

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,730	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,730	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,303	85	34,312	50,700	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,303	85	34,312	50,700	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.37%

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

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

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

N/A

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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 05/01/87

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

YES Date 05/01/87 NO

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

YES NO If YES, enter number of beds certified 155 and days of care provided 2,625

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL 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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

Page 3 Supplemental Schedule

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

Facility Name & ID Number Kensington Place Nsg & Rehab

#0052712

Report Period Beginning:

01/01/16

Ending:

12/31/16

V. COST CENTER EXPENSES (continued)

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

**Kensington Place Nsg & Rehab
 Medicaid Cost Report
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Page 4 Supplemental Schedule

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

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

Report Period Beginning:

01/01/16

Ending:

12/31/16

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,953)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(297)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,290)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(756,050)	21		24
25	Fund Raising, Advertising and Promotional	(7,046)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,118)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Supplemental Schedule	(74,442)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (851,196)		\$	30

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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(560,910)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (560,910)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,412,106)		37

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

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

		1	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' PREPARATION REPORT

Kensington Place Nsg & Rehab

ID# 0052712

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Other Income	\$ (5,747)	21	1
2	Jury Duty Income	(400)	10	2
3	Professional Fees - Collections	(2,448)	19	3
4	Professional Fees - Lobbying	(2,339)	19	4
5	Professional Fees - Line of Credit	(3,450)	19	5
6	Professional Fees - Legal	(3,454)	19	6
7	Professional Fees - Appraisal	(3,000)	19	7
8	Bank Charges	(3,454)	21	8
9				9
10				10
11				11
12				12
13	Boulevard Property, LLC			13
14	Professional Fees	(7,750)	19	14
15	License	(500)	21	15
16	Bank Charges	(189)	21	16
17	State Replacement Tax	(6,313)	21	17
18	Other	(30,069)	21	18
19	Amortization	(5,329)	31	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(74,442)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

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

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

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

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 - Supp		See Page 6 - Supp		See Page 6 - Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 926,417	Boulevard Property, LLC	100.00%	\$	\$ (926,417)	1
2	V	32 Interest	34,162	Boulevard Property, LLC	100.00%		(34,162)	2
3	V	19 Professional Fees		Boulevard Property, LLC	100.00%	7,750	7,750	3
4	V	21 Office		Boulevard Property, LLC	100.00%	37,071	37,071	4
5	V	26 Property Insurance		Boulevard Property, LLC	100.00%			5
6	V	30 Depreciation		Boulevard Property, LLC	100.00%	92,963	92,963	6
7	V	31 Amortization		Boulevard Property, LLC	100.00%	5,329	5,329	7
8	V	32 Interest		Boulevard Property, LLC	100.00%	158,162	158,162	8
9	V	33 Real Estate Taxes	256,581	Boulevard Property, LLC	100.00%	256,581		9
10	V	36 Mortgage Insurance Premiums		Boulevard Property, LLC	100.00%			10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,217,160			\$ 557,856	\$ * (659,304)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Kensington Place Nsg & Rehab

0052712

Report Period Beginning:

01/01/16

Ending:

12/31/16

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Sheffield Manor Assisted Living	Dyer, IN				1
2			Kenosha Estates	Kenosha, WI				2
3			Milwaukee Estates	Milwaukee, WI				3
4			Appleton	Appleton, WI				4
5								5
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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 225	\$	225	15
16	V	2 Food		Extended Care Consulting, LLC	100.00%	484		484	16
17	V	3 Housekeeping		Extended Care Consulting, LLC	100.00%	1,245		1,245	17
18	V	5 Utilities		Extended Care Consulting, LLC	100.00%	1,736		1,736	18
19	V	6 Maintenance		Extended Care Consulting, LLC	100.00%	3,627		3,627	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	3,631		3,631	20
21	V	19 Professional Fees	134,400	Extended Care Consulting, LLC	100.00%	7,248		(127,152)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,179		1,179	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	7,315		7,315	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	185		185	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,256		1,256	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	2,174		2,174	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	2,898		2,898	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	10,520		10,520	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	5,067		5,067	29
30	V	35 Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	1,187		1,187	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 134,400			\$ 49,977	\$ *	(84,423)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 Maintenance (Pooled)	\$	Extended Care Consulting, LLC	100.00%	\$ 10,868	\$ 10,868	15
16	V	6 Maintenance (Direct)		Extended Care Consulting, LLC	100.00%	0		16
17	V	7 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,019	1,019	17
18	V	7 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	0		18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	20,668	20,668	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	125,246	125,246	20
21	V	21 Office and Clerical (Direct)	17,706	Extended Care Consulting, LLC	100.00%	20,272	2,566	21
22	V	27 Emp. Gen. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	26,688	26,688	22
23	V	27 Emp. Gen. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,844	1,844	23
24	V	22 Employee Benefits	6,082	Extended Care Consulting, LLC	100.00%		(6,082)	24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 23,788			\$ 206,605	\$ * 182,817	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Benefits	\$ 168,693	CCS VEBA	100.00%	\$ 168,693	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 168,693			\$ 168,693	\$ *	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yechiel Mashiach	Owner	Administrator	15.20%	N/A	40.00	100.00%	Salary	\$ 130,670	17 - 01	1
2	Adam Vales	Relative	Clerical	0.00%	See Attached	0.86	2.14%	Alloc. Salary	1,572	22 - 07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 132,242		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

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

Boulevard Property, LLC

Street Address

3405 S Michigan Avenue

City / State / Zip Code

Chicago, Illinois 60616

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

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 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905 - 3000
 Fax Number (847) 491 - 9565

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	Dietary	Patient Days	1,380,761	34	\$ 5,206	\$ 59,681	\$ 225	1
2	2	Food	Patient Days	1,380,761	34	11,203	59,681	484	2
3	3	Housekeeping	Patient Days	1,380,761	34	28,798	59,681	1,245	3
4	5	Utilities	Patient Days	1,380,761	34	40,168	59,681	1,736	4
5	6	Maintenance	Patient Days	1,380,761	34	83,922	59,681	3,627	5
6	17	Administrative	Patient Days	1,380,761	34	84,000	59,681	3,631	6
7	19	Professional Fees	Patient Days	1,380,761	34	167,697	59,681	7,248	7
8	20	Dues and Subscriptions	Patient Days	1,380,761	34	27,266	59,681	1,179	8
9	21	Office and Clerical	Patient Days	1,380,761	34	169,235	59,681	7,315	9
10	24	Travel and Seminar	Patient Days	1,380,761	34	4,279	59,681	185	10
11	25	Other Staff Admin. Trans.	Patient Days	1,380,761	34	29,053	59,681	1,256	11
12	26	Insurance	Patient Days	1,380,761	34	50,289	59,681	2,174	12
13	30	Depreciation	Patient Days	1,380,761	34	67,038	59,681	2,898	13
14	32	Interest	Patient Days	1,380,761	34	243,379	59,681	10,520	14
15	33	Real Estate Taxes	Patient Days	1,380,761	34	117,233	59,681	5,067	15
16	35	Rent - Equipment and Auto	Patient Days	1,380,761	34	27,451	59,681	1,187	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,156,217	\$	\$ 49,977	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

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 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905 - 3000
 Fax Number (847) 941 - 9565

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	6	Maintenance	Patient Days	1,380,761	34	\$ 251,431	\$ 251,431	59,681	\$ 10,868	1
2	6	Maintenance	Direct	373,682	34	373,682	373,682			2
3	7	Emp. Ben. - Gen. Serv.	Patient Days	1,380,761	34	23,565		59,681	1,019	3
4	7	Emp. Ben. - Gen. Serv.	Direct	46,748	34	46,748				4
5	17	Administrative	Patient Days	1,380,761	34	478,172	478,172	59,681	20,668	5
6	21	Office and Clerical	Patient Days	1,380,761	34	2,897,656	2,897,656	59,681	125,246	6
7	21	Office and Clerical	Direct	460,382	34	460,382	460,382	20,272	20,272	7
8	27	Emp. Gen. - Gen. Admin.	Patient Days	1,380,761	34	617,434		59,681	26,688	8
9	27	Emp. Gen. - Gen. Admin.	Direct	73,413	34	73,413		1,844	1,844	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					\$ 5,222,483	\$ 4,461,323		\$ 206,605	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

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 VEBA
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905 - 3000
 Fax Number (847) 491 - 9565

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	22	Employee Benefits	Direct Allocation	7,877,989	\$ 7,877,989	\$	168,693	\$ 168,693	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				\$ 7,877,989	\$		\$ 168,693	25

SEE ACCOUNTANTS' PREPARATION REPORT

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Private Bank		X	Mortgage			\$	\$ 5,300,000		\$ 158,162	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	HFG		X	Line of Credit				750,000		13,621	6									
7	Alloc. - Extended Care		X							10,520	7									
8											8									
9	TOTAL Facility Related						\$	\$ 6,050,000		\$ 182,303	9									
B. Non-Facility Related*																				
10											10									
11											11									
12	Int. Income - Operating		X							(6,953)	12									
13	Int. Income - Building		X							(34,162)	13									
14	TOTAL Non-Facility Related						\$	\$		\$ (41,115)	14									
15	TOTALS (line 9+line14)						\$	\$ 6,050,000		\$ 141,188	15									

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 report.		\$	202,926	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	229,216	2
3. Under or (over) accrual (line 2 minus line 1).		\$	26,290	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	235,358	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	261,648	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	177,238	8	
	2012	186,917	9	
	2013	189,446	10	
	2014	193,263	11	
	2015	224,149	12	
2016 Real Estate Tax Accrual = \$224,149 * 1.05 = \$235,358				
Alloc. - Extended Care Consulting, LLC = \$5,067				

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Kensington Place Nsg & Rehab COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0052712
 CONTACT PERSON REGARDING THIS REPORT Edward N. Slack, CPA
 TELEPHONE (847) 628 - 8796 FAX #: (248) 327 - 8417

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

Report Period Beginning:

01/01/16 Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,293 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

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

Report Period Beginning:

01/01/16

Ending:

12/31/16**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Hot Water Heater - 80 Gallon 199,000 BTU	2013	\$ 8,400	\$		\$	\$	\$	37
38	New 30 Circuit Panelboard	2013	6,500						38
39	Fire Alarm System Devises	2013	3,161						39
40	Elevator - 3D Infrared Detector Edge	2013	3,200						40
41	Elevator - Valve Replacement	2013	5,308						41
42	Parking Lot - Asphalt and Striping	2013	13,863						42
43	Roof Drain	2013	5,635						43
44	Hallway Doors - Egress Locks	2014	14,894						44
45	Canopy - Main Entrance	2014	9,620						45
46	Hot Water / Cold Water Riser	2014	10,370						46
47	Electrical Outlets - Nurses Stations	2014	2,893						47
48	Elevator - Vale	2014	8,910						48
49	Sprinkler System - Grounds	2014	3,800						49
50	Elevator - Remove and Replace Casings	2016	27,200						50
51	Elevator - Control System Board	2016	4,488						51
52	Painting - Group, Therapy, Dishwasher, Basement, Dining, Recreation, Kitchen, Storage, 2nd and 3rd Floors	2016	22,845						52
53	Nurse Call System	2016	12,094						53
55	Elevator - Two Door Opener	2016	9,500						55
56	Elevator - Hydraulic Cylindar	2016	33,000						56
57	Flooring - Dishwashing Room	2016	4,590						57
58	Facility Renovations								58
59	Structural Engineering, Permits, and Project Management	2016	12,239						59
60	Guest Bathroom - New Tile, Cove Base, Drywall, and Fixture	2016	2,569						60
61	Vestibule - Electric Doors, Electric Signs, Fire Alarm Switch, Carpet Tile, Millwork, and Painting	2016	18,977						61
63	Therapy Room - Cornices	2016	317						63
64	Offices - Carpet Tile, Cove Base, Window Treatments, Painting	2016	8,828						64
65	Elevator - Wallcovering, Handrail, Bumper, and Flooring	2016	10,990						65
66	Dayroom - Fireplace, Cove Base, Wallcoverinig, and Window Tr	2016	18,259						66
67	Conference Room - Carpet Tile, Cove Base, Wallcoverings, Lighting, and Painting	2016	10,091						67
68	Corridors - Cove Base, Signage, Lights, Wallcoverings, and Han	2016	55,317						68
69	Corridors - Cove Base, Signage, Lights, Wallcoverings, and Han	2016	55,317						69
70	TOTAL (lines 4 thru 69)		\$ 2,837,231	\$		\$	\$	\$	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,837,231	\$		\$	\$	\$	1
2									2
3	Facility Renovations (Continued)								3
4	Administrator Bathroom - Tile, Drywall, Lights, and Fixtures	2016	3,062						4
5	Lobby - Cove Base, New Wall, Drop Ceiling, Wallcoverings,								5
6	Electrical Fixtures, Double Doors and Framing, Signs,								6
7	Cornices, and Sheers	2016	29,625						7
8	Resident Rooms - Cove Base, Overbed Lights, Cubicle								8
9	Curtains, Window Treatments, Bumper Guards and								9
10	End Caps, and Painting	2016	52,481						10
11	1st Floor Corridors, Dining Room, and Lobby - Ceiling Tiles	2016	18,557						11
12	1st Floor - New Doors, Hardware, and Installation	2016	34,496						12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,975,452	\$		\$	\$	\$	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 93,485	\$	\$	\$		\$	71
72	Current Year Purchases	68,812						72
73	Fully Depreciated Assets							73
74	See Supplemental	275,488						74
75	TOTALS	\$ 437,785	\$	\$	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Alloc. - Extended Care			\$ 6,627	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 6,627	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,642,349	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 159,553	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 159,553	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,693,318	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO
If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	See Suppl				0			5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2017</u>	\$ _____
13.	<u>/2018</u>	\$ _____
14.	<u>/2019</u>	\$ _____

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

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: \$ 14,973 Description: See Supplemental Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Facility</u>	<u>Lexus</u>	\$	<u>10,078</u>	17
18					18
19					19
20					20
21	TOTAL		\$	10,078	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' PREPARATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	162,224	\$		\$	162,224	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				36,771				36,771	2
3	Licensed Recreational Therapist		hrs				157,360				157,360	3
4	Licensed Physical Therapist	39 - 03	hrs									4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					62,351			62,351	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>See Supplemental</u>	39 - 02						69			69	12
13	Other (specify): <u>See Supplemental</u>	39 - 03					13,108				13,108	13
14	TOTAL			\$		\$	369,463	\$	62,420	\$	431,883	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/16

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 163,733	\$ 465,536	1
2	Cash-Patient Deposits	44,617	44,617	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>1,144,918</u>)	1,652,934	1,652,934	3
4	Supply Inventory (priced at <u>Cost - FIFO</u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	272,547	272,547	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>	2,360	2,360	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,136,191	\$ 2,437,994	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		3,624,354	14
15	Leasehold Improvements, at Historical Cost	499,055	499,055	15
16	Equipment, at Historical Cost	146,923	301,923	16
17	Accumulated Depreciation (book methods)	(90,878)	(3,621,509)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Supplemental Schedule</u>	656,182	2,967,938	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,211,282	\$ 3,871,761	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,347,473	\$ 6,309,755	25

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

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

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

Page 17 Supplemental Schedule

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 580,829	1
2	Restatements (describe):		2
3	<u>Rounding</u>	<u>6</u>	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 580,835	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	387,239	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(555,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (167,761)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 413,074	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

1

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

2

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,041	2,211	\$ 103,603	\$ 46.86	1
2	Assistant Director of Nursing	2,041	2,211	85,113	38.50	2
3	Registered Nurses	7,884	8,510	247,072	29.03	3
4	Licensed Practical Nurses	29,521	32,227	823,280	25.55	4
5	CNAs & Orderlies	67,700	74,193	812,647	10.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,341	8,258	147,502	17.86	8
9	Activity Director	1,918	2,120	33,494	15.80	9
10	Activity Assistants	5,295	5,729	59,687	10.42	10
11	Social Service Workers	12,740	14,065	242,254	17.22	11
12	Dietician					12
13	Food Service Supervisor	1,873	2,113	47,161	22.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,418	18,438	193,661	10.50	15
16	Dishwashers					16
17	Maintenance Workers	5,485	6,067	103,626	17.08	17
18	Housekeepers	13,356	14,494	149,383	10.31	18
19	Laundry	4,854	5,443	58,569	10.76	19
20	Administrator	2,041	2,207	130,670	59.21	20
21	Assistant Administrator	2,041	2,211	93,218	42.16	21
22	Other Administrative	908	1,020	38,250	37.50	22
23	Office Manager					23
24	Clerical	11,540	12,461	331,245	26.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,268	2,588	33,644	13.00	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	8,798	9,410	275,292	29.26	33
34	TOTAL (lines 1 - 33)	206,063	225,976	\$ 4,009,371 *	\$ 17.74	34

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 15,697	01 - 03	35
36	Medical Director	9,000	09 - 03	36
37	Medical Records Consultant	2,731	10 - 03	37
38	Nurse Consultant	32,230	10 - 03	38
39	Pharmacist Consultant	14,617	10 - 03	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	217	10 - 03	42
43	Speech Therapy Consultant			43
44	Activity Consultant	2,779	11 - 03	44
45	Social Service Consultant	713	12 - 03	45
46	Other(specify)			46
47	<u>See Supplemental Schedule</u>			47
48				48
49	TOTAL (lines 35 - 48)	\$ 77,984		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

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

Report Period Beginning:

01/01/16Ending: 12/31/16**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. ICLTC - \$18,299 Yes
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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?
What was the average life used for new equipment added during this period? Yes
5 - 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10 - 02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? 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. \$ 362,154
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 benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (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? N/A
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? 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. N/A
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT