

		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.

<p><b>I. IDPH License ID Number:</b> <u>0051144</u></p> <p><b>Facility Name:</b> <u>Oak Lawn Respiratory &amp; Rehab</u></p> <p><b>Address:</b> <u>9525 South Mayfield</u> <u>Oak Lawn</u> <u>60453</u>        Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(708) 449-1900</u> <b>Fax #</b> <u>(708) 449-1500</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>9/1/10</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/16</u> to <u>12/31/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Flora Reznik</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>CFO</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u></td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(317) 237-5500</u> <b>Fax #</b> <u>(317) 237-5503</u></td> <td></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Flora Reznik</u>			(Title) <u>CFO</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u>		(Firm Name & Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225</u>		(Telephone) <u>(317) 237-5500</u> <b>Fax #</b> <u>(317) 237-5503</u>	
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<p>In the event there are further questions about this report, please contact:  <b>Name:</b> <u>Daniel S. Gaafar</u> <b>Telephone Number:</b> <u>(317) 237-5500</u>  <b>Email Address:</b> _____</p>	<p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b></p>																																									

Facility Name & ID Number Oak Lawn Respiratory & Rehab

# 0051144 Report Period Beginning: 1/1/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>75</u>	Skilled (SNF)	<u>75</u>	<u>27,450</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>68</u>	Intermediate (ICF)	<u>68</u>	<u>24,888</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>143</u>	TOTALS	<u>143</u>	<u>52,338</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>13,533</u>	<u>17</u>	<u>1,945</u>	<u>15,495</u>	8
9	SNF/PED					9
10	ICF	<u>12,269</u>	<u>15</u>	<u>963</u>	<u>13,247</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>25,802</u>	<u>32</u>	<u>2,908</u>	<u>28,742</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.92%

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 9/1/10

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

YES  Date \_\_\_\_\_ NO

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

YES  NO  If YES, enter number of beds certified 54 and days of care provided 882

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/16 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
	<b>A. General Services</b>										
1	Dietary	221,496		31,168	252,664		252,664	(4,846)	247,818		1
2	Food Purchase		129,837		129,837		129,837	621	130,458		2
3	Housekeeping	159,830	32,311		192,141		192,141	393	192,534		3
4	Laundry	44,714	39,788		84,502		84,502		84,502		4
5	Heat and Other Utilities			158,749	158,749		158,749	530	159,279		5
6	Maintenance	30,708	30,625	103,340	164,673		164,673	951	165,624		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	456,748	232,561	293,257	982,566		982,566	(2,351)	980,215		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			22,400	22,400		22,400		22,400		9
10	Nursing and Medical Records	2,333,538	665,906	46,196	3,045,640		3,045,640	(31,242)	3,014,398		10
10a	Therapy	501,538		397,469	899,007		899,007		899,007		10a
11	Activities	71,110	13,822		84,932		84,932	2,495	87,427		11
12	Social Services	40,736		6,662	47,398		47,398		47,398		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Pharmacy Consult</b>			8,496	8,496		8,496		8,496		15
16	<b>TOTAL Health Care and Programs</b>	2,946,922	679,728	481,223	4,107,873		4,107,873	(28,747)	4,079,126		16
	<b>C. General Administration</b>										
17	Administrative	115,748			115,748		115,748	(45,000)	70,748		17
18	Directors Fees										18
19	Professional Services			356,832	356,832		356,832	(111,627)	245,205		19
20	Dues, Fees, Subscriptions & Promotions			7,983	7,983		7,983	16	7,999		20
21	Clerical & General Office Expenses	202,690	69,628	91,584	363,902		363,902	107,754	471,656		21
22	Employee Benefits & Payroll Taxes			985,393	985,393		985,393	45,995	1,031,388		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,437	3,437		3,437	1,303	4,740		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			321,008	321,008		321,008	35,975	356,983		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	318,438	69,628	1,766,237	2,154,303		2,154,303	34,416	2,188,719		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,722,108	981,917	2,540,717	7,244,742		7,244,742	3,318	7,248,060		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 Oak Lawn Respiratory & Rehab #0051144 Report Period Beginning: 1/1/16 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
	<b>D. Ownership</b>										
30	Depreciation			60,056	60,056		60,056	182,291	242,347		30
31	Amortization of Pre-Op. & Org.							33,336	33,336		31
32	Interest			307,946	307,946		307,946	161,839	469,785		32
33	Real Estate Taxes							341,437	341,437		33
34	Rent-Facility & Grounds			1,083,048	1,083,048		1,083,048	(1,077,630)	5,418		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			1,451,050	1,451,050		1,451,050	(358,727)	1,092,323		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation			385	385		385		385		38
39	Ancillary Service Centers		136,256		136,256		136,256		136,256		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			244,189	244,189		244,189		244,189		42
43	Other (specify):* <b>Bad Debt</b>			422,545	422,545		422,545	(422,545)			43
44	<b>TOTAL Special Cost Centers</b>		136,256	667,119	803,375		803,375	(422,545)	380,830		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,722,108	1,118,173	4,658,886	9,499,167		9,499,167	(777,954)	8,721,213		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.)

		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	(154,947)	30		9
10	Interest and Other Investment Income	(5,434)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1)	1		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	(50)	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	(422,545)	43		24
25	Fund Raising, Advertising and Promotional	(5,327)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(8,857)	various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (597,161)</b>		<b>\$</b>	<b>30</b>

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)	(180,793)	various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (180,793)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (777,954)</b>		<b>37</b>

\*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.		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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

BHF USE ONLY							
48		49		50		51	

Oak Lawn Respiratory & Rehab

ID# 0051144

Report Period Beginning: 1/1/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (7,030)	21	1
2	Vending Income	(1,568)	1	2
3	Lobbying Expense	(259)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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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	<b>Total</b>	(8,857)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oak Lawn Respiratory & Rehab# 0051144

Report Period Beginning:

1/1/16

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	(1,569)	(3,277)	0	0	0	0	0	0	0	0	0	(4,846)	1
2	Food Purchase	0	621	0	0	0	0	0	0	0	0	0	621	2
3	Housekeeping	0	393	0	0	0	0	0	0	0	0	0	393	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	530	0	0	0	0	0	0	0	0	0	530	5
6	Maintenance	0	951	0	0	0	0	0	0	0	0	0	951	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,569)</b>	<b>(782)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,351)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(31,242)	0	0	0	0	0	0	0	0	0	(31,242)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	2,495	0	0	0	0	0	0	0	0	0	2,495	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>(28,747)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(28,747)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(45,000)	0	0	0	0	0	0	0	0	0	(45,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(106,917)	(4,710)	0	0	0	0	0	0	0	0	(111,627)	19
20	Fees, Subscriptions & Promotions	(259)	275	0	0	0	0	0	0	0	0	0	16	20
21	Clerical & General Office Expenses	(12,407)	119,942	219	0	0	0	0	0	0	0	0	107,754	21
22	Employee Benefits & Payroll Taxes	0	45,995	0	0	0	0	0	0	0	0	0	45,995	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,303	0	0	0	0	0	0	0	0	0	1,303	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	35,975	0	0	0	0	0	0	0	0	35,975	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(12,666)</b>	<b>15,598</b>	<b>31,484</b>	<b>0</b>	<b>34,416</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(14,235)</b>	<b>(13,931)</b>	<b>31,484</b>	<b>0</b>	<b>3,318</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(154,947)	0	337,238	0	0	0	0	0	0	0	0	182,291	30
31	Amortization of Pre-Op. & Org.	0	0	33,336	0	0	0	0	0	0	0	0	33,336	31
32	Interest	(5,434)	0	167,273	0	0	0	0	0	0	0	0	161,839	32
33	Real Estate Taxes	0	0	341,437	0	0	0	0	0	0	0	0	341,437	33
34	Rent-Facility & Grounds	0	0	(1,077,630)	0	0	0	0	0	0	0	0	(1,077,630)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(160,381)</b>	<b>0</b>	<b>(198,346)</b>	<b>0</b>	<b>(358,727)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(422,545)	0	0	0	0	0	0	0	0	0	0	(422,545)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(422,545)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(422,545)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(597,161)</b>	<b>(13,931)</b>	<b>(166,862)</b>	<b>0</b>	<b>(777,954)</b>	<b>45</b>							

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
Michael Blisko	20%	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Management Co
GELP	20%	Belhaven Nursing & Rehab Center	Chicago			
A&F Realty	20%	City View Multicare Center	Cicero			
Rosie Schwartz	20%	Continental Nursing & Rehab Center	Chicago			
SYSNY	20%	Forest View Rehab & Nursing Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			

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	1 Dietary	\$ 14,079	Infinity Healthcare Management		\$ 10,802	\$ (3,277)	1
2	V	2 Food Purchase		Infinity Healthcare Management		621	621	2
3	V	3 Housekeeping		Infinity Healthcare Management		393	393	3
4	V	5 Utilities		Infinity Healthcare Management		530	530	4
5	V	6 Maintenance		Infinity Healthcare Management		951	951	5
6	V	10 Nursing	46,196	Infinity Healthcare Management		14,954	(31,242)	6
7	V	11 Activities		Infinity Healthcare Management		2,495	2,495	7
8	V	17 Administrator	45,000	Infinity Healthcare Management			(45,000)	8
9	V	19 Professional Fees	223,406	Infinity Healthcare Management		116,489	(106,917)	9
10	V	20 Dues & Fees		Infinity Healthcare Management		275	275	10
11	V	21 Office Expense	84,887	Infinity Healthcare Management		204,829	119,942	11
12	V	22 Employee Benefits		Infinity Healthcare Management		45,995	45,995	12
13	V	24 Travel Expense	79	Infinity Healthcare Management		1,382	1,303	13
14	Total		\$ 413,647			\$ 399,716	\$ * (13,931)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	26 Insurance	\$	Infinity Healthcare Management		\$ 324	\$	324	15
16	V	30 Depreciation		Infinity Healthcare Management		230		230	16
17	V	32 Interest		Infinity Healthcare Management		2,980		2,980	17
18	V	34 Rent		Infinity Healthcare Management		5,418		5,418	18
19	V								19
20	V	33 Property Tax		Oak Lawn Realty LLC		341,437		341,437	20
21	V	26 Insurance		Oak Lawn Realty LLC		35,651		35,651	21
22	V	31 Amortization		Oak Lawn Realty LLC		33,336		33,336	22
23	V	19 Professional Fees		Oak Lawn Realty LLC		(4,710)		(4,710)	23
24	V	21 Office Expense		Oak Lawn Realty LLC		219		219	24
25	V	30 Depreciation		Oak Lawn Realty LLC		337,008		337,008	25
26	V	32 Interest		Oak Lawn Realty LLC		164,293		164,293	26
27	V	34 Rent	1,083,048	Oak Lawn Realty LLC				(1,083,048)	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		\$ 1,083,048			\$ 916,186	\$ *	(166,862)	39

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

Facility Name & ID Number

Oak Lawn Respiratory & Rehab

# 0051144

Report Period Beginning:

1/1/16

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			Momence Meadows Nursing & Rehab Ctr	Momence				1
2			Niles Nursing & Rehab Center	Niles				2
3			Parker Nursing & Rehab Center	Streator				3
4			Parkshore Estates Nursing & Rehab Ctr	Chicago				4
5			Southpoint Nursing & Rehab Center	Chicago				5
6			West Suburban Nursing & Rehab Center	Bloomington				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 Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/16 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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 Oak Lawn Respiratory & Rehab

# 0051144

Report Period Beginning:

1/1/16

Ending: 12/31/16

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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.

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Oak Lawn Respiratory & Rehab

# 0051144

Report Period Beginning:

1/1/16

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	HUD Loan		X	Mortgage	\$21,117.00	9/24/14	\$ 4,587,800	\$ 4,399,389	10/1/44	3.7000	\$ 164,293	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	Capital One		X	Working capital	None	8/31/14	26,000,000	7,510,032	8/31/15	various	310,604	6						
7	Infinity Funding	X		Working capital	None	various	various	7,783	various	various	322	7						
8												8						
9	<b>TOTAL Facility Related</b>				\$21,117.00		\$ 30,587,800	\$ 11,917,204			\$ 475,219	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 30,587,800	\$ 11,917,204			\$ 475,219	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 29,045      Line # 26

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

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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (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.		\$	<b>16,793</b>	<b>1</b>
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.)		\$	<b>334,468</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>317,675</b>	<b>3</b>
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>23,762</b>	<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>341,437</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	<b>271,403</b>	<b>8</b>	
	2012	<b>253,105</b>	<b>9</b>	
	2013	<b>258,880</b>	<b>10</b>	
	2014	<b>331,492</b>	<b>11</b>	
	2015	<b>334,468</b>	<b>12</b>	
				<b>FOR BHF USE ONLY</b>
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2015	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

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

**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Oak Lawn Respiratory & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051144

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

**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>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>24-08-201-007-0000</u>	<u>Nursing Home</u>	\$ <u>334,468.28</u>	\$ <u>334,468.28</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>334,468.28</u></u>	\$ <u><u>334,468.28</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

Facility Name & ID Number Oak Lawn Respiratory & Rehab

# 0051144

Report Period Beginning:

1/1/16

Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,070 B. General Construction Type: Exterior Brick Frame 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).

Blank lines for listing other business entities.

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: 500,000 2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 33,336 4. Dates Incurred: 9/1/10

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Nursing Home, 2010, \$100,000. Row 2: (blank). Row 3: TOTALS, \$100,000.

Facility Name &amp; ID Number Oak Lawn Respiratory &amp; Rehab

# 0051144

Report Period Beginning:

1/1/16

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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	143	2010	1960	\$ 2,000,000	\$ 51,288	39	\$ 51,282	\$ (6)	\$ 290,628	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Painting		2010	1,981	51	39	51		326	9
10	Drywall		2010	1,500	38	39	38		246	10
11	Roofing		2010	40,500	1,038	39	1,038		6,663	11
12	Signs		2010	3,102	80	39	80		511	12
13	Windows		2010	16,500	423	39	423		2,715	13
14	Walls, Wallpaper, Flooring, Doors		2010	88,500	2,270	39	2,269	(1)	14,560	14
15	Signs		2010	6,298	161	39	161		1,035	15
16	Windows		2010	50,630	1,299	39	1,298	(1)	8,330	16
17	Concrete and Asphalt for driveway		2010	38,000	974	39	974		6,251	17
18	Concrete and Asphalt for driveway		2010	17,490	448	39	448		2,877	18
19	Air conditioner		2011	753	19	39	19		115	19
20	Chair mats		2011	346	9	39	9		53	20
21	Fire alarm system		2011	16,210	416	39	416		2,495	21
22	Drywall		2011	1,696	43	39	43		260	22
23	Electrical Outlets		2011	3,200	82	39	82		492	23
24	Subpanel in 2nd floor med room		2011	3,500	90	39	90		539	24
25	remove & install new shingle roof		2010	20,490	525	39	525		3,152	25
26	Mirrors, Vanity Lights, Ceiling Painting		2011	45,280	1,160	39	1,161	1	6,966	26
27	Signage permit for mirros, vanity, etc.		2010	450	12	39	12		70	27
28	Window permit for mirrors, vanity, etc.		2010	900	23	39	23		138	28
29	Air conditioner		2011	3,620	93	39	93		557	29
30	Tables and Chairs		2010	5,525	142	39	142		851	30
31	Mirrors, Vanity Lights, Ceiling Painting		2010	67,919	1,741	39	1,742	1	10,450	31
32	Aluminum and glass store front, wiring, sidewalk, sprinkler		2010	39,750	1,019	39	1,019		6,115	32
33	Sprinkler system		2011	9,500	244	39	244		1,462	33
34	Shower Door Frame		2011	550	14	39	14		84	34
35	Granite shelf		2011	300	8	39	8		47	35
36	Drywall soffit for sprinkler pipe enclosure		2011	650	17	39	17		101	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 Oak Lawn Respiratory & Rehab# 0051144

Report Period Beginning:

1/1/16

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	Profile cove base	2011	\$ 1,350	\$ 35	39	\$ 35		\$ 208	37
38	Laminate column covers	2011	945	24	39	24		145	38
39	Drywall for spinkler pipe enclosure	2011	500	13	39	13		77	39
40	Hallway & Shower room walls, tiles, wander board, lighting, grab	2011	66,717	1,710	39	1,711	1	10,265	40
41	build new closet	2011	1,100	28	39	28		169	41
42	Plumbing for lobby bathroom	2011	1,600	41	39	41		246	42
43	Drywall and insulation for dining room & hallway	2011	5,344	137	39	137		822	43
44	Granite countertop and wood front	2011	8,500	218	39	218		1,308	44
45	Profile cove base	2011	1,350	35	39	35		208	45
46	Bathroom doors and frames	2011	1,200	31	39	31		185	46
47	Bathroom doors and frames	2011	1,200	31	39	31		185	47
48	Office walls, rewiring, lighting, doors	2011	3,900	100	39	100		600	48
49	Door and frame	2011	1,450	37	39	37		223	49
50	Bulletin boards	2011	1,256	32	39	32		193	50
51	Foundation, tiles, exit signs, lighting	2011	8,160	209	39	209		1,255	51
52	Shower room plumbing, drain, door, drywall	2011	2,050	53	39	53		316	52
53	Room repair for canopy, steel column, wood cover	2011	11,450	294	39	294		1,762	53
54	Elevator new valve (Maxton UC 4)	2011	3,650	94	39	94		562	54
55	Fire dampers and smoke detectors	2011			39				55
56	Fire dampers and smoke detectors	2011	4,250	109	39	109		652	56
57	Plumbing	2011	2,800	72	39	72		431	57
58	Lights	2011	3,165	81	39	81		487	58
59	Ejector pumps and control panel	2011	1,385	36	39	36		214	59
60	Replace ventor motor on stove	2012	2,318	59	39	59		296	60
61	Ceiling tiles	2012	1,833	47	39	47		235	61
62	Fire sprinkler for elevator pit and hallway	2012	4,100	105	39	105		525	62
63	Painting of resident rooms	2012	1,920	49	39	49		246	63
64	Painting of resident rooms	2012	7,600	195	39	195		975	64
65	Painting of resident rooms	2012	10,950	282	39	281	(1)	1,403	65
66	Painting of resident rooms	2012	4,300	110	39	110		551	66
67	Painting of resident rooms	2012	3,350	86	39	86		430	67
68	Painting of resident rooms	2012	5,200	133	39	133		666	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,660,032	\$ 68,213		\$ 68,207	\$ (6)	\$ 393,929	70

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

Facility Name &amp; ID Number Oak Lawn Respiratory &amp; Rehab

# 0051144

Report Period Beginning:

1/1/16

Ending:

12/31/16

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,660,032	\$ 68,213		\$ 68,207	\$ (6)	\$ 393,929	1
2	Priming/Sanding/painting on 1st floor	2013	4,599	118	39	118		413	2
3	Laminate walls panels - 1st floor nurse station	2013	1,850	47	39	47		165	3
4	Shutters	2013	1,900	49	39	49		171	4
5	Cement Board panels - exterior columns	2013	1,500	38	39	38		134	5
6	Drywall	2013	1,421	36	39	36		127	6
7	Air ducts - 1st floor	2013	2,895	74	39	74		259	7
8	Air ducts - 2nd floor	2013	3,250	83	39	83		291	8
9	Bathroom exhaust - 2nd floor	2013	4,467	115	39	115		402	9
10	Fire dampers / exhaust - 1st floor	2013	7,850	201	39	201		704	10
11	Outlets - 2nd floor	2013	7,800	200	39	200		700	11
12	Outlets - 1st floor	2013	2,750	70	39	71	1	248	12
13	Outlets - basement	2013	4,680	120	39	120		420	13
14	Ceiling - basement	2013	1,315	34	39	34		119	14
15	Electrical switches	2013	1,755	45	39	45		157	15
16	Ceiling patch	2013	1,860	48	39	48		168	16
17	Electrical wiring - nurse stations	2013	11,200	287	39	287		1,005	17
18									18
19	Danny Golmayo - repair exit doors	2014	3,750	96	39	96		240	19
20	Precision Heating - work on RTU	2013	3,925	101	39	101		252	20
21	Superior Const.- drywall, electrical, paint near fire exit door	2014	3,857	99	39	99		247	21
22	Repair door frames & install outlets all resident rms 2nd flr	2014	6,837	175	39	175		438	22
23	Superior Const. - Replace drywall & insulation in 2 hallways	2014	7,161	184	39	184		460	23
24	Pegasus Custom Furn - beds, wardrobes, dressers	2014	3,130	80	39	80		200	24
25	Alliance Construction - plumbing / sewer line diverted	2014	5,700	146	39	146		365	25
26	New wander guard system for the dementia unit	2014	3,522	90	39	90		225	26
27	Charles Equipment Energy Systems - inspect/repaid Generac	2014	2,054	53	39	53		132	27
28	Five Star - replaces asphalt, removed debris	2014	2,375	61	39	61		152	28
29	Cement boards on ext. columns/handrails 1st flr nrse station	2014	4,006	103	39	103		257	29
30	Remove asbestos from boiler room	2014	7,244	186	39	186		465	30
31	On-Line Communications, Inc. - cable installation	2014	28,465	730	39	730		1,825	31
32	OTIS - Door restrictor down payment	2014	3,313	85	39	85		212	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,806,463	\$ 71,967		\$ 71,962	\$ (5)	\$ 404,882	34

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

Facility Name & ID Number Oak Lawn Respiratory & Rehab# 0051144

Report Period Beginning:

1/1/16

Ending:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 2,806,463	\$ 71,967		\$ 71,962	\$ (5)	\$ 404,882	1
2	Precision Heating - replace 1st floor furnace	2014	3,250	83	39	83		208	2
3	Precision Heating - replace fan motors and contactors	2014	2,191	56	39	56		140	3
4	Precision Heating - install new a/c compressor/unit	2014	3,665	94	39	94		235	4
5	Precision Heating - new high efficient 10-ton RTU	2014	12,550	322	39	322		805	5
6	Superior Construction - basement kitchen doors	2014	2,963	76	39	76		190	6
7	Superior Construction - remove/repair chair rail/hinges	2014	5,915	152	39	152		380	7
8	Superior Construction - install approx. 50 locks, closet door	2014	4,108	105	39	105		263	8
9	Superior Construction - drywall / painting / wiring	2014	1,666	43	39	43		107	9
10	Superior Construction - new outlets, electrical work	2014	3,497	90	39	90		225	10
11	Superior Construction - replace ceiling tiles, paint	2014	2,549	65	39	65		163	11
12	Superior Construction - repair walls / install new flooring / ceiling	2014	4,291	110	39	110		275	12
13	Various - test all outlets, plumbing/clog issue	2014	15,640	401	39	401		1,003	13
14									14
15	Hot Water Heater Repair	2015	2,598	67	39	67		136	15
16	Hot Water Heater Repair	2015	8,000	205	39	205		416	16
17	Paint/Repair Walls/Replace Ceiling Light on 2nd floor	2015	4,319	111	39	111		225	17
18									18
19	Safety Code Repairs - close hole in ceiling in med records &	2015	4,861	125	39	125		253	19
20	boiler rm, replace latches to rms 111&116, seal fire damper								20
21	b/w FL 1&2, replace locks, to therapy rms & stairwell FLs 1&2								21
22									22
23	Inspection of Sprinkler System/Additional Sprinkler Head	2015	2,572	66	39	66		134	23
24	New Fire Doors for Laundry Room	2015	2,920	75	39	75		152	24
25	New Linen Closet Doors for Floors 1-4 & Basement	2015	4,047	104	39	104		211	25
26	Rewired Lights/Repaired Walls in 1st Floor Med Room	2015	5,534	142	39	142		288	26
27	Repaired Bed Lights/Walls in Patient Rooms on 1st Floor	2015	3,988	102	39	102		207	27
28	Repaired Bed Lights/Walls in Patient Rooms on 1st Floor	2015	4,735	121	39	121		245	28
29	Installed Additional Outlets in Patient Rooms on 1st Floor	2015	8,309	213	39	213		432	29
30	New Boiler	2015	42,887	1,100	39	1,100		2,229	30
31	Electrical and Lighting Repairs in Boiler Room	2015	18,500	474	39	474		960	31
32	Install New Doors, Hinges, & Bolts on Floors 1-4 & Basement	2015	4,387	112	39	112		227	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,986,404	\$ 76,581		\$ 76,576	\$ (5)	\$ 414,991	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	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	<b>Totals from Page 12C, Carried Forward</b>		\$ 2,986,404	\$ 76,581		\$ 76,576	\$ (5)	\$ 414,991	1
2	New Gibs for Elevator	2016	3,454	99	39	89	(10)	99	2
3	Paint 1st Floor Dining Room	2016	3,560	102	39	91	(11)	102	3
4	New Condenser Fan Motor & Blade for Chiller	2016	2,670	77	39	68	(9)	77	4
5	New Control Board for Chiller	2016	3,815	109	39	98	(11)	109	5
6	Install New Drwall & Paint Activity Room	2016	2,676	77	39	69	(8)	77	6
7	Laundry Room Fresh Air Duct	2016	2,950	85	39	76	(9)	85	7
8	New Floor for Shower Room	2016	2,998	86	39	77	(9)	86	8
9	New Bowl Since for 1st & 2nd Floor Utility Closets	2016	4,150	119	39	106	(13)	119	9
10	IDPH Capital Report Adjustments 6/30/16	2016	(63,866)						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	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,948,811	\$ 77,335		\$ 77,250	\$ (85)	\$ 415,745	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,369,901	\$ 306,309	\$ 160,756	\$ (145,553)	5	\$ 1,853,360	71
72	Current Year Purchases	21,704	13,650	4,341	(9,309)	5	13,650	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,391,605	\$ 319,959	\$ 165,097	\$ (154,862)		\$ 1,867,010	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 5,440,416	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 397,294	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 242,347	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (154,947)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,282,755	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

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							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(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	<b>TOTAL</b>		\$	\$	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.

**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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

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

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

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

	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	10A-3	hrs	\$	2,968	\$ 144,523	\$	2,968	\$ 144,523	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		982	67,443		982	67,443	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		2,269	140,503		2,269	140,503	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				136,008		136,008	10
11	Academic Education		hrs							11
12	Other (specify): <u>Laboratory/Xray</u>	39-2					250		250	12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	6,219	\$ 352,469	\$ 136,258	6,219	\$ 488,727	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.

**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	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (114,990)	\$ 245,789	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	3,639,295	3,639,295	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	182,744	182,744	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		188,981	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,707,049	\$ 4,256,809	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		2,000,000	14
15	Leasehold Improvements, at Historical Cost	1,012,677	1,012,677	15
16	Equipment, at Historical Cost	391,605	2,391,605	16
17	Accumulated Depreciation (book methods)	(420,670)	(2,282,755)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		510,505	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(188,902)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <b>Replacement Res</b> )		89,597	22
23	Other(specify): <b>Insurance Exchange</b>	76,530	76,530	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,060,142	\$ 3,709,257	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,767,191	\$ 7,966,066	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,203,892	\$ 1,338,954	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,551	28,551	28
29	Short-Term Notes Payable		92,180	29
30	Accrued Salaries Payable	128,070	128,070	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,718	16,718	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		13,565	33
34	Deferred Compensation	322	322	34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>Line of Credit</b>	7,510,032	7,510,032	36
37	<b>Due to Infinity</b>	7,783	7,783	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 8,895,368	\$ 9,136,175	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		4,307,209	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 4,307,209	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 8,895,368	\$ 13,443,384	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (4,128,177)	\$ (5,477,318)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,767,191	\$ 7,966,066	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(2,712,272)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(2,712,272)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	\$ <b>(1,415,905)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,415,905)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(4,128,177)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,429,148	1
2	Discounts and Allowances for all Levels	395,026	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,824,174	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	201,408	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 201,408	8
<b>C. Other Operating Revenue</b>			
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	41,608	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,882	19
20	Radiology and X-Ray	355	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 43,845	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	5,237	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 5,237	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>Miscellaneous Income</u>	8,598	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 8,598	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,083,262	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	990,637	31
32	Health Care	4,102,671	32
33	General Administration	2,151,434	33
<b>B. Capital Expense</b>			
34	Ownership	1,451,050	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	136,641	35
36	Provider Participation Fee	244,189	36
<b>D. Other Expenses (specify):</b>			
37	<u>Bad Debt</u>	422,545	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,499,167	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,415,905)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,415,905)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,497,292	44
45	Private Pay - Net Inpatient Revenue	6,080	45
46	Medicare - Net Inpatient Revenue	485,526	46
47	Other-(specify)	835,276	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 7,824,174	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 Oak Lawn Respiratory & Rehab

# 0051144

Report Period Beginning:

1/1/16

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	2,069	2,206	\$ 101,518	\$ 46.02	1
2	Assistant Director of Nursing	3,381	4,045	142,224	35.16	2
3	Registered Nurses	7,043	7,752	275,356	35.52	3
4	Licensed Practical Nurses	30,088	32,752	869,075	26.54	4
5	CNAs & Orderlies	76,526	86,289	1,299,413	15.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,598	5,936	75,775	12.77	9
10	Activity Assistants					10
11	Social Service Workers	1,991	2,142	43,973	20.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,851	17,711	225,281	12.72	15
16	Dishwashers					16
17	Maintenance Workers	1,442	1,563	31,505	20.16	17
18	Housekeepers	12,697	14,145	163,144	11.53	18
19	Laundry	4,153	4,543	44,889	9.88	19
20	Administrator	1,909	2,180	114,170	52.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,977	17,470	297,311	17.02	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	1,837	1,987	38,474	19.36	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	180,562	200,721	\$ 3,722,108 *	\$ 18.54	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	402	\$ 14,079	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,320	46,196	10-3	38
39	Pharmacist Consultant	170	8,496	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	900	45,000	10A-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	164	5,735	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,956	\$ 119,506		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



Facility Name & ID Number Oak Lawn Respiratory & Rehab# 0051144

Report Period Beginning:

1/1/16

Ending:

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? Yes  
If YES, give association name and amount. Illinois Council - \$5,013
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 51,414 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. 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. \$ 244,189  
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? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees