



Facility Name & ID Number Community Nursing & Rehabilitation Center, LLC

# 0044750

Report Period Beginning:

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	<u>153</u>	Skilled (SNF)	<u>153</u>	<u>55,845</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>153</u>	TOTALS	<u>153</u>	<u>55,845</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>20,140</u>	<u>3,498</u>	<u>6,999</u>	<u>30,637</u>	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>20,140</u>	<u>3,498</u>	<u>6,999</u>	<u>30,637</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.86%

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

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 04/01/2000

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

YES  Date 04/01/2000 NO

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

YES  NO  If YES, enter number of beds certified 153 and days of care provided 3,426

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.

**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	430,925	67,772	-	498,697		498,697	-	498,697		1
2	Food Purchase		225,170		225,170		225,170	(20,245)	204,925		2
3	Housekeeping	215,900	31,407	-	247,307		247,307	-	247,307		3
4	Laundry	97,699	17,214	-	114,913	-	114,913	-	114,913		4
5	Heat and Other Utilities			209,492	209,492		209,492	-	209,492		5
6	Maintenance	75,608	33,146	106,365	215,119		215,119	-	215,119		6
7	Other (specify):*	-	-	-	-		-	-	-		7
8	<b>TOTAL General Services</b>	<b>820,132</b>	<b>374,709</b>	<b>315,857</b>	<b>1,510,698</b>	<b>-</b>	<b>1,510,698</b>	<b>(20,245)</b>	<b>1,490,453</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	-	-	12,500	12,500		12,500	-	12,500		9
10	Nursing and Medical Records	3,071,143	204,510	46,754	3,322,407		3,322,407	40,604	3,363,011		10
10a	Therapy	-	-	-	-		-	-	-		10a
11	Activities	158,252	3,789	3,590	165,631		165,631	-	165,631		11
12	Social Services	181,107	620	992	182,719		182,719	-	182,719		12
13	CNA Training	-	-	-	-		-	-	-		13
14	Program Transportation	-	-	-	-		-	-	-		14
15	Other (specify):*	-	-	-	-		-	-	-		15
16	<b>TOTAL Health Care and Programs</b>	<b>3,410,502</b>	<b>208,919</b>	<b>63,836</b>	<b>3,683,257</b>	<b>-</b>	<b>3,683,257</b>	<b>40,604</b>	<b>3,723,861</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	121,871	-	360,000	481,871		481,871	(179,230)	302,641		17
18	Directors Fees			-	-		-	-	-		18
19	Professional Services			197,217	197,217		197,217	(36,981)	160,236		19
20	Dues, Fees, Subscriptions & Promotions			50,065	50,065		50,065	14,381	64,446		20
21	Clerical & General Office Expenses	194,197	37,647	63,970	295,814		295,814	(28,648)	267,166		21
22	Employee Benefits & Payroll Taxes			726,083	726,083		726,083	15,501	741,584		22
23	Inservice Training & Education			2,069	2,069		2,069	-	2,069		23
24	Travel and Seminar			5,387	5,387		5,387	-	5,387		24
25	Other Admin. Staff Transportation		-	8,578	8,578		8,578	-	8,578		25
26	Insurance-Prop.Liab.Malpractice			280,345	280,345		280,345	18,325	298,670		26
27	Other (specify):*	-	-	-	-		-	-	-		27
28	<b>TOTAL General Administration</b>	<b>316,068</b>	<b>37,647</b>	<b>1,693,714</b>	<b>2,047,429</b>	<b>-</b>	<b>2,047,429</b>	<b>(196,652)</b>	<b>1,850,777</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,546,702</b>	<b>621,275</b>	<b>2,073,407</b>	<b>7,241,384</b>	<b>-</b>	<b>7,241,384</b>	<b>(176,293)</b>	<b>7,065,091</b>		<b>29</b>

\*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 &amp; ID Number

Community Nursing &amp; Rehabilitation Center, LLC

#0044750

Report Period Beginning:

Ending:

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## 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			166,331	166,331		166,331	216,911	383,242			30
31	Amortization of Pre-Op. & Org.			-	-		-	-	-			31
32	Interest			98,354	98,354		98,354	267,187	365,541			32
33	Real Estate Taxes			-	-		-	92,117	92,117			33
34	Rent-Facility & Grounds			663,984	663,984		663,984	(663,984)	-			34
35	Rent-Equipment & Vehicles			50,630	50,630		50,630	-	50,630			35
36	Other (specify):* Mortgage Insurance			-	-		-	37,687	37,687			36
37	<b>TOTAL Ownership</b>			979,299	979,299	-	979,299	(50,082)	929,217			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation	-	-	-	-		-	-	-			38
39	Ancillary Service Centers	2,923	488,186	1,306,166	1,797,275		1,797,275	-	1,797,275			39
40	Barber and Beauty Shops	-	-	14	14		14	-	14			40
41	Coffee and Gift Shops	-	-	-	-		-	-	-			41
42	Provider Participation Fee			243,021	243,021		243,021	-	243,021			42
43	Other (specify):* Non-Allowable Cos	42,706	-	312,317	355,023		355,023	(355,023)	-			43
44	<b>TOTAL Special Cost Centers</b>	45,629	488,186	1,861,518	2,395,333	-	2,395,333	(355,023)	2,040,310			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	4,592,331	1,109,461	4,914,224	10,616,016	-	10,616,016	(581,398)	10,034,618			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	(4,744)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,946)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	64,684	30		9
10	Interest and Other Investment Income	(17,210)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(264)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(12,305)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(240,000)	43		24
25	Fund Raising, Advertising and Promotional	(60,096)	43		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 See Page 5A	(245,101)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (518,982)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(62,416)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (62,416)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (581,398)		37

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		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		X		45
46	Other-Attach Schedule		X		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	52

Community Nursing & Rehabilitation Center, LLC

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (8,129)	43	1
2	NH X Ray	(14,482)	43	2
3	Miscellaneous Income	(5,118)	21	3
4	Cable TV	(17,279)	43	4
5	Non-Allowable Lobbying Expense	(5,453)	20	5
6	Medicare consolidated billing expenses	(14,773)	43	6
7	Computer services	(637)	19	7
8	Adjust Owner Compensation	(179,230)	17	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(245,101)		49

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**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
Mark Weldler	29.50	Pine Acres Rehab & Living Center, LLC	DeKalb	Community Nursing & Rehab Realty, LLC	Naperville	Real Estate
Steve Jeremias	29.50					
Malka Mermelstein	.50	The Springs at Crystal Lake, LLC	Crystal Lake			
Herman Mermelstein Decl of Trust 27-610789	.50			Pine Acres Realty, LLC	DeKalb	Real Estate
Estate of Hirsch Wolf	40					
				TS Realty, LLC	Crystal Lake	Real Estate

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	19 Accounting	\$	Community Nursing & Rehab Realty, LLC	100.00%	\$ 16,565	\$ 16,565	1
2	V	20 Licenses		Community Nursing & Rehab Realty, LLC	100.00%	250	250	2
3	V	26 Insurance		Community Nursing & Rehab Realty, LLC	100.00%	56,012	56,012	3
4	V	30 Depreciation		Community Nursing & Rehab Realty, LLC	100.00%	152,227	152,227	4
5	V	32 Interest	473	Community Nursing & Rehab Realty, LLC	100.00%	284,870	284,397	5
6	V	33 Real Estate Tax		Community Nursing & Rehab Realty, LLC	100.00%	92,117	92,117	6
7	V	34 Building Rent	663,984	Community Nursing & Rehab Realty, LLC	100.00%		(663,984)	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 664,457			\$ 602,041	\$ * (62,416)	14

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

Facility Name & ID Number Community Nursing & Rehabilitation Cente # 0044750 Report Period Beginning: \_\_\_\_\_ 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	Steve Jeremias	Manager	Administrative	29.50	See Att Sch 7A	35	70.00	Guar Pmts	\$ 76,707	L17, C3	1
2	Mark Weldler	Manager	Finance	29.50	See Att Sch 7A	35	70.00	Guar Pmts	104,063	L17, C3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 180,770		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

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**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 N/A  
 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		N/A							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 Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	2015 Subaru		X	Facility Vehicle	\$651.00	04/30/15	\$ 37,666	\$ 17,834	04/30/20	0.0190	\$ 456	1								
2	Midland States Bank f/k/a Heartland		X	Mortgage	\$52,698.00	6/27/14	7,247,900	6,800,898	07/01/44	0.0415	284,871	2								
3	Lenovo		X	Computer Equipment	\$1,672.72	9/22/14	54,350		10/22/17	0.0900	3,728	3								
4	Lenovo		X	Computer Equipment	\$127.98	10/15/14	4,271		12/15/17	0.0900	19	4								
5												5								
<b>Working Capital</b>																				
6	Lake Forest Bank		X	Working Capital	Varies	9/15/11	1,000,000	908,387	9/1/2017	0.0500	47,095	6								
7	Member Loan	X		Working Capital	Varies	8/29/2016	1,000,000	1,000,000	Demand	0.0550	47,055	7								
8												8								
9	<b>TOTAL Facility Related</b>				\$55,149.70		\$ 9,344,187	\$ 8,727,119			\$ 383,224	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11											Nonallowable Related Party Interest	(8,555)	11							
12											Interest Income	(9,128)	12							
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (17,683)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 9,344,187	\$ 8,727,119			\$ 365,541	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 37,687 Line # 36

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

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

**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.			\$	<b>94,600</b>	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.)		2016	\$	<b>93,217</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(1,383)</b>	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>93,500</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>92,117</b>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2012	<b>101,323</b>	8	<b>FOR BHF USE ONLY</b>	
	2013	<b>101,891</b>	9	13	FROM R. E. TAX STATEMENT FOR 2016 \$
	2014	<b>102,627</b>	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2015	<b>98,542</b>	11	15	LESS REFUND FROM LINE 6 \$
	2016	<b>93,217</b>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
<b>Real estate tax accrual based on 94.6% of 2015 tax bill</b>					
<b>98,542 X 94.6% = 93,217. Use 93,500</b>					

**NOTES:**

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

**2016 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Community Nursing & Rehabilitation Center, LLC COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0044750

CONTACT PERSON REGARDING THIS REPORT Mark Weldler

TELEPHONE (630) 355-3300 FAX #: (630) 355-1417

**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</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>07-12-403-042</u>	<u>Nursing Home</u>	\$ <u>93,217.40</u>	\$ <u>93,217.40</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>93,217.40</u></u>	\$ <u><u>93,217.40</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 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 Community Nursing & Rehabilitation Center, LLC

# 0044750

Report Period Beginning:

Ending:

12/31/17

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 62,087 B. General Construction Type: Exterior Brick Frame Steel Number of Stories Two

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Use</u>	<u>164,335</u>	<u>2000</u>	<u>\$ 453,622</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>164,335</b>		<b>\$ 453,622</b>	<b>3</b>

**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	153	2000	1986	\$ 4,184,589	\$	40	\$ 104,615	\$ 104,615	\$ 1,856,922
5									
6									
7									
8									
	<b>Improvement Type**</b>								
9	CABLE	2000		4,305	108	40	108		1,917
10	ELEVATOR DOOR	2000		4,389	110	40	110		1,943
11	PARKING LOT	2000		38,200	955	40	955		16,872
12	LANDSCAPING	2000		8,736	218	40	218		3,833
13	SIGN	2000		4,541	114	40	114		2,004
14	ARCHITECT FEES	2000		3,060	77	40	77		1,364
15	DOOR LOCK	2000		2,248	56	40	56		985
16	CLOSETS	2000		7,729	193	40	193		3,361
17	COVE BASE	2000		4,459	111	40	111		1,915
18	HANDRAILS AND KICKPLATES	2000		15,146	379	40	379		6,538
19	LIGHTING	2000		65,796	1,645	40	1,645		28,376
20	TILE	2000		2,317	58	40	58		1,000
21	FLOORING	2000		16,378	409	40	409		7,006
22	EXIT DOORS	2000		1,598	40	40	40		690
23	WINDOW AND CUBICLE TREATMENTS	2000		34,021	851	40	851		14,680
24	LIGHTING	2000		1,729	43	40	43		742
25	CARPETING	2000		27,139	678	40	678		11,696
26	FIRE PANEL	2000		4,500	113	40	113		1,949
27	NURSE'S STATION	2000		8,913	223	40	223		3,828
28	DOOR HANDLES	2000		1,644	41	40	41		704
29	CUBICLE TRACK	2000		915	23	40	23		393
30	MOTOR	2000		13,276	332	40	332		5,810
31	STOVE HOODS	2000		1,429	36	40	36		615
32	COVER BASE - RESIDENTS' ROOMS	2001		865		10			865
33	CERAMIC TILES	2001		10,930		10			10,930
34	CEILING & LIGHTING	2001		9,063		10			9,063
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

Facility Name &amp; ID Number Community Nursing &amp; Rehabilitation Center, LLC

# 0044750

Report Period Beginning:

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	
37	RENOVATIONS - THERAPY ROOM	2001	\$ 10,558	\$	10	\$	\$	\$ 10,558	37
38	TILE & COVE BASE - BASEMENT	2001	2,327		10			2,327	38
39	SHAMPOO STATION	2001	5,431		10			5,431	39
40	COVE BASE - SECOND FLOOR	2001	1,699		10			1,699	40
41	WALLPAPER/COVEBASE/CARPETING/LIGHTING	2001	1,403		10			1,403	41
42	ABS PUMP	2001	11,908		10			11,908	42
43	CARPETING	2001	14,572		10			14,572	43
44	FLOORING	2001	1,320		10			1,320	44
45	2ND FLOOR RENOVATIONS	2001	38,875		10			38,875	45
46	AVERY	2001	2,419		10			2,419	46
47	KITCHEN - COOLING AIR UNIT	2001	2,275		10			2,275	47
48	WALLCOVERINGS	2001	12,289		10			12,289	48
49	SIGNAGE/ELECTRIC BALLAST (ADMISSIONS OFFICE)	2001	3,131		10			3,131	49
50	ROOM CURTAIN DIVIDER	2001	2,003		10			2,003	50
51	HANDRAILS & BUMPER GUARDS	2001	17,855		10			17,855	51
52	FIRE ALARM TRANSFORMER	2001	1,715		10			1,715	52
53	TEMP CONTROL ON AIR HANDLER	2001	9,519		10			9,519	53
54	COVEBASE/LANDSCAPING/LIGHTING/FLOORING	2001	2,642		10			2,642	54
55	LIGHTING - CORRIDORS & RESIDENT ROOMS	2001	20,544		10			20,544	55
56	NEW BEARING & SHAFT	2001	1,402		10			1,402	56
57	DIALYSIS ROOM RENOVATIONS	2001	23,351		10			23,351	57
58	ASPHALT SEALCOATING & STRIPING	2001	1,405		10			1,405	58
59	KITCHEN TILE	2001	930		10			930	59
60	SEPTIC TANK PUMPS	2001	13,862		10			13,862	60
61	CARPETING	2001	5,729		10			5,729	61
62	PAINTING & WALLPAPER	2001	20,440		10			20,440	62
63	PAINTING & WALLPAPER	2001	11,875		10			11,875	63
64	PAINTING & WALLPAPER	2001	4,500		10			4,500	64
65	NEW DOORS	2002	1,731		10			1,731	65
66	MURAL FOR SECOND FLOOR DINING ROOM	2002	7,000		10			7,000	66
67	NEW TROUGH IN LAUNDRY ROOM	2002	6,300		10			6,300	67
68	WINDOW MOLDINGS	2002	210		10			210	68
69	NEW THRESHHOLDS	2002	205		10			205	69
70	TOTAL (lines 4 thru 69)		\$ 4,739,340	\$ 6,813		\$ 111,428	\$ 104,615	\$ 2,257,426	70

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

Facility Name &amp; ID Number Community Nursing &amp; Rehabilitation Center, LLC

# 0044750

Report Period Beginning:

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	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,739,340	\$ 6,813		\$ 111,428	\$ 104,615	\$ 2,257,426	1
2	NEW PVC PIPING IN KITCHEN	2002	1,320		10			1,320	2
3	UPGRADE BACKFLOW SYSTEM	2002	1,695		10			1,695	3
4	ALARM FOR RAMP EXIT	2002	1,443		10			1,443	4
5	FLOORING IN ELEVATOR	2002	856		10			856	5
6	CORNER GUARDS/WATER SOFTENER	2002	1,328		10			1,328	6
7	NEW DRAINAGE PIPES - DISPOSAL	2002	9,985		10			9,985	7
8	CORNER GUARDS	2003	276		10			276	8
9	UPGRADE DIALYSIS ROOM	2003	28,103		10			28,103	9
10	NEW AWNINGS FOR PATIO	2003	3,940		10			3,940	10
11	INSTALL GREASE TRAP IN KITCHEN	2003	3,250		10			3,250	11
12	NEW COIL FOR AIR HANDLER	2003	3,493		10			3,493	12
13	INSTALL LASER EYE ON ELEVATOR	2003	1,590		10			1,590	13
14	UPGRADE DIALYSIS ROOM	2004	30,778		10			30,778	14
15	NEW ROOF	2004	8,600		10			8,600	15
16	REMODEL VESTIBULE, NEW FLOORING	2004	10,044		10			10,044	16
17	INSTALL NEW SMOKE DETECTORS	2004	4,911		10			4,911	17
18	NEW OXYGEN ROOM	2004	5,688		10			5,688	18
19	NEW ELEVATOR TANK, PUMP AND MOTOR	2004	11,960		10			11,960	19
20	ROOF REPLACEMENT	2005	5,800		10			5,800	20
21	WIRE GLASS FOR RECEPTION WINDOW	2005	1,348		10			1,348	21
22	NEW CEMENT WALKWAYS	2005	2,400		10			2,400	22
23	NEW WALL HUNG SINK	2006	3,410		10	1	1	3,410	23
24	MOTOR FOR A/C	2006	664		10	4	4	664	24
25	NEW PUMP SYSTEM	2006	5,108		10			5,108	25
26	NEW HOT WATER HEATER	2006	7,998		10			7,998	26
27	SOLID STATE STARTER	2006	3,900		10			3,900	27
28	PUMP	2006	1,553		10	4	4	1,553	28
29	NEW FIRE ALARM	2006	6,800		10			6,800	29
30	NEW PUMP FOR BASEMENT A/C	2006	988		10			988	30
31	PAVE PARKING LOT	2006	3,500		10			3,500	31
32	NEW TIME CLOCK	2006	4,345		10			4,345	32
33	REPLACE HVAC ROOF TOP UNIT	2007	3,511		10	175	175	3,511	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,919,925	\$ 6,813		\$ 111,612	\$ 104,799	\$ 2,438,011	34

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

Facility Name &amp; ID Number Community Nursing &amp; Rehabilitation Center, LLC

# 0044750

Report Period Beginning:

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	<b>Totals from Page 12B, Carried Forward</b>		\$ 4,919,925	\$ 6,813		\$ 111,612	\$ 104,799	\$ 2,438,011	1
2	BALANCE OF TIME CLOCK	2007	4,345	56	10	217	161	4,345	2
3	HOT WATER HEATER	2007	9,212	462	10	462		9,212	3
4	SECURITY CAMERAS	2008	5,458	546	10	546		5,187	4
5	RELOCATE GAS LINE	2008	21,900	2,190	10	2,190		20,805	5
6	FRONT & BACK LANDSCAPING	2008	33,000	3,300	10	3,300		31,350	6
7									7
8	Architect Services	2009	29,257		10	2,926	2,926	24,869	8
9	Roof	2009	230,100	24,139	10	23,010	(1,129)	195,585	9
10	Construction Period Interest	2009	32,240		10	3,224	3,224	27,404	10
11	1st floor resident room baths - remove existing vinyl floor,								11
12	floor prep, installation of sheet vinyl, ceramic tile	2009	22,546		10	2,255	2,255	19,165	12
13	1st floor dining room - remove existing cove base and sheet								13
14	vinyl, floor prep, pvt install, pvt wallcovering	2009	32,001		10	3,200	3,200	27,201	14
15	Activity room - wall covering, remove cove base, install pvt &								15
16	cove base, cornices, custom built in computer work station,								16
17	remove existing ceiling tile, furnish & install new acoustic								17
18	ceiling tile, furnish & install new can lights	2009	20,443		10	2,044	2,044	17,376	18
19	Shower room - install 4 shower stalls, remove existing cove								19
20	base & sheet vinyl, install new ceramic tile	2009	43,873		10	4,387	4,387	37,292	20
21	Basement corridor - cove base, flooring, paint doors & frames,								21
22	wallpaper purchase & installation	2009	46,436		10	4,644	4,644	39,472	22
23	Therapy room - wallcovering, remove existing cove base and								23
24	vct installation of pvt, glue down carpet, remove cinder-								24
25	block wall and office separating OT & PT rooms, demo of								25
26	old and installation of new acoustical ceiling	2009	30,482		10	3,048	3,048	25,909	26
27	Foyer - remove old flooring, install new ceramic flooring &								27
28	pedimat, wallcovering	2009	12,181		10	1,218	1,218	10,354	28
29	Lobby - remove old cove base and flooring, install new ceramic								29
30	tile and cove base, wallcovering, built in reception desk,								30
31	remove mirror, door, frame & glass. Install new moldings,								31
32	remove existing receptionist wall and rebuild wall, re-								32
33	install door 3 feet from current location	2009	34,706		10	3,471	3,471	29,501	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,528,105	\$ 37,506		\$ 171,754	\$ 134,248	\$ 2,963,036	34

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

Facility Name &amp; ID Number Community Nursing &amp; Rehabilitation Center, LLC

# 0044750

Report Period Beginning:

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	<b>Totals from Page 12C, Carried Forward</b>		\$ 5,528,105	\$ 37,506		\$ 171,754	\$ 134,248	\$ 2,963,036	1
2	<b>Building Facade &amp; Renovation</b>								2
3	- General requirements	2009	19,795		10	1,981	1,981	16,835	3
4	- Permits	2009	5,000		10	500	500	4,250	4
5	- Excavation and site demolition	2009	22,626		10	2,263	2,263	19,234	5
6	- Asphalt Patching	2009	5,928		10	593	593	5,040	6
7	- Mansard and patio canopy demolition	2009	9,300		10	930	930	7,905	7
8	- Concrete work	2009	23,807		10	2,381	2,381	20,237	8
9	- Brick pavers	2009	13,440		10	1,344	1,344	11,424	9
10	- Masonry columns & Screen wall	2009	16,190		10	1,619	1,619	13,762	10
11	- Steel	2009	9,700		10	970	970	8,245	11
12	- Wood fencing	2009	1,580		10	158	158	1,343	12
13	- Pylon Sign	2009	8,000		10	800	800	6,800	13
14	- Room framing and sheathing	2009	81,769		10	8,177	8,177	69,504	14
15	- Cut and patch existing roofing for new construction	2009	17,310		10	1,731	1,731	14,714	15
16	- Roofing and sheetmetal	2009	40,835		10	4,084	4,084	34,713	16
17	- Electrical	2009	4,150		10	415	415	3,528	17
18	- Dry fire sprinkler system	2009	7,000		10	700	700	5,950	18
19	- Duct demolition	2009	2,160		10	216	216	1,836	19
20	- Homosote sheathing	2009	7,549		10	755	755	6,417	20
21	- Eifs	2009	13,350		10	1,335	1,335	11,348	21
22	- Fypon Moldings	2009	6,790		10	679	679	5,772	22
23	- Painting	2009	3,400		10	340	340	2,890	23
24	- Main exfrance roof tower	2009	47,588		10	4,759	4,759	40,451	24
25	- Asphalt sidewalk on north side of bldg	2009	4,920		10	492	492	4,182	25
26	- Landscaping	2009	18,000		10	1,800	1,800	15,300	26
27	- Landscape demo	2009	5,566		10	557	557	4,733	27
28	- Insurance	2009	3,562		10	357	357	3,032	28
29	- General contractor fee	2009	13,685		10	1,369	1,369	11,635	29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,941,105	\$ 37,506		\$ 213,059	\$ 175,553	\$ 3,314,116	34

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

Facility Name &amp; ID Number Community Nursing &amp; Rehabilitation Center, LLC

# 0044750

Report Period Beginning:

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	<b>Totals from Page 12D, Carried Forward</b>		\$ 5,941,105	\$ 37,506		\$ 213,059	\$ 175,553	\$ 3,314,116	1
2	1st floor elevator lobby - remove old flooring and install new								2
3	pvt tile, wallcovering	2009	2,699		10	270	270	2,294	3
4	1st floor corridor - corner guard, remove old and install new								4
5	wood look pvt flooring and carpet, wallcovering	2009	55,531		10	5,553	5,553	47,201	5
6	1st floor wallcovering and paint	2009	38,491		10	3,849	3,849	32,717	6
7	2nd floor shower rooms - remove existing ceramic tile, furnish								7
8	and install new ceramic tile	2009	7,067		10	707	707	6,008	8
9	1st floor resident rooms - cove base, built in double wardrobe,								9
10	remove old wallpaper and glue, paint ceilings, walls, doors								10
11	and radiators, custom built in wardrobes, cornices and								11
12	cubicle curtains	2009	159,255		10	15,926	15,926	135,371	12
13									13
14									14
15	Landmark-building facade renovation	2009	9,419	942	10	942		8,007	15
16	Satellite TV-Installation and wiring	2009	9,000	900	10	900		7,650	16
17	Architect Fees	2009	713	71	10	71		605	17
18	Sprinkler System	2009	134,000	13,400	10	13,400		113,900	18
19	Window Treatments	2009	44,355		10	4,436	4,436	37,705	19
20	Alzheimers Nurses Station Remodel	2009	18,328		10	1,833	1,833	15,580	20
21	Adjust for accounts payable invoice	2009	(23,592)						21
22									22
23	Pump Motor	2010	7,004	700	10	700		5,250	23
24	Telephone Paging System	2010	7,047	287	40	176	(111)	1,320	24
25	Wanderguard	2010	12,289	418	40	308	(110)	2,310	25
26	2nd Floor Common Area Flooring	2010	6,860	686	10	686		5,145	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,429,571	\$ 54,910		\$ 262,816	\$ 207,906	\$ 3,735,178	34

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

Facility Name &amp; ID Number Community Nursing &amp; Rehabilitation Center, LLC

# 0044750

Report Period Beginning:

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	<b>Totals from Page 12E, Carried Forward</b>		\$ 6,429,571	\$ 54,910		\$ 262,816	\$ 207,906	\$ 3,735,178	1
2	Compressor Replacement	2011	9,763	976	10	976		6,344	2
3	Sprinkler system	2011	9,933	993	20	497	(496)	3,230	3
4	Patio	2011	3,708	371	20	185	(186)	1,203	4
5	Business office thermostat	2011	5,988	599	5		(599)	5,988	5
6	Transformer	2011	13,500	1,350	20	675	(675)	4,388	6
7	Rehab corridor(Flooring, wallcovering)	2011	40,509	4,051	7	5,787	1,736	37,616	7
8	Rehab corridor(Handrails, Door & Frame)	2011	43,724	4,372	20	2,186	(2,186)	14,209	8
9	Nursing home (Relaminate)	2011	13,483	1,348	10	1,348		8,762	9
10									10
11	3 Broan fans, sheet metal work - Entire Facility	2012	4,300	430	10	430		2,365	11
12	Roof Chiller - Roof of Main Building	2012	4,455	446	10	446		2,452	12
13	Automatic Door - Homeward Bound Unit	2012	4,200	420	10	420		2,310	13
14									14
15	Resurface parking lot	2013	8,033	1,606	10	803	(803)	3,615	15
16	Condensor fan & water heater	2013	5,932	1,186	10	593	(593)	2,670	16
17	Rod floor drains, install new drains	2013	3,000	600	10	300	(300)	1,350	17
18	Replace door	2013	3,000	600	10	300	(300)	1,350	18
19									19
20	Mechanical door restrictor device-Elevators	2014	2,910	291	10	291		1,019	20
21	Repair 5 leaks in cold water supply throughout facility	2014	4,712	471	10	471		1,649	21
22	Replace Wi-Fi & low voltage cabling & elec-Entire facility	2014	18,642	1,864	10	1,864		6,525	22
23	Replace concrete ramp	2014	3,900	390	10	390		1,365	23
24	Replace heat pump at nurses station	2014	4,195	420	10	420		1,468	24
25	175 KW Standby diesel generator-Entire facility	2014	72,800		40	1,820	1,820	6,370	25
26	Fire dampers-Entire facility	2014	36,960		40	924	924	3,234	26
27	Replace 25 bay windows-Homeward Bound Unit	2014	62,400		40	1,560	1,560	5,460	27
28	Recover canopy awning-Front Door	2014	16,866		40	422	422	1,476	28
29	Remodel Homeward Bound Unit: wall covering, wood trim,	2014	112,500		40	2,813	2,813	9,844	29
30	doors & hardware, flooring, carpentry, paint, electrical								30
31	Remodel Nurses Station - Homeward Bound Unit: wall covering,	2014	12,464		40	312	312	1,091	31
32	wood trim, countertop, carpentry, labor								32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,951,448	\$ 77,693		\$ 289,047	\$ 211,354	\$ 3,872,529	34

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

Facility Name &amp; ID Number Community Nursing &amp; Rehabilitation Center, LLC

# 0044750

Report Period Beginning:

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	<b>Totals from Page 12F, Carried Forward</b>		\$ 6,951,448	\$ 77,693		\$ 289,047	\$ 211,354	\$ 3,872,529	1
2	Install Sewer Pit Pump - Back of building	2015	7,103	1,065	10	710	(355)	1,776	2
3	Electrical Work - Computer Room	2015	3,300	495	10	330	(165)	825	3
4	Add door to Wanderguard System - Resident Patio Smoking Door	2015	3,070	462	10	307	(155)	768	4
5	Evaporator chilled water coil pipe replacement - Entire Facility HVAC	2015	8,518	1,278	10	852	(426)	2,129	5
6									6
7	Gas piping drawing for Pulmonary Unit Project	2016	3,100	310	10	310		465	7
8	Pulmonary Wing-Electrical, install oxygen outlets, medical air	2016	180,997	18,100	10	18,100		27,150	8
9	outlets, medical vacuum inlets & vacuum slides								9
10	Electrical Work - Pulmonary Wing	2016	21,642	2,164	10	2,164		3,246	10
11	Medical Gas Enclosure - North Wing	2016	74,600	7,460	10	7,460		11,190	11
12	Doors & drywall, carpentry, trim, pre-stain & finish - North Wing	2016	71,200	7,120	10	7,120		10,680	12
13	3 Doors in small dining room, 2 doors at soiled & clean utility room	2016	7,550	756	10	756		1,134	13
14	Architect Fees - North Wing	2016	15,289	1,528	10	1,528		2,292	14
15	Replace roof mounted exhaust fans - Roof	2016	2,972	298	10	298		447	15
16	Chilled water condenser-HVAC System	2016	9,977	998	10	998		1,497	16
17	Replaced 18 smoke detectors - throughout facility	2016	4,229	422	10	422		633	17
18	Sewer Pump	2016	5,522	552	10	552		828	18
19	Window Treatments - North Wing	2016	6,323	632	5	1,264	632	1,896	19
20	Recessed medicine cabinets - North Wing	2016	4,037	404	5	808	404	1,212	20
21	Wallpaper, countertop, lighting, electrical - Dining Room Remodel	2016	9,922	992	5	1,984	992	2,976	21
22									22
23	Kitchen and laundry water heater	2017	14,369	718	10	718		718	23
24	Sanitary lift station - rebuild motor, replace cutter bars,	2017	9,748	487	10	487		487	24
25	repair controls, install new 4" check valves - Rear of building								25
26	Replace heat exchanger - Lift Station Pump P2	2017	5,059	253	10	253		253	26
27									27
28									28
29									29
30	Adjust book depreciation to financial statements			3,407			(3,407)		30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,419,975	\$ 127,595		\$ 336,469	\$ 208,874	\$ 3,945,130	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	\$ 579,209	\$ 31,286	\$ 39,324	\$ 8,038	3-10	\$ 474,282	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,023,462					1,023,462	73
74								74
75	TOTALS	\$ 1,602,671	\$ 31,286	\$ 39,324	\$ 8,038		\$ 1,497,744	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	Facility	GMC Truck	2011	\$ 44,128	\$	\$	\$	5	\$ 44,128	76
77	Facility	Subaru	2015	37,246	7,450	7,450		5	18,625	77
78										78
79										79
80	TOTALS			\$ 81,374	\$ 7,450	\$ 7,450	\$		\$ 62,753	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)	\$ 9,557,642	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 166,331	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 383,242	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 216,912	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,505,627	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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 Community Nursing & Rehabilitation Center, LLC

# 0044750

Report Period Beginning:

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:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	<u>/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: \$ 50,630 Description: See Attached Schedule 14A

(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>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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.

**Facility Name:** Community Nursing & Rehabilitation Center, LLC  
**IDPH License ID Number:** 0044750  
**Fiscal Year End:** 12/31/17

**Schedule 14A**

**XIV. Rental Costs**

**Line 16 Rental Amount for Moveable Equipment**

<b>Rental Description</b>	<b>Amount</b>
Medical Equip	24,141
Dietary Equipment	140
Maint. Equip.	824
Copier	25,525
<b>Total - Line 16</b>	<b><u>50,630</u></b>

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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	39(3)	hrs	\$	3,926	\$ 282,659	\$	3,926	\$ 282,659	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,482	106,674		1,482	106,674	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		3,964	285,423	9,099	3,964	294,522	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 prescripts				443,393		443,393	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Resp Ther/Oxygen</u>	39(1)(2)(3)		2,923	7,345	528,905	35,694	7,345	567,522	12
13	Other (specify): <u>Dialysis services</u>	39(3)				73,985			73,985	13
14	<b>TOTAL</b>			\$ 2,923	16,717	\$ 1,277,646	\$ 488,186	16,717	\$ 1,768,755	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 **Community Nursing & Rehabilitation Center, LLC**

# **0044750**

Report Period Beginning:

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 449	\$ 449	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>393,840</u> )	1,542,207	1,542,207	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	212,049	239,645	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	761,148	717,797	8
9	Other(specify): <u>See Schedule 17A</u>	59,090	553,784	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,574,943	\$ 3,053,882	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		453,622	13
14	Buildings, at Historical Cost		4,184,589	14
15	Leasehold Improvements, at Historical Cost	1,985,995	3,235,386	15
16	Equipment, at Historical Cost	600,499	1,684,045	16
17	Accumulated Depreciation (book methods)	(1,709,797)	(5,505,627)	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 (spe			22
23	Other(specify): <u>Mortgage Costs, Net</u>		52,841	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 876,697	\$ 4,104,856	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,451,640	\$ 7,158,738	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 2,479,604	\$ 2,487,460	26
27	Officer's Accounts Payable	13,861	13,861	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	112,012	112,012	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,330	3,330	31
32	Accrued Real Estate Taxes(Sch.IX-B)		93,500	32
33	Accrued Interest Payable	8,647	32,166	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	1,723,040	1,723,040	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,340,494	\$ 4,465,369	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,926,221	1,926,221	39
40	Mortgage Payable		6,800,898	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>	\$ 1,926,221	\$ 8,727,119	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,266,715	\$ 13,192,488	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,815,075)	\$ (6,033,750)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,451,640	\$ 7,158,738	48

\*(See instructions.)

**Facility Name:** Community Nursing & Rehabilitation Center, LLC  
**IDPH License ID Number:** 0044750  
**Fiscal Year End:** 12/31/17

**Schedule 17A**

**XV. Balance Sheet**

**Line 9 Current Assets Other (specify):**

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
11500.000 Rent Receivable	-	1,848
14100.000 Escrow - MIP	-	19,466
14200.000 Escrow - Insurance	-	6,254
14300.000 Escrow - Real Estate Taxes	-	46,248
14400.000 Escrow - Replacement Reserve	-	420,878
20810.000 Due To/from AdminAstar	59,090	59,090
<b>Total - Line 9</b>	<b>59,090</b>	<b>553,784</b>

**XV. Balance Sheet**

**Line 36 Other Current Liabilities (specify):**

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
20230.000 Accrued Management Fees	591,593	591,593
20260.000 Accrued Rent	1,848	1,848
20430.000 Accrued Assessment Fee	8	8
20435.000 Accrued Assessment Fee #2	26,065	26,065
20570.000 Insurance payable	188,356	188,356
20800.000 Due To State	374,410	374,410
20815.000 Resident Credit Balances	44,312	44,312
20820.000 Due To/From Insurance (BC-BS Etc)	-	-
20830.000 Due To/From BC-BS	7,441	7,441
20840.000 Due To/From Hospice	-	-
20905.000 Due To/From Pine Acres	80,270	80,270
20910.000 Due To/From The Springs	408,737	408,737
<b>Total - Line 36</b>	<b>1,723,040</b>	<b>1,723,040</b>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(321,797)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior period adjustment</b>	<b>6,813</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>(314,984)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(2,500,091)</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>(2,500,091)</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>(2,815,075)</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**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,473,229	1
2	Discounts and Allowances for all Levels	(1,955,765)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,517,464	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,525,377	6
7	Oxygen	20,925	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,546,302	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	3,253	12
13	Barber and Beauty Care	2,647	13
14	Non-Patient Meals	1,491	14
15	Telephone, Television and Radio	3,946	15
16	Rental of Facility Space		16
17	Sale of Drugs	394,653	17
18	Sale of Supplies to Non-Patients	539,429	18
19	Laboratory	69,909	19
20	Radiology and X-Ray	14,845	20
21	Other Medical Services	6,656	21
22	Laundry	1,557	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,038,386	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	8,655	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 8,655	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Miscellaneous Income</b>	5,118	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 5,118	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,115,925	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,510,698	31
32	Health Care	3,683,257	32
33	General Administration	2,047,429	33
<b>B. Capital Expense</b>			
34	Ownership	979,299	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,152,312	35
36	Provider Participation Fee	243,021	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,616,016	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(2,500,091)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (2,500,091)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 3,266,754	44
45	Private Pay - Net Inpatient Revenue	742,897	45
46	Medicare - Net Inpatient Revenue	930,962	46
47	Other-(specify) <b>Managed Care</b>	327,233	47
48	Other-(specify) <b>Hospice</b>	249,618	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,517,464	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No^ 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.

^ - This entity is a cash basis taxpayer

Facility Name & ID Number Community Nursing & Rehabilitation Center, LLC

# 0044750

Report Period Beginning:

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	1,944	2,109	\$ 105,509	\$ 50.03	1
2	Assistant Director of Nursing	2,161	2,639	109,383	41.45	2
3	Registered Nurses	22,554	23,659	784,976	33.18	3
4	Licensed Practical Nurses	17,269	18,121	476,826	26.31	4
5	CNAs & Orderlies	75,865	81,794	1,268,494	15.51	5
6	CNA Trainees					6
7	Licensed Therapist	75	85	2,923	34.39	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,864	2,080	48,312	23.23	9
10	Activity Assistants	8,226	8,701	109,940	12.64	10
11	Social Service Workers	3,754	4,173	181,107	43.40	11
12	Dietician	1,729	1,977	56,961	28.81	12
13	Food Service Supervisor	1,900	2,114	53,765	25.43	13
14	Head Cook	10,240	10,996	151,734	13.80	14
15	Cook Helpers/Assistants	14,470	15,181	168,465	11.10	15
16	Dishwashers					16
17	Maintenance Workers	3,944	4,396	75,608	17.20	17
18	Housekeepers	15,998	17,557	215,900	12.30	18
19	Laundry	9,044	9,517	97,699	10.27	19
20	Administrator	1,742	1,961	121,871	62.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,153	10,122	194,197	19.19	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	1,508	1,720	35,535	20.66	31
32	Other Health C: <u>Schedule 20A</u>	9,962	10,854	290,420	26.76	32
33	Other(specify) <u>Marketing and Ho</u>	4,102	4,575	42,706	9.33	33
34	TOTAL (lines 1 - 33)	217,504	234,331	\$ 4,592,331 *	\$ 19.60	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	\$		35	
36	Medical Director	Monthly	12,500	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	607	28,520	39(3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant	17	896	11(3)	44
45	Social Service Consultant	16	992	12(3)	45
46	Other(specify)				46
47	<u>Infectious Disease Consultant</u>	Monthly	24,254	10(3)	47
48	<u>Pulmonary Consultant</u>	75	22,500	10(3)	48
49	TOTAL (lines 35 - 48)	715	\$ 89,662		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	N/A		51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

**Facility Name:** Community Nursing & Rehabilitation Center, LLC  
**IDPH License ID Number:** 0044750  
**Fiscal Year End:** 12/31/17

**Schedule 20A**

**XVIII. Staffing and Salary Costs**  
**Line 32 Other Health Care (specify):**

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Restorative nurses	5,226	5,697	117,940	\$ 20.70
MDS Coord	2,219	2,281	80,794	\$ 35.42
Treatment Nurse	2,281	2,588	82,395	\$ 31.84
Case Manager	236	288	9,291	\$ 32.26
<b>Total - Line 32 Other Health Care (specify):</b>	<b>9,962</b>	<b>10,854</b>	<b>290,420</b>	<b>\$ 26.76</b>

**XVIII. Staffing and Salary Costs**  
**Line 33 Other (specify):**

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
<b>Total - Line 33 Other (specify):</b>	<b>-</b>	<b>-</b>	<b>-</b>	



**Facility Name:** Community Nursing & Rehabilitation Center, LLC  
**IDPH License ID Number:** 0044750  
**Fiscal Year End:** 12/31/17

**Schedule 21C**

**XIX. SUPPORT SCHEDULES**

**C. Professional Services**

<u>Vendor</u>	<u>Type</u>	<u>Amount</u>
Total from pg 21		116,350.00
Ashman & Stein	Legal	7,500.00
Polsinelli	Legal	2,751.44
Marilyn P Dunn	Legal	357.72
Much Shelist Attorneys At Law	Legal	10,725.00
Vanek, Larson & Kolb LLC	Legal	8,704.87
ABILITY Network Inc.	Computer services	6,048.02
American Express	Computer services	637.00
CDW	Computer services	3,303.54
Experian Health Inc	Computer services	410.00
HCA	Computer services	3,000.00
Information Controls, Inc.	Computer services	2,377.22
Red Eyed Moose Technologies	Computer services	3,672.00
Singer Networks LLC	Computer services	22,956.64
Telemedicine Solutions , LLC	Computer services	8,424.00
<b>Total (agree to Schedule V, line 19, column 3)</b>		<b><u>197,217</u></b>
Reclass to appropriate line		(40,604)
Allocated from Management Company Accounting fee		16,565
Allocated from Management Company Professional Services		
Less: Non-Allowable Legal Fees		(12,305)
Less: Non-Allowable Computer services		(637)
<b>Total (agree to Schedule V, line 19, column 8)</b>		<b><u>160,236</u></b>

**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. Illinois Council -LTC - \$16,524
- (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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,443 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  NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO  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. \$ 243,021  
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. \$ 15,501 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,744
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
  - c. What percent of all travel expense relates to transportation of nurses and patients? None
  - d. Have vehicle usage logs been maintained? Adequate records have been maintained
  - 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