/CONTRIB/ETC		0			
						EMPLOYEE BENEFITS - OTHER		2,841		MARKETING/ADV/PROMO		34,038			
						EMPLOYEE PHYSICAL EXAMS		250		LICENSES/DUES/SUBSCRIPTIONS		41,794			
						PENSION/PROFIT SHARING PLANS		20,308		NON ALLOWABLE DUES		(6,984)			
						INSURANCE - EXECUTIVE LIFE		0		TRUST/FRANCHISE/CONTRIB/ETC		0			
										Less: Public Relations Expense		(0)			
										Non-allowable advertising		(34,038)			
						INSURANCE - EXECUTIVE LIFE VI 21		0		Yellow page advertising		(0)			
TOTAL (agree to Schedule V, line 17, col. 1)						TOTAL (agree to Schedule V,		\$ 338,056		TOTAL (agree to Sch. V,		\$ 34,810			
(List each licensed administrator separately.)						line 22, col.8)				line 20, col. 8)					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**							
Description		Amount		Description		Line #		Amount		Description		Amount			
JOAN WILLEY MANAGEMENT FEES		\$ 120,000								Out-of-State Travel		\$			
										In-State Travel		0			
TOTAL (agree to Schedule V, line 17, col. 3)		\$ 120,000								Seminar Expense		5,670			
(Attach a copy of any management service agreement)															
C. Professional Services															
Vendor/Payee		Type		Amount											
KBKB CPA LTD		ACCOUNTING FEES		4,200											
FLS GROUP		ACCOUNTING FEES		4,050											
HAIVNAK ASSOC.		ARCHITECT		1,700											
TOTAL (agree to Schedule V, line 19, column 3)						TOTAL		\$		Entertainment Expense		()			
(For legal fee disclosure, see page 39 of instructions)										(agree to Sch. V,					
										line 24, col. 8)		\$ 5,670			

* Attach copy of IMRF notifications

**See instructions.

SKOKIE MEADOWS NRSG CTR #2
SCHEDULE-LEGAL
12/31/2016

XX. GENERAL INFORMATION:

(1)

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

YES

(2)

Are there any dues to nursing home associations included on the cost report?

YES

If YES, give association name and amount.

ALLIANCE FOR LIVING \$14,400

(3)

Did the nursing home make political contributions or payments to a political action organization?

YES

If YES, have these costs been properly adjusted out of the cost report?

YES

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?

(5)

Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?

10 YR

(6)

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

\$

Line

10-2

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.

(8)

Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

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.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

0

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.

\$

5,505

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$

(16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

NO

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

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

5%

d. Have vehicle usage logs been maintained?

NO

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

NO

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

YES

g. Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

N/A

(17)

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

NO

Firm Name:

(18)

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

YES

(19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

YES

Attach invoices and a summary of services for all architect and appraisal fees

HFS 3745 (N-4-99)

IL478-2471