

Facility Name & ID Number Chalet Living And Rehab

0053843 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	219	Skilled (SNF)	219	79,935	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	219	TOTALS	219	79,935	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	62,076	3,814	3,901	69,791	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	62,076	3,814	3,901	69,791	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.31%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 10/01/2011

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/01/2011 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 219 and days of care provided 3,358

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Chalet Living And Rehab # 0053843 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	402,762	31,634	4,313	438,709		438,709		438,709		1
2	Food Purchase		396,159		396,159		396,159	(9,290)	386,869		2
3	Housekeeping	277,617	63,887		341,504		341,504	291	341,795		3
4	Laundry	79,039	19,856		98,895		98,895	8	98,903		4
5	Heat and Other Utilities			276,194	276,194		276,194	(12,083)	264,111		5
6	Maintenance	112,647	29,484	154,739	296,870		296,870	88,438	385,308		6
7	Other (specify):*										7
8	TOTAL General Services	872,065	541,020	435,246	1,848,331		1,848,331	67,363	1,915,694		8
	B. Health Care and Programs										
9	Medical Director			18,075	18,075		18,075	894	18,969		9
10	Nursing and Medical Records	3,785,416	91,751	46,360	3,923,527		3,923,527	144,027	4,067,554		10
10a	Therapy	247,659			247,659		247,659		247,659		10a
11	Activities	144,334	9,089	863	154,286		154,286	6,790	161,076		11
12	Social Services	216,763		3,662	220,425		220,425	2,438	222,863		12
13	CNA Training										13
14	Program Transportation			13,647	13,647		13,647		13,647		14
15	Other (specify):*							23,302	23,302		15
16	TOTAL Health Care and Programs	4,394,172	100,840	82,607	4,577,619		4,577,619	177,450	4,755,069		16
	C. General Administration										
17	Administrative	141,101			141,101		141,101	233,480	374,581		17
18	Directors Fees										18
19	Professional Services			139,834	139,834	(312)	139,522	5,091	144,613		19
20	Dues, Fees, Subscriptions & Promotions			60,102	60,102		60,102	(12,543)	47,559		20
21	Clerical & General Office Expenses	182,344	2,537	345,931	530,812		530,812	24,303	555,115		21
22	Employee Benefits & Payroll Taxes			894,400	894,400		894,400		894,400		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,123	3,123		3,123	2,693	5,816		24
25	Other Admin. Staff Transportation			653	653		653		653		25
26	Insurance-Prop.Liab.Malpractice			212,889	212,889		212,889	4,965	217,854		26
27	Other (specify):*							97,722	97,722		27
28	TOTAL General Administration	323,445	2,537	1,656,932	1,982,914	(312)	1,982,602	355,710	2,338,312		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,589,682	644,397	2,174,785	8,408,864	(312)	8,408,552	600,524	9,009,076		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

Chalet Living And Rehab

#0053843

Report Period Beginning:

01/01/17

Ending:

12/31/17

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							720,299	720,299			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			68,618	68,618		68,618	1,498,735	1,567,353			32
33	Real Estate Taxes			227,436	227,436	312	227,748	6,286	234,034			33
34	Rent-Facility & Grounds			3,094,055	3,094,055		3,094,055	(3,093,841)	214			34
35	Rent-Equipment & Vehicles			6,505	6,505		6,505	6,183	12,688			35
36	Other (specify):*											36
37	TOTAL Ownership			3,396,614	3,396,614	312	3,396,926	(862,338)	2,534,588			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		326,955	587,791	914,746		914,746		914,746			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			529,679	529,679		529,679		529,679			42
43	Other (specify):*			719,343	719,343		719,343	(719,343)				43
44	TOTAL Special Cost Centers		326,955	1,836,813	2,163,768		2,163,768	(719,343)	1,444,425			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,589,682	971,352	7,408,212	13,969,246		13,969,246	(981,157)	12,988,089			45

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

Chalet Living And Rehab

ID# 0053843

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	PAC Dues	\$ (9,861)	20	1
2	Non-Allowable Legal Fees	(8,813)	19	2
3	Miscellaneous Income	(2,673)	21	3
4	Patient Personal Items	(2,408)	10	4
5	Sequestration Expense	(37,767)	21	5
6	Non-Allowable Expense	(719,343)	43	6
7	Pharmacy Discounts	(3,238)	10	7
8	Additional R&M	24,082	06	8
9	Capitalized R&M	(2,935)	06	9
10	Bldg Co - Replacement Tax Fee	(2,732)	21	10
11	Bldg Co - Tax Extension Fee	(3,900)	19	11
12	Bldg Co - Title Fees	(4,683)	20	12
13	Bldg Co - Accounting	(2,884)	19	13
14	Bldg Co - Legal	(17,207)	19	14
15	Bldg Co - Loan Fee	(82,389)	36	15
16	Bldg Co - Management Fee	(476,695)	21	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,353,446)		49

Chalet Living And Rehab

ID# 0053843
 Report Period Beginning: 01/01/17
 Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chalet Living And Rehab# 0053843

Report Period Beginning:

01/01/17

Ending:

12/31/17

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
2	Food Purchase	(9,380)		65	25								(9,290)	2
3	Housekeeping			291									291	3
4	Laundry			8									8	4
5	Heat and Other Utilities	(13,781)				1,698							(12,083)	5
6	Maintenance	21,147		3,930	61,214	2,146							88,438	6
7	Other (specify):*													7
8	TOTAL General Services	(2,014)		4,294	61,239	3,844							67,363	8
	B. Health Care and Programs													
9	Medical Director			894									894	9
10	Nursing and Medical Records	(5,646)		55	149,942		(325)						144,027	10
10a	Therapy													10a
11	Activities			6,764	26								6,790	11
12	Social Services			107	2,332								2,438	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				23,302								23,302	15
16	TOTAL Health Care and Programs	(5,646)		7,820	175,601		(325)						177,450	16
	C. General Administration													
17	Administrative			30,748	202,732								233,480	17
18	Directors Fees													18
19	Professional Services	(32,804)	23,991	20,890	512	427			(7,925)				5,091	19
20	Fees, Subscriptions & Promotions	(18,667)	4,683	1,188	250	3							(12,543)	20
21	Clerical & General Office Expenses	(742,489)	479,427	243,937	43,427	1							24,303	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,570	1,123								2,693	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,317	3,208	440							4,965	26
27	Other (specify):*			50,054	47,667								97,722	27
28	TOTAL General Administration	(793,960)	508,101	349,703	298,919	871			(7,925)				355,710	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(801,620)	508,101	361,817	535,760	4,715			(7,925)				600,524	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chalet Living And Rehab # 0053843 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	719,172			1,127								720,299	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(32,486)	1,523,526	25		7,670							1,498,735	32
33	Real Estate Taxes					6,286							6,286	33
34	Rent-Facility & Grounds		(3,094,055)	60,867	87	(60,740)							(3,093,841)	34
35	Rent-Equipment & Vehicles			4,457	1,726								6,183	35
36	Other (specify):*	(82,389)	82,389											36
37	TOTAL Ownership	604,297	(1,488,140)	65,349	2,940	(46,784)							(862,338)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(719,343)											(719,343)	43
44	TOTAL Special Cost Centers	(719,343)											(719,343)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(916,666)	(980,039)	427,166	538,700	(42,069)	(325)		(7,925)				(981,157)	45

Facility Name & ID Number

Chalet Living And Rehab

0053843

Report Period Beginning:

01/01/17

Ending:

12/31/17

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-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 3,094,055	Chalet Real Property LLC	100.00%	\$		\$ (3,094,055) 1
2	V	21 Replacement Tax Fee		Chalet Real Property LLC	100.00%	2,732		2,732 2
3	V	19 Tax Extension Fee		Chalet Real Property LLC	100.00%	3,900		3,900 3
4	V	20 Title Fees		Chalet Real Property LLC	100.00%	4,683		4,683 4
5	V	19 Accounting		Chalet Real Property LLC	100.00%	2,884		2,884 5
6	V	19 Legal		Chalet Real Property LLC	100.00%	17,207		17,207 6
7	V	36 Loan Fee		Chalet Real Property LLC	100.00%	82,389		82,389 7
8	V	21 Management Fee		Chalet Real Property LLC	100.00%	476,695		476,695 8
9	V	32 Interest		Chalet Real Property LLC	100.00%	1,523,526		1,523,526 9
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 3,094,055			\$ 2,114,016	\$ *	(980,039) 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	2	FOOD	Legacy Healthcare Financial Services	100.00%	\$ 65	\$	65	15
16	V	3	HOUSEKEEPING SUPPLIES	Legacy Healthcare Financial Services	100.00%	291		291	16
17	V	4	LINEN REPLACEMENT	Legacy Healthcare Financial Services	100.00%	8		8	17
18	V	6	UTILITIES	Legacy Healthcare Financial Services	100.00%	17		17	18
19	V	6	GROUNDS & MAINTENANCE	Legacy Healthcare Financial Services	100.00%	3,913		3,913	19
20	V	9	MEDICAL DIRECTOR CONSULTANT	Legacy Healthcare Financial Services	100.00%	894		894	20
21	V	10	MEDICAL SUPPLIES	Legacy Healthcare Financial Services	100.00%	55		55	21
22	V	11	ACTIVITIES PROGRAM	Legacy Healthcare Financial Services	100.00%	6,764		6,764	22
23	V	12	SOCIAL SERVICE CONSULTANT	Legacy Healthcare Financial Services	100.00%	107		107	23
24	V	17	ADMINISTRATIVE SALARY	Legacy Healthcare Financial Services	100.00%	30,748		30,748	24
25	V	19	PROFESSIONAL FEES	Legacy Healthcare Financial Services	100.00%	20,890		20,890	25
26	V	20	FEES, SUBSCRIPTIONS	Legacy Healthcare Financial Services	100.00%	1,188		1,188	26
27	V	21	CLERICAL & GENERAL WAGES	Legacy Healthcare Financial Services	100.00%	237,377		237,377	27
28	V	21	CLERICAL & GENERAL OTHER COSTS	Legacy Healthcare Financial Services	100.00%	6,560		6,560	28
29	V	24	SEMINARS	Legacy Healthcare Financial Services	100.00%	1,570		1,570	29
30	V	26	INSURANCE	Legacy Healthcare Financial Services	100.00%	1,317		1,317	30
31	V	27	EMP. BEN.-GEN. ADMIN.	Legacy Healthcare Financial Services	100.00%	50,054		50,054	31
32	V	32	INTEREST	Legacy Healthcare Financial Services	100.00%	25		25	32
33	V	34	RENT	Legacy Healthcare Financial Services	100.00%	60,740		60,740	33
34	V	34	STORAGE	Legacy Healthcare Financial Services	100.00%	127		127	34
35	V	35	EQUIPMENT RENTAL	Legacy Healthcare Financial Services	100.00%	31		31	35
36	V	35	AUTO RENTAL	Legacy Healthcare Financial Services	100.00%	4,426		4,426	36
37	V								37
38	V								38
39	Total		\$			\$ 427,166	\$ *	427,166	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2	FOOD	Progressive Healthcare Consulting	100.00%	\$ 25	\$	25	15
16	V	6	MAINTENANCE SALARY	Progressive Healthcare Consulting	100.00%	61,032		61,032	16
17	V	6	BUILDING MAINTENANCE AND R&M	Progressive Healthcare Consulting	100.00%	182		182	17
18	V	10	NURSING SALARIES	Progressive Healthcare Consulting	100.00%	149,942		149,942	18
19	V	11	ACTIVITIES PROGRAM	Progressive Healthcare Consulting	100.00%	26		26	19
20	V	12	CLERGY CONSULTANT	Progressive Healthcare Consulting	100.00%	2,326		2,326	20
21	V	12	SOCIAL SERVICE	Progressive Healthcare Consulting	100.00%	6		6	21
22	V	15	EMP. BEN.-NURSING	Progressive Healthcare Consulting	100.00%	23,302		23,302	22
23	V	17	ADMIN SALARY- NON OWNER	Progressive Healthcare Consulting	100.00%	202,732		202,732	23
24	V	19	PROFESSIONAL FEES	Progressive Healthcare Consulting	100.00%	512		512	24
25	V	20	DUES, SUBSCRIPTIONS, LICENSES	Progressive Healthcare Consulting	100.00%	250		250	25
26	V	21	CLERICAL WAGES	Progressive Healthcare Consulting	100.00%	42,969		42,969	26
27	V	21	CLERICAL & GENERAL - OTHER	Progressive Healthcare Consulting	100.00%	458		458	27
28	V	24	SEMINARS	Progressive Healthcare Consulting	100.00%	1,123		1,123	28
29	V	27	EMP. BEN.-NON-NURSING	Progressive Healthcare Consulting	100.00%	47,667		47,667	29
30	V	26	INSURANCE	Progressive Healthcare Consulting	100.00%	3,208		3,208	30
31	V	30	DEPRECIATION	Progressive Healthcare Consulting	100.00%	1,127		1,127	31
32	V	34	STORAGE RENTAL	Progressive Healthcare Consulting	100.00%	87		87	32
33	V	35	AUTO RENTAL	Progressive Healthcare Consulting	100.00%	1,726		1,726	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 538,700	\$ *	538,700	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	CF ST. LOUIS, LLC	100.00%	\$ 1,698	\$ 1,698
16	V	6 REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	2,146	2,146
17	V	19 PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	427	427
18	V	20 DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	3	3
19	V	21 OFFICE EXPENSE		CF ST. LOUIS, LLC	100.00%	1	1
20	V	26 INSURANCE		CF ST. LOUIS, LLC	100.00%	440	440
21	V	32 INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	7,670	7,670
22	V	33 REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	6,286	6,286
23	V						
24	V						
25	V						
26	V	34 RENT	60,740	CF ST. LOUIS, LLC	100.00%		(60,740)
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 60,740			\$ 18,671	\$ * (42,069)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 Medical Supplies	\$ 7,981	ReMED Services		\$ 7,656	\$ (325)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 7,981			\$ 7,656	\$ * (325)

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

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning: 01/01/17

Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06 Maintenance	\$ 17,100	ML Group Design and Development		\$ 17,100	\$	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		\$ 17,100			\$ 17,100	\$ *	39

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

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning: 01/01/17

Ending: 12/31/17

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	19 Payroll Services	\$ 33,020	ProPay HR, LLC	24.00%	\$ 25,095	\$ (7,925)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 33,020			\$ 25,095	\$ * (7,925)

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number Chalet Living And Rehab # 0053843 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	N/A								\$	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 Chalet Living And Rehab

0053843

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 Legacy Healthcare Financial Services
 Street Address 3450 Oakton Street
 City / State / Zip Code Skokie, IL 60076
 Phone Number (847) 679-9797
 Fax Number (847) 683-2900

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	2	FOOD	AVAIL. BED DAYS	30	\$ 1,460	\$	79,935	\$ 65	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	30	6,519		79,935	291	2
3	4	LINEN REPLACEMENT	AVAIL. BED DAYS	30	171		79,935	8	3
4	6	UTILITIES	AVAIL. BED DAYS	30	372		79,935	17	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	30	87,596		79,935	3,913	5
6	9	MEDICAL DIRECTOR CONSU	AVAIL. BED DAYS	30	20,000		79,935	894	6
7	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	30	1,237		79,935	55	7
8	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	30	151,405		79,935	6,764	8
9	12	SOCIAL SERVICE CONSULTA	AVAIL. BED DAYS	30	2,392		79,935	107	9
10	17	ADMINISTRATIVE SALARY	AVAIL. BED DAYS	30	688,242	688,242	79,935	30,748	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	30	467,580		79,935	20,890	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	30	26,590		79,935	1,188	12
13	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	30	5,313,296	5,313,296	79,935	237,377	13
14	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	30	146,833		79,935	6,560	14
15	24	SEMINARS	AVAIL. BED DAYS	30	35,138		79,935	1,570	15
16	26	INSURANCE	AVAIL. BED DAYS	30	29,475		79,935	1,317	16
17	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	30	1,120,380		79,935	50,054	17
18	32	INTEREST	AVAIL. BED DAYS	30	561		79,935	25	18
19	34	RENT	AVAIL. BED DAYS	30	1,359,562		79,935	60,740	19
20	34	STORAGE	AVAIL. BED DAYS	30	2,842		79,935	127	20
21	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	30	694		79,935	31	21
22	35	AUTO RENTAL	AVAIL. BED DAYS	30	99,069		79,935	4,426	22
23									23
24									24
25	TOTALS				\$ 9,561,416	\$ 6,001,539		\$ 427,166	25

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning:

01/01/17

Ending: 12/31/17

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

Name of Related Organization Progressive Healthcare Consulting
 Street Address 3450 Oakton Street
 City / State / Zip Code Skokie, IL 60076
 Phone Number (847) 679-9797
 Fax Number (847) 683-2900

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

1	2	3	4	5	6	7	8	9	
Schedule V	Unit of Allocation	Number of	Total Indirect	Amount of Salary	Facility	Allocation			
Line	(i.e.,Days, Direct Cost,	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6			
Reference	Square Feet)	Allocated Among	Allocated	in Column 6					
Item	Total Units								
1	2	FOOD	AVAIL. BED DAYS	1,374,590	21	\$ 432	\$ 79,935	\$ 25	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,374,590	21	1,049,531	1,049,531	79,935	61,032
3	6	BUILDING MAINTENANCE A	AVAIL. BED DAYS	1,374,590	21	3,133	79,935		182
4	10	NURSING SALARIES	AVAIL. BED DAYS	1,374,590	21	2,578,462	2,578,462	79,935	149,942
5	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,374,590	21	443	79,935		26
6	12	CLERGY CONSULTANT	AVAIL. BED DAYS	1,374,590	21	39,998	79,935		2,326
7	12	SOCIAL SERVICE	AVAIL. BED DAYS	1,374,590	21	95	79,935		6
8	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,374,590	21	400,703	79,935		23,302
9	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,374,590	21	3,486,246	3,486,246	79,935	202,732
10	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,374,590	21	8,800	79,935		512
11	20	DUES, SUBSCRIPTIONS, LICE	AVAIL. BED DAYS	1,374,590	21	4,293	79,935		250
12	21	CLERICAL WAGES	AVAIL. BED DAYS	1,374,590	21	738,904	738,904	79,935	42,969
13	21	CLERICAL & GENERAL - OTI	AVAIL. BED DAYS	1,374,590	21	7,880	79,935		458
14	24	SEMINARS	AVAIL. BED DAYS	1,374,590	21	19,314	79,935		1,123
15	27	EMP. BEN.-NON-NURSING	AVAIL. BED DAYS	1,374,590	21	819,705	79,935		47,667
16	26	INSURANCE	AVAIL. BED DAYS	1,374,590	21	55,168	79,935		3,208
17	30	DEPRECIATION	AVAIL. BED DAYS	1,374,590	21	19,384	79,935		1,127
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,374,590	21	1,500	79,935		87
19	35	AUTO RENTAL	AVAIL. BED DAYS	1,374,590	21	29,674	79,935		1,726
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 9,263,664	\$ 7,853,142	\$ 538,700	25

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 CF St. Louis LLC
 Street Address 3450 Oakton Street
 City / State / Zip Code Skokie, IL 60076
 Phone Number (847) 676-5300
 Fax Number (847) 676-5348

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	5	UTILITIES	AVAIL. BED DAYS	1,789,215	30	\$ 37,998	\$ 79,935	\$ 1,698	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	48,042	79,935	2,146	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	9,551	79,935	427	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	76	79,935	3	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,789,215	30	32	79,935	1	5
6	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	9,839	79,935	440	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,789,215	30	171,679	79,935	7,670	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,789,215	30	140,710	79,935	6,286	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					\$ 417,927	\$	\$ 18,671	25

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 ReMED Services LLC
 Street Address 3424 Oakton Street, Suite 102
 City / State / Zip Code Skokie, IL
 Phone Number (847) 440-2600
 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	10	Medical Supplies	Direct		\$	\$		\$ 7,656	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				\$	\$		\$ 7,656	25

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization ML Group Design and Development
 Street Address 3424 Oakton Street
 City / State / Zip Code Skokie, IL
 Phone Number (847) 676-5300
 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	06	Maintenance	Direct		\$	\$		\$ 17,100	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 17,100	25

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 ProPay HR LLC

Street Address 2201 W. Main St.

City / State / Zip Code Evanston, IL 60202

Phone Number (847) 905-3268

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	19	Payroll Services	Direct		\$	\$		\$ 25,095	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				\$	\$		\$ 25,095	25

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Chalet Living And Rehab

0053843

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	The Private Bank		X	Mortgage			\$	28,088,294		\$	1,523,526	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	The Private Bank		X					63,370			68,618	6								
7												7								
8												8								
9	TOTAL Facility Related						\$	28,151,664		\$	1,592,144	9								
B. Non-Facility Related*																				
10	Interest Income		X								(32,486)	10								
11	Allocated from Legacy HC		X								25	11								
12	Allocated from CF St. Louis		X								7,670	12								
13												13								
14	TOTAL Non-Facility Related						\$			\$	(24,791)	14								
15	TOTALS (line 9+line14)						\$	28,151,664		\$	1,567,353	15								

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (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 2016 report.		\$	238,807	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.)		\$	254,882	2
3. Under or (over) accrual (line 2 minus line 1).		\$	16,075	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	217,647	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.)		\$	312	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.		\$	234,034	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	188,105	8
	2013	189,529	9
	2014	183,129	10
	2015	220,514	11
	2016	248,596	12

2017 - Accrual: \$241,023 x 0.90 = \$217,647

***Beginning Accrual Adjusted**

Allocated from CF St. Louis: \$6,286

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	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:

- 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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2016 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 real estate tax bill.

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Chalet Living And Rehab COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0053843
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
2.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
3.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
4.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
5.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
6.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
7.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
8.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
9.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
10.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
		TOTALS	\$ <hr/> <hr/>	\$ <hr/> <hr/>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Chalet Living And Rehab

0053843 Report Period Beginning:

01/01/17 Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 76,920 B. General Construction Type: Exterior Masonry Frame _____ Number of Stories 4

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

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2014</u>	<u>\$ 1,752,000</u>	<u>1</u>
2	<u>Alloc from Legacy Real Prop/CHStLouis</u>			<u>29,039</u>	<u>2</u>
3	TOTALS			\$ 1,781,039	3

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	219	2014	1979	\$ 14,673,000	\$	35	\$ 419,229	\$ 419,229	\$ 1,457,774
5									
6									
7									
8									
Improvement Type**									
9	Various		2012	858,803		20	42,940	42,940	128,826
10	Various		2013	957,090		20	47,855	47,855	143,566
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			349,077		16,436	16,436	32,531	68
69								69
70		\$	16,837,970	\$	526,460	526,460	1,762,697	70

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

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 16,837,970	\$		\$ 526,460	\$ 526,460	\$ 1,762,697	1
2	Locker Double Tier 6 Door Assembled	2014	1,671		20	84	84	335	2
3	Install Delayed Egress Locks And Associated Components	2014	11,900		20	595	595	2,380	3
4	Build & Install Wall Decorating Panel-Remove Wallpaper & Pain	2014	18,650		20	933	933	3,731	4
5	Wall, Install New Led Lights Strip & Outlets, Build & Stall New	2014			20				5
6	Kitchen Cabinets With Sink In The Basement, Build & Install	2014			20				6
7	Tv Panel; Remove Hallway By The Kitchen; Staff Launch Rooms	2014			20				7
8	Patio Ceiling And Wallcovering	2014	4,940		20	247	247	988	8
9	One Lot Of Signage	2014	4,947		20	247	247	989	9
10	Renovate Room 200 & 227; Repair Countertrop By Nurses	2014	14,650		20	733	733	2,931	10
11	Station On 2Nd Floor;Renovate Two Elevators;Demo Floors & Ce	2014			20				11
12	Install New Cement Baord On The Walls; Install New Vct Floor T	2014			20				12
13	Install New Stainless Steel Ceiling Panels; Install New Led Lightin	2014			20				13
14	Install New Realigns; Seat Esprsd	2014	3,787		20	189	189	757	14
15	Install Owner Supplied Crossville Laminam Col Sketch Avorio Th	2014	5,857		20	293	293	1,172	15
16	Porcelain Panels On The Walls Of Two Elevators Of Compost	2014			20				16
17	Provide Electrical Outlets And Install New Computers And	2014	5,950		20	298	298	1,191	17
18	Other Repairing Work	2014			20				18
19	Replacement Of Valve Tamper Panel & Fire Alarm System Device	2014	5,233		20	262	262	1,047	19
20	Flashcan Address Monitor Module; Labor & Materials Fire Alarn	2014	3,831		20	192	192	767	20
21	Fire Pump Repairs & Fire Pump Power Monitor	2014	1,511		20	76	76	303	21
22	Condensor Tube Cleaning; Oil Filter;Filter Replacement Labor	2014	4,746		20	237	237	949	22
23	Install Summer Annuals To 5 Pots And All Flower Beds	2014	4,250		20	213	213	851	23
24	Amend Soil With 2 Cubic Yards	2014			20				24
25	Painting - Exterior Railings And Gate	2015	6,876		20	344	344	1,032	25
26	Elevator Handrails	2015	3,618		20	181	181	543	26
27	Pavement Repairs - Wheelstops/Milling/Priming/Striping	2015	43,290		20	2,165	2,165	6,494	27
28	32 Fire Rated Drop Ceiling Light Fixtures-4Th Floor	2015	9,280		20	464	464	1,392	28
29	Plumbing - Faucet/Levers/Valves/Drains	2015	4,950		20	248	248	743	29
30	Concrete Work On Smoking Deck	2015	2,500		20	125	125	375	30
31	Repaired Chiller	2015	9,436		20	472	472	1,416	31
32	Installed Water Heater In Kitchen	2015	3,400		20	170	170	510	32
33	Shower Room - Remove Wall Tiles/Framing/Valves	2016	11,950		20	598	598	1,196	33
34	TOTAL (lines 1 thru 33)		\$ 17,025,193	\$		\$ 535,821	\$ 535,821	\$ 1,794,784	34

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

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning:

01/01/17

Ending:

12/31/17

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		\$ 17,025,193	\$		\$ 535,821	\$ 535,821	\$ 1,794,784	1
2	Installed Ceiling Tile Boxes Firelight Fixtures	2016	9,680		20	484	484	968	2
3	Upgrade Elevator Doors & Sector	2016	11,655		20	583	583	1,166	3
4	Installed 4Th Floor Tamper/Fire Alarm System	2016	5,033		20	252	252	504	4
5	Repaired Deck - Permits/Gate Handle/Electrical Switch	2016	12,550		20	1,255	1,255	2,510	5
6	Repaired 3Rd/4Th Floor Bathrooms - Tiles/Shower Heads/Pipes	2016	4,630		20	463	463	926	6
7	Installation For Door Security On 6 Doors	2016	6,546		20	327	327	654	7
8	Repaired 4Th Floor Main Line/Ac Condensation	2016	2,775		20	139	139	278	8
9	Architect Fees - Shower Room	2016	2,500		20	125	125	250	9
10	Installed New Insulation And Drywall/Prime/Paint - Back Loading	2016	7,945		20	397	397	794	10
11	Installed New Garbage Disposal	2016	3,250		20	163	163	326	11
12	Repaired Elevator	2016	2,511		20	126	126	252	12
13	Installed Ceiling Tile/Hvac Film Tape/Fire Barriers	2016	2,618		20	131	131	262	13
14	Remove Wall, Drop Ceiling Installment, Install Wallpaper/Vinyl T	2017	11,900		20	545	545	545	14
15	Wiring On Wander Guard Security System	2017	4,750		20	178	178	178	15
16	Fire Damper Inspection & Service	2017	6,883		20	258	258	258	16
17	Install New Fire Proof Insulation/Framing/Drywall & Paint	2017	2,884		20	96	96	96	17
18	Replace Defective Batery/Block Heater/Water-Pump/Breather Ho	2017	5,795		20	869	869	869	18
19	Radiator/Alternator/Pulley	2017	4,486		20	299	299	299	19
20	Replacement Of South Exit Door	2017	3,240		20	54	54	54	20
21	Pump Repair	2017	3,933		20	16	16	16	21
22	Serving Shelf, Freezer	2017	3,571		20	60	60	60	22
23	Elevator Repairs	2017	6,641		20	498	498	498	23
24	Elevator Repairs	2017	39,537		20	2,636	2,636	2,636	24
25	Electrical Work	2017	7,925		20	396	396	396	25
26	Boiler - Replacement Of Flame Safety And Ignition Controls	2017	5,851		20	293	293	293	26
27	Repairs Of Mixing Valve And Gate Valve	2017	3,773		20	189	189	189	27
28	Install Three 4" Cast Iron P-Traps And Section Of Pipe - Reconn	2017	2,935		20	147	147	147	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 17,210,989	\$		\$ 546,799	\$ 546,799	\$ 1,810,207	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	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		\$ 17,210,989	\$		\$ 546,799	\$ 546,799	\$ 1,810,207	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 17,210,989	\$		\$ 546,799	\$ 546,799	\$ 1,810,207	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	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		\$ 17,210,989	\$		\$ 546,799	\$ 546,799	\$ 1,810,207	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 17,210,989	\$		\$ 546,799	\$ 546,799	\$ 1,810,207	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$	34

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

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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Legacy Real Prop/CFStLouis	2016	47,476		35	1,356	1,356	2,713	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis LLC	2016	294,760		20	14,738	14,738	29,476	9
10	Allocated from CF St. Louis LLC	2017	6,841		20	342	342	342	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 349,077	\$		\$ 16,436	\$ 16,436	\$ 32,531	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	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		\$ 349,077	\$		\$ 16,436	\$ 16,436	\$ 32,531	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 349,077	\$		\$ 16,436	\$ 16,436	\$ 32,531	34

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

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	\$ 1,720,007	\$ 1,127	\$ 172,000	\$ 170,873	10	\$ 511,253	71
72	Current Year Purchases	18,693		1,499	1,499	10	1,499	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,738,700	\$ 1,127	\$ 173,499	\$ 172,372		\$ 512,752	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)	\$ 20,730,728	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,127	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 720,299	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 719,172	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,322,960	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.

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning: 01/01/17

Ending: 12/31/17

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	<u>Allocated from Legacy HC</u>			<u>127</u>			5
6	<u>Allocated from Progressive HC</u>			<u>87</u>			6
7	TOTAL			\$ 214			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> /2018</u>	\$ _____
13.	<u> /2019</u>	\$ _____
14.	<u> /2020</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: \$ 6,536 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from Legacy HC</u>		\$ _____	\$ <u>4,426</u>	17
18	<u>Allocated from Progressive HC</u>			<u>1,726</u>	18
19					19
20					20
21	TOTAL		\$ _____	\$ 6,152	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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs					\$ 180,965							\$ 180,965	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					104,361							104,361	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs					256,875							256,875	4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39 - 02	# of prescrpts							135,123					135,123	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):							45,590		191,832					237,422	13
14	TOTAL				\$			\$ 587,791		\$ 326,955				\$	914,746	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.

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning: 01/01/17

Ending:

12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 19,503	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,844,241	1,844,241	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	125,016	125,016	6
7	Other Prepaid Expenses	8,450	70,472	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	274,193	274,193	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,251,900	\$ 2,333,425	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,752,000	13
14	Buildings, at Historical Cost		11,891,700	14
15	Leasehold Improvements, at Historical Cost	109,955	2,017,771	15
16	Equipment, at Historical Cost	151,836	1,235,709	16
17	Accumulated Depreciation (book methods)	(12,399)	(2,559,382)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	1,179,434	5,486,644	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,428,826	\$ 19,824,442	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,680,726	\$ 22,157,867	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 762,413	\$ 767,161	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	63,370	736,946	29
30	Accrued Salaries Payable	280,863	280,863	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,161	10,161	31
32	Accrued Real Estate Taxes(Sch.IX-B)		217,647	32
33	Accrued Interest Payable		139,584	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	56,134	156,134	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,172,941	\$ 2,308,496	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		27,414,719	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	1,829,578		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,829,578	\$ 27,414,719	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,002,519	\$ 29,723,215	46
47	TOTAL EQUITY(page 18, line 24)	\$ 678,207	\$ (7,565,348)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,680,726	\$ 22,157,867	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 328,386	1
2	Restatements (describe):		2
3	Equity Adjustment	(122,392)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 205,994	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	472,213	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	()	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)	\$ 472,213	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)	\$ 678,207	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning: 01/01/17

Ending:

12/31/17

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	\$ 21,184,110	1
2	Discounts and Allowances for all Levels	(9,239,824)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,944,286	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,289,225	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,289,225	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	139,174	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,200	19
20	Radiology and X-Ray		20
21	Other Medical Services	8,013	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 160,387	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	32,486	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 32,486	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	15,075	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,075	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,441,459	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,848,331	31
32	Health Care	4,577,619	32
33	General Administration	1,982,914	33
B. Capital Expense			
34	Ownership	3,396,614	34
C. Ancillary Expense			
35	Special Cost Centers	1,634,089	35
36	Provider Participation Fee	529,679	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,969,246	40
41	Income before Income Taxes (line 30 minus line 40)**	472,213	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 472,213	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 10,515,699	44
45	Private Pay - Net Inpatient Revenue	443,770	45
46	Medicare - Net Inpatient Revenue	847,693	46
47	Other-(specify) <u>Insurance</u>	137,124	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,944,286	49

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

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

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

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

Facility Name & ID Number Chalet Living And Rehab

0053843

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,949	2,070	\$ 89,517	\$ 43.24	1
2	Assistant Director of Nursing	1,976	2,178	85,740	39.37	2
3	Registered Nurses	21,666	23,646	784,515	33.18	3
4	Licensed Practical Nurses	44,451	47,992	1,426,936	29.73	4
5	CNAs & Orderlies	94,920	102,729	1,291,956	12.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,207	13,255	247,659	18.68	8
9	Activity Director	2,441	2,709	60,351	22.28	9
10	Activity Assistants	6,628	7,303	83,983	11.50	10
11	Social Service Workers	8,992	10,034	216,763	21.60	11
12	Dietician					12
13	Food Service Supervisor	3,140	3,406	76,875	22.57	13
14	Head Cook	5,064	5,338	74,229	13.91	14
15	Cook Helpers/Assistants	20,250	21,961	251,658	11.46	15
16	Dishwashers					16
17	Maintenance Workers	6,087	6,529	112,647	17.25	17
18	Housekeepers	22,966	24,768	277,617	11.21	18
19	Laundry	6,407	6,845	79,039	11.55	19
20	Administrator	1,999	2,096	85,615	40.85	20
21	Assistant Administrator	1,821	2,008	55,486	27.63	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,661	11,471	182,344	15.90	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	3,563	3,996	90,776	22.72	31
32	Other Health Care(specify)					32
33	Other(specify)	1,140	1,267	15,980	12.61	33
34	TOTAL (lines 1 - 33)	278,328	301,601	\$ 5,589,686 *	\$ 18.53	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	Monthly	\$ 4,313	01-03	35
36	Medical Director	Monthly	18,075	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	29,421	10-03	38
39	Pharmacist Consultant	Monthly	16,939	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	863	11-03	44
45	Social Service Consultant	Monthly	3,162	12-03	45
46	Other(specify)				46
47	Psychological Consultant	Monthly	500	12-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 73,273		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 **Chalet Living And Rehab**

0053843

Report Period Beginning: **01/01/17**

Ending: **12/31/17**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Anthony Carbonari	Administrator	0	\$ 85,831	Workers' Compensation Insurance	\$ 118,432	IDPH License Fee	\$	
Rachel Krumm	Assistant Admin	0	18,842	Unemployment Compensation Insurance	60,685	Advertising: Employee Recruitment	142	
Angela Pfamatter	Assistant Admin	0	21,250	FICA Taxes	419,190	Health Care Worker Background Check		
Anuoluwapo Osideko	Assistant Admin	0	15,178	Employee Health Insurance	207,982	(Indicate # of checks performed <u>466</u>)	4,658	
				Employee Meals		Patient Background Checks	<u>76</u> 764	
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	18,739	
				Union Pension	34,802	Licenses and Permits	21,815	
				401K Expense	13,420	Allocated from Legacy HC	1,188	
				Employee Physical Exams	13,327	Allocated from Progressive HC	250	
				Other Employee Benefits	16,767	See Supplemental Schedule	3	
				Voluntary Benefit Contributions	9,795	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 141,101	TOTAL (agree to Schedule V, line 22, col.8)		\$ 47,559		
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	3,123
							Allocated from Legacy HC	1,570
							Allocated from Progressive HC	1,123
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)							\$ 5,816	
C. Professional Services								
Vendor/Payee	Type		Amount					
Marcum LLP	Accounting Fees		\$ 31,155					
Documentation Solutions	Compliance Audit		5,366					
Compliance Resources	Compliance Audit		911					
Paycor	Payroll Processing		33,020					
Achieve Accreditation	Accreditation Services		3,645					
IIT/Sourcotech	Data Processing		1,830					
Lexis Nexis	Data Processing		68					
See Attached	Legal Services		40,856					
BlueOrange Compliance	Cyber Security Solutions		1,805					
McCabe Kirshner	Insurance Solutions Consulting		1,198					
ML Group Design	Building Design Services		1,640					
See Supplemental Schedule			18,340					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 139,833					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Chalet Living And Rehab# 0053843

Report Period Beginning:

01/01/17

Ending:

12/31/17**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC - \$19,721
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 45,174 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Chalet Living & Rehab Center, IDPH #0051615
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 529,679
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. \$ Has any meal income been offset against related costs? No 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? 100% Ln 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: 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