

Facility Name & ID Number Kensington Place Nursing & Rehabilitation Center, LLC

0052712 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	155	Skilled (SNF)	155	56,575	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,575	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	46,888	1,010	2,990	50,888	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,888	1,010	2,990	50,888	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.95%

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

0 (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)

N/A

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 05/01/87

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

YES Date 05/01/87 NO

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

YES NO If YES, enter number of beds certified 155 and days of care provided 2,570

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Kensington Place Nursing & Rehabilitation C # 0052712 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	255,771	49,318	11,359	316,448		316,448	188	316,636		1
2	Food Purchase		293,612		293,612		293,612	(85)	293,527		2
3	Housekeeping	186,329	30,964		217,293		217,293	1,134	218,427		3
4	Laundry	47,858	15,003	151	63,012		63,012		63,012		4
5	Heat and Other Utilities			136,147	136,147		136,147	1,405	137,552		5
6	Maintenance	116,538		147,499	264,037		264,037	12,170	276,207		6
7	Other (specify):* See Supplemental	21,331		28,800	50,131		50,131	770	50,901		7
8	TOTAL General Services	627,827	388,897	323,956	1,340,680		1,340,680	15,582	1,356,262		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	2,487,804	106,029	38,447	2,632,280		2,632,280	(1,852)	2,630,428		10
10a	Therapy	131,974			131,974		131,974		131,974		10a
11	Activities	105,674	15,312	2,262	123,248		123,248		123,248		11
12	Social Services	221,297	13,614	2,016	236,927		236,927		236,927		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* See Supplemental										15
16	TOTAL Health Care and Programs	2,946,749	134,955	51,725	3,133,429		3,133,429	(1,852)	3,131,577		16
	C. General Administration										
17	Administrative	252,275			252,275		252,275	19,542	271,817		17
18	Directors Fees										18
19	Professional Services			231,676	231,676	(4,167)	227,509	(149,676)	77,833		19
20	Dues, Fees, Subscriptions & Promotions			48,638	48,638		48,638	(8,564)	40,074		20
21	Clerical & General Office Expenses	393,452	3,620	566,280	963,352		963,352	(423,912)	539,440		21
22	Employee Benefits & Payroll Taxes			794,343	794,343		794,343	(10,725)	783,618		22
23	Inservice Training & Education			619	619		619		619		23
24	Travel and Seminar			2,608	2,608		2,608	36	2,644		24
25	Other Admin. Staff Transportation			20,503	20,503		20,503	939	21,442		25
26	Insurance-Prop.Liab.Malpractice			215,893	215,893		215,893	1,694	217,587		26
27	Other (specify):* See Supplemental							27,472	27,472		27
28	TOTAL General Administration	645,727	3,620	1,880,560	2,529,907	(4,167)	2,525,740	(543,194)	1,982,546		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,220,303	527,472	2,256,241	7,004,016	(4,167)	6,999,849	(529,464)	6,470,385		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Kensington Place Nursing & Rehabilitation Center, LLC

Medicaid Cost Report

01/01/17 - 12/31/17

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 7 - Other General Services				
Security	21,331			21,331
Valet			28,800	28,800
				-
Alloc - Extended Care Consulting, LLC				-
Gen. Services - Employee Benefits			770	770
				-
				-
Sub-Total	<u>21,331</u>	<u>-</u>	<u>29,570</u>	<u>50,901</u>
Line 15 - Other Health Care Services				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Line 27 - Other General Administration				
Alloc - Extended Care Consulting, LLC				-
Gen. Admin. - Employee Benefits			27,472	27,472
				-
				-
				-
				-
				-
Sub-Total	<u>-</u>	<u>-</u>	<u>27,472</u>	<u>27,472</u>

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			31,266	31,266		31,266	95,371	126,637			30
31	Amortization of Pre-Op. & Org.			1,600	1,600		1,600	(1,600)				31
32	Interest			38,481	38,481		38,481	(7,691)	30,790			32
33	Real Estate Taxes			266,885	266,885	4,167	271,052	4,231	275,283			33
34	Rent-Facility & Grounds			926,416	926,416		926,416	(926,416)				34
35	Rent-Equipment & Vehicles			28,033	28,033		28,033	1,037	29,070			35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			1,292,681	1,292,681	4,167	1,296,848	(835,068)	461,780			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		43,357	328,983	372,340		372,340	(3,053)	369,287			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			381,753	381,753		381,753		381,753			42
43	Other (specify):* See Supplemental											43
44	TOTAL Special Cost Centers		43,357	710,736	754,093		754,093	(3,053)	751,040			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,220,303	570,829	4,259,658	9,050,790		9,050,790	(1,367,585)	7,683,205			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Kensington Place Nursing & Rehabilitation Center, LLC

Medicaid Cost Report

01/01/17 - 12/31/17

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 36 - Other Capital Costs				
				-
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-

Line 43 - Other Special Cost Centers				
Non-Allowable				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(22,770)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(633)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,136)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(528,864)	21		24
25	Fund Raising, Advertising and Promotional	(9,330)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(75)	20		28
29	Other-Attach Schedule See Supplemental	(108,086)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (675,894)		\$	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)	(691,691)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (691,691)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,367,585)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' PREPARATION REPORT

Kensington Place Nursing & Rehabilitation Center, LLC

ID# 0052712

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	Legal - Non Allowable	(16,524)	19	2
3	Professional - Non Allowable	(2,474)	19	3
4	Bank Charges	(1,349)	21	4
5	Amortization	(1,600)	31	5
6				6
7				7
8				8
9	Boulevard Property, LLC			9
10	Professional Fees	(7,750)	19	10
11	Office	(9,002)	21	11
12	Amortization	(9,387)	31	12
13	Interest	(60,000)	32	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(108,086)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Kensington Place Nursing & Rehabilitation Center, LLC# 0052712

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	0	0	188	0	0	0	0	0	0	0	0	188	1
2	Food Purchase	(633)	0	548	0	0	0	0	0	0	0	0	(85)	2
3	Housekeeping	0	0	1,134	0	0	0	0	0	0	0	0	1,134	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,405	0	0	0	0	0	0	0	0	1,405	5
6	Maintenance	0	0	3,869	8,301	0	0	0	0	0	0	0	12,170	6
7	Other (specify):*	0	0	0	770	0	0	0	0	0	0	0	770	7
8	TOTAL General Services	(633)	0	7,144	9,071	0	0	0	0	0	0	0	15,582	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(1,852)	0	0	0	0	0	(1,852)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	(1,852)	0	0	0	0	0	(1,852)	16
	C. General Administration													
17	Administrative	0	0	2,895	16,647	0	0	0	0	0	0	0	19,542	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(26,748)	7,750	(130,678)	0	0	0	0	0	0	0	0	(149,676)	19
20	Fees, Subscriptions & Promotions	(9,405)	0	841	0	0	0	0	0	0	0	0	(8,564)	20
21	Clerical & General Office Expenses	(545,351)	9,002	8,319	104,118	0	0	0	0	0	0	0	(423,912)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(10,725)	0	0	0	0	0	0	0	(10,725)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	36	0	0	0	0	0	0	0	0	36	24
25	Other Admin. Staff Transportation	0	0	939	0	0	0	0	0	0	0	0	939	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,694	0	0	0	0	0	0	0	0	1,694	26
27	Other (specify):*	0	0	0	27,472	0	0	0	0	0	0	0	27,472	27
28	TOTAL General Administration	(581,504)	16,752	(115,954)	137,512	0	0	0	0	0	0	0	(543,194)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(582,137)	16,752	(108,810)	146,583	0	(1,852)	0	0	0	0	0	(529,464)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Kensington Place Nursing & Rehabilitation Center, LLC# 0052712

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	92,963	2,408	0	0	0	0	0	0	0	0	95,371	30
31	Amortization of Pre-Op. & Org.	(10,987)	9,387	0	0	0	0	0	0	0	0	0	(1,600)	31
32	Interest	(82,770)	60,000	15,079	0	0	0	0	0	0	0	0	(7,691)	32
33	Real Estate Taxes	0	0	4,231	0	0	0	0	0	0	0	0	4,231	33
34	Rent-Facility & Grounds	0	(926,416)	0	0	0	0	0	0	0	0	0	(926,416)	34
35	Rent-Equipment & Vehicles	0	0	1,037	0	0	0	0	0	0	0	0	1,037	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(93,757)	(764,066)	22,755	0	0	0	0	0	0	0	0	(835,068)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(3,053)	0	0	0	0	0	(3,053)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	(3,053)	0	0	0	0	0	(3,053)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(675,894)	(747,314)	(86,055)	146,583	0	(4,905)	0	0	0	0	0	(1,367,585)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 926,416	Boulevard Property, LLC	100.00%	\$	\$ (926,416)	1
2	V	32 Interest	190,562	Boulevard Property, LLC	100.00%		(190,562)	2
3	V	19 Professional Fees		Boulevard Property, LLC	100.00%	7,750	7,750	3
4	V	21 Office		Boulevard Property, LLC	100.00%	9,002	9,002	4
5	V	26 Property Insurance		Boulevard Property, LLC	100.00%			5
6	V	30 Depreciation		Boulevard Property, LLC	100.00%	92,963	92,963	6
7	V	31 Amortization		Boulevard Property, LLC	100.00%	9,387	9,387	7
8	V	32 Interest		Boulevard Property, LLC	100.00%	250,562	250,562	8
9	V	33 Real Estate Taxes	261,894	Boulevard Property, LLC	100.00%	261,894		9
10	V	36 Mortgage Insurance Premiums		Boulevard Property, LLC	100.00%			10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,378,872			\$ 631,558	\$ * (747,314)	14

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

Facility Name & ID Number

Kensington Place Nursing & Rehabilitation Center, LLC

0052712

Report Period Beginning:

01/01/17

Ending:

12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Kensington Place Nursing & Rehabilitation Center, LLC

0052712

Report Period Beginning:

01/01/17

Ending:

12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Sheffield Manor Assisted Living	Dyer, IN				1
2			Kenosha Estates	Kenosha, WI				2
3			Milwaukee Estates	Milwaukee, WI				3
4			Appleton	Appleton, WI				4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 188	\$	188	15
16	V	2 Food		Extended Care Consulting, LLC	100.00%	548		548	16
17	V	3 Housekeeping		Extended Care Consulting, LLC	100.00%	1,134		1,134	17
18	V	5 Utilities		Extended Care Consulting, LLC	100.00%	1,405		1,405	18
19	V	6 Maintenance		Extended Care Consulting, LLC	100.00%	3,869		3,869	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	2,895		2,895	20
21	V	19 Professional Fees	134,400	Extended Care Consulting, LLC	100.00%	3,722		(130,678)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	841		841	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	8,319		8,319	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	36		36	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	939		939	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	1,694		1,694	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	2,408		2,408	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	15,079		15,079	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	4,231		4,231	29
30	V	35 Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	1,037		1,037	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 134,400			\$ 48,345	\$ *	(86,055)	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	6	Maintenance (Pooled)	\$	Extended Care Consulting, LLC	100.00%	\$ 8,301	\$ 8,301	15
16	V	6	Maintenance (Direct)		Extended Care Consulting, LLC	100.00%	0		16
17	V	7	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	770	770	17
18	V	7	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	0		18
19	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	16,647	16,647	19
20	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	104,118	104,118	20
21	V	21	Office and Clerical (Direct)	17,176	Extended Care Consulting, LLC	100.00%	17,176		21
22	V	27	Emp. Gen. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	23,334	23,334	22
23	V	27	Emp. Gen. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,138	4,138	23
24	V	22	Employee Benefits	10,725	Extended Care Consulting, LLC	100.00%		(10,725)	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		\$ 27,901				\$ 174,484	\$ * 146,583	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	22 Employee Benefits	\$ 230,151	CCS VEBA	100.00%	\$ 230,151	\$	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		\$ 230,151			\$ 230,151	\$ *	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	10 Nursing	\$ 22,427	Mac RX, LLC	100.00%	\$ 20,575	\$	(1,852)	15
16	V	39 Ancillary	36,958	Mac RX, LLC	100.00%	33,905		(3,053)	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		\$ 59,385			\$ 54,480	\$ *	(4,905)	39

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

Facility Name & ID Number Kensington Place Nursing & Rehabilitation # 0052712 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	Yechiel Mashiach	Owner	Administrator	15.20%	N/A	40.00	100.00%	Salary	\$ 156,067	17 - 01	1
2	Adam Vales	Relative	Clerical	0.00%	See Supplemental	1.02	2.56%	Alloc. Salary	1,768	22 - 07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 157,835		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kensington Place Nursing & Rehabilitation Center, LLC # 0052712 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 Boulevard Property, LLC
 Street Address 3405 S. Michigan Avenue
 City / State / Zip Code Chicago, Illinois 60616
 Phone Number (_____) _____
 Fax Number (_____) _____

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kensington Place Nursing & Rehabilitation Center, LLC # 0052712 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 Extended Care Consulting, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905 - 3000
 Fax Number (847) 491 - 9565

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	1,476,506	37	\$ 5,451	\$ 50,888	\$ 188	1
2	2	Food	Patient Days	1,476,506	37	15,903	50,888	548	2
3	3	Housekeeping	Patient Days	1,476,506	37	32,901	50,888	1,134	3
4	5	Utilities	Patient Days	1,476,506	37	40,755	50,888	1,405	4
5	6	Maintenance	Patient Days	1,476,506	37	112,249	50,888	3,869	5
6	17	Administrative	Patient Days	1,476,506	37	84,000	50,888	2,895	6
7	19	Professional Fees	Patient Days	1,476,506	37	107,994	50,888	3,722	7
8	20	Dues and Subscriptions	Patient Days	1,476,506	37	24,409	50,888	841	8
9	21	Office and Clerical	Patient Days	1,476,506	37	241,371	50,888	8,319	9
10	24	Travel and Seminar	Patient Days	1,476,506	37	1,048	50,888	36	10
11	25	Other Staff Admin. Trans.	Patient Days	1,476,506	37	27,239	50,888	939	11
12	26	Insurance	Patient Days	1,476,506	37	49,139	50,888	1,694	12
13	30	Depreciation	Patient Days	1,476,506	37	69,861	50,888	2,408	13
14	32	Interest	Patient Days	1,476,506	37	437,528	50,888	15,079	14
15	33	Real Estate Taxes	Patient Days	1,476,506	37	122,769	50,888	4,231	15
16	35	Rent - Equipment and Auto	Patient Days	1,476,506	37	30,092	50,888	1,037	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,402,709	\$	\$ 48,345	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kensington Place Nursing & Rehabilitation Center, LLC # 0052712 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 Extended Care Consulting, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905 - 3000
 Fax Number (847) 941 - 9565

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	Maintenance	Patient Days	1,476,506	37	\$ 240,841	\$ 240,841	50,888	\$ 8,301	1
2	6	Maintenance	Direct	358,056	37	358,056	358,056			2
3	7	Emp. Ben. - Gen. Serv.	Patient Days	1,476,506	37	22,330		50,888	770	3
4	7	Emp. Ben. - Gen. Serv.	Direct	51,193	37	51,193				4
5	17	Administrative	Patient Days	1,476,506	37	483,002	483,002	50,888	16,647	5
6	21	Office and Clerical	Patient Days	1,476,506	37	3,020,951	3,020,951	50,888	104,118	6
7	21	Office and Clerical	Direct	498,631	37	498,631	498,631	17,176	17,176	7
8	27	Emp. Gen. - Gen. Admin.	Patient Days	1,476,506	37	677,040		50,888	23,334	8
9	27	Emp. Gen. - Gen. Admin.	Direct	74,203	37	74,203		4,138	4,138	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 5,426,247	\$ 4,601,481		\$ 174,484	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kensington Place Nursing & Rehabilitation Center, LLC # 0052712 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 CCS VEBA
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905 - 3000
 Fax Number (847) 491 - 9565

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Benefits	Direct Allocation	9,005,461	37	\$ 9,005,461	\$ 230,151	\$ 230,151	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					\$ 9,005,461	\$	\$ 230,151	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kensington Place Nursing & Rehabilitation Center, LLC # 0052712 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 Mac RX, LLC
 Street Address 2307 S. Mount Prospect Road
 City / State / Zip Code Des Plaines, Illinois 60018
 Phone Number (224) 220 - 2700
 Fax Number (224) 220 - 2730

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	Nursing	Profit Margin	736,709	21	\$ 675,856	\$ 22,427	\$ 20,575	1
2	39	Ancillary	Profit Margin	3,852,332	21	3,534,127	36,958	33,905	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					\$ 4,209,983	\$	\$ 54,480	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kensington Place Nursing & Rehabilitation C # 0052712 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	Private Bank		X	Mortgage			\$	3,650,000		\$	190,562	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	HFG		X	Line of Credit							38,481	6								
7	Alloc. - Extended Care		X	Line of Credit							15,079	7								
8												8								
9	TOTAL Facility Related						\$	3,650,000		\$	244,122	9								
B. Non-Facility Related*																				
10												10								
11												11								
12	Interest Income		X								(22,770)	12								
13	Interest Income		X								(190,562)	13								
14	TOTAL Non-Facility Related						\$			\$	(213,332)	14								
15	TOTALS (line 9+line14)						\$	3,650,000		\$	30,790	15								

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

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

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

Facility Name & ID Number Kensington Place Nursing & Rehabilitation Center, LLC

0052712

Report Period Beginning:

01/01/17 Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	51,000	1995	\$ 100,000	1
2	Alloc. - Ext. Care			19,165	2
3	TOTALS	51,000		\$ 119,165	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Bed* FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	155	1989		\$ 1,209,350	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1987	8,296						9
10	Various		1988	11,646						10
11	Various		1989	5,250						11
12	Various		1990	7,780						12
13	Various		1991	16,578						13
14	Various		1992	17,269						14
15	Various		1993	21,968						15
16	Various		1994	13,356						16
17	Various		1995	12,270						17
18	Various		1996	15,797						18
19	Various		1997	7,187						19
20	Various		1998	17,815						20
21	Various		1999	6,043						21
22	Various		2000	235,020						22
23	Various		2001	61,023						23
24	Various		2002	236,588						24
25	Various		2003	110,588						25
26	Various		2004	98,820						26
27	Various		2005	1,500						27
28	Various		2006	18,167						28
29	Various		2007	7,963						29
30	Various		2008	12,185						30
31	Various		2009	10,849						31
32	Various		2010	87,696						32
33	Various		2011	66,198						33
34	Various		2012	162,288						34
35	Various		2013	55,948						35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kensington Place Nursing & Rehabilitation Center, LLC# 0052712

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	
37	Hallway Doors - Egress Locks	2014	\$ 14,894	\$		\$	\$	\$	37
38	Canopy - Main Entrance	2014	9,620						38
39	Hot Water / Cold Water Riser	2014	10,370						39
40	Electrical Outlets - Nurses Stations	2014	2,893						40
41	Elevator - Vale	2014	8,910						41
42	Sprinkler System - Grounds	2014	3,800						42
43	Elevator - Remove and Replace Casings	2016	27,200						43
44	Elevator - Control System Board	2016	4,488						44
45	Painting - Group, Therapy, Dishwasher, Basement,								45
46	Basement, Dining, Recreation, Kitchen, Storage,								46
47	2nd and 3rd Floors	2016	22,845						47
48	Nurse Call System	2016	12,094						48
49	Elevator - Two Door Opener	2016	9,500						49
50	Elevator - Hydraulic Cylinder	2016	33,000						50
51	Flooring - Dishwashing Room	2016	4,590						51
52	Facility Renovations								52
53	Structural Engineering, Permits, and Project Management	2016	12,239						53
54	Guest Bathroom - New Tile, Cove Base, Drywall, and Fixture	2016	2,569						54
55	Vestibule - Electric Doors, Electric Signs, Fire Alarm Switch,								55
56	Carpet Tile, Millwork, and Painting	2016	18,977						56
57	Therapy Room - Cornices	2016	317						57
58	Offices - Carpet Tile, Cove Base, Window Treatments, Painting	2016	8,828						58
59	Elevator - Wallcovering, Handrail, Bumper, and Flooring	2016	10,990						59
60	Dayroom - Fireplace, Cove Base, Wallcovering, and Window Tr	2016	18,259						60
61	Conference Room - Carpet Tile, Cove Base, Wallcoverings,								61
62	Lighting, and Painting	2016	10,091						62
63	Corridors - Cove Base, Signage, Lights, Wallcoverings, and Han	2016	55,317						63
64	Administrator Bathroom - Tile, Drywall, Lights, and Fixtures	2016	3,062						64
65	Lobby - Cove Base, New Wall, Drop Ceiling, Wallcoverings,								65
66	Electrical Fixtures, Double Doors and Framing, Signs,								66
67	Cornices, and Sheers	2016	29,625						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,869,918	\$		\$	\$	\$	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 2,869,918	\$		\$	\$	\$	1
2									2
3	Facility Renovations								3
4	Resident Rooms - Cove Base, Overbed Lights, Cubicle								4
5	Curtains, Window Treatments, Bumper Guards and								5
6	End Caps, and Painting	2016	52,481						6
7	1st Floor Corridors, Dining Room, and Lobby - Ceiling Tiles	2016	18,557						7
8	1st Floor - New Doors, Hardware, and Installation	2016	34,496						8
9	Elevators - Shunt Trip, Heat Exchangers, and Sprinkler Heads	2017	14,980						9
10	Resident Rooms - Repair walls and repaint, including doors,								10
11	trim, radiator covers, and ceilings (as necessary)	2017	46,000						11
12	Signage - Resident Rooms and Common Areas	2017	4,695						12
13	Resident Rooms - Replace rotted framing and drywall	2017	8,350						13
14	Vinyle Cove Base - 2,650 sq. ft. - Remove and Replace	2017	4,650						14
15	Elevator - Car Top Safety Handrain and Mounting Unit	2017	2,578						15
16	Elevator - Component replacements for modernization	2017	31,310						16
17	Fire Pump	2017	4,081						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)		\$ 3,092,096	\$		\$	\$	\$	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Kensington Place Nursing & Rehabilitation Center, LLC# 0052712

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		\$ 3,092,096	\$		\$	\$	\$	1
2									2
3	<u>Related Party Allocations - See Supplemental Schedules</u>								3
4									4
5	<u>Allocations - Extended Care Consulting, LLC</u>	2007	159						5
6	<u>Allocations - Extended Care Consulting, LLC</u>	2009	95						6
7	<u>Allocations - Extended Care Consulting, LLC</u>	2010	930						7
8	<u>Allocations - Extended Care Consulting, LLC</u>	2011	335						8
9	<u>Allocations - Extended Care Consulting, LLC</u>	2012	110						9
10	<u>Allocations - Extended Care Consulting, LLC</u>	2014	1,529						10
11	<u>Allocations - Extended Care Consulting, LLC</u>	2016	1,833						11
12	<u>Allocations - Extended Care Consulting, LLC</u>	2017							12
13									13
14	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2002	26,410						14
15	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2002	21,817						15
16	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2003	25,710						16
17	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2005	1,277						17
18	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2009	231						18
19	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2014	2,212						19
20	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2015	363						20
21	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2016	1,436						21
22	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2017	2,490						22
23									23
24	<u>Allocations - Extended Care Consulting, LLC / Dyer Building</u>	2007	8,272						24
25									25
26									26
27									27
28									28
29									29
30									30
31	<u>Depreciation - Kensington Nursing & Rehabilitation Center, LLC</u>			31,266		31,266		122,144	31
32	<u>Depreciation - Boulevard Property, LLC</u>			92,963		92,963		3,623,594	32
33	<u>Depreciation - Extended Care Consulting, LLC</u>			2,408		2,408		179,027	33
34	TOTAL (lines 1 thru 33)		\$ 3,187,305	\$ 126,637		\$ 126,637	\$	\$ 3,924,765	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 177,588	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	See Supplemental	267,858						74
75	TOTALS	\$ 445,446	\$	\$	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Alloc. - Extended Care			\$ 6,220	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 6,220	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,758,136	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 126,637	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 126,637	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,924,765	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	See Suppl.							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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 15,376 Description: See Supplemental Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Lexus	\$	\$ 13,694	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 13,694	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.
- SEE ACCOUNTANTS' PREPARATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	147,693	\$		\$	147,693	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				55,055				55,055	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				117,471				117,471	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					43,357			43,357	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): See Supplemental	39 - 02						0				12
13	Other (specify): See Supplemental	39 - 03					8,764				8,764	13
14	TOTAL			\$		\$	328,983	\$	43,357	\$	372,340	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Kensington Place Nursing & Rehabilitation Center, LLC** # **0052712**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 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 121,389	\$ 407,294	1
2	Cash-Patient Deposits	42,453	42,453	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>903,555</u>)	1,881,641	1,881,641	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	71,663	71,663	6
7	Other Prepaid Expenses	2,317	2,317	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>	5,982	140,730	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,125,445	\$ 2,546,098	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		3,624,354	14
15	Leasehold Improvements, at Historical Cost	577,730	577,730	15
16	Equipment, at Historical Cost	184,891	339,891	16
17	Accumulated Depreciation (book methods)	(122,144)	(3,745,738)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Supplemental Schedule</u>	779,582	3,154,582	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,420,059	\$ 4,050,819	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,545,504	\$ 6,596,917	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 550,153	\$ 550,153	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,716	45,716	28
29	Short-Term Notes Payable	650,000	650,000	29
30	Accrued Salaries Payable	362,849	362,849	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,625	13,625	31
32	Accrued Real Estate Taxes(Sch.IX-B)		257,246	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Supplemental Schedule</u>	1,211,978	637,093	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,834,321	\$ 2,516,682	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,650,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Supplemental Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,650,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,834,321	\$ 6,166,682	46
47	TOTAL EQUITY (page 18, line 24)	\$ 711,183	\$ 430,235	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,545,504	\$ 6,596,917	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Kensington Place Nursing & Rehabilitation Center, LLC

Medicaid Cost Report

01/01/17 - 12/31/17

Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
Due from Employees	5,982		5,982
Real Estate Tax Advance Payments		134,748	134,748
			-
			-
			-
Sub-Total	<u>5,982</u>	<u>134,748</u>	<u>140,730</u>
Line 23 - Long Term Assets			
Financing Costs (Net of Amortization)	3,200		3,200
Option Deposit	775,000	(775,000)	-
State Replacement Tax Benefit	1,382		1,382
Due from Non-Related Entities		3,150,000	3,150,000
			-
Sub-Total	<u>779,582</u>	<u>2,375,000</u>	<u>3,154,582</u>
Line 36 - Other Current Liability			
Due to Affiliated Entities	1,211,978	(574,885)	637,093
			-
			-
			-
			-
Sub-Total	<u>1,211,978</u>	<u>(574,885)</u>	<u>637,093</u>
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 413,074	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 413,073	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	577,667	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	(279,557)	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)	\$ 298,110	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)	\$ 711,183	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Kensington Place Nursing & Rehabilitation Center, # 0052712 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	\$ 9,546,118	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,546,118	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	59,569	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 59,569	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	22,770	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,770	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,628,457	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,340,680	31
32	Health Care	3,133,429	32
33	General Administration	2,529,907	33
B. Capital Expense			
34	Ownership	1,292,681	34
C. Ancillary Expense			
35	Special Cost Centers	372,340	35
36	Provider Participation Fee	381,753	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,050,790	40
41	Income before Income Taxes (line 30 minus line 40)**	577,667	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 577,667	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,683,784	44
45	Private Pay - Net Inpatient Revenue	169,015	45
46	Medicare - Net Inpatient Revenue	1,317,571	46
47	Other-(specify) Insurance - Net Inpatient Revenue	247,298	47
48	Other-(specify) Hospice - Net Inpatient Revenue	128,450	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,546,118	49

* This must agree with page 4, line 45, column 4.
 ** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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 Kensington Place Nursing & Rehabilitation Center, LLC

0052712

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	1,933	2,190	\$ 111,700	\$ 51.00	1
2	Assistant Director of Nursing	2,037	2,197	86,732	39.48	2
3	Registered Nurses	11,268	12,088	355,485	29.41	3
4	Licensed Practical Nurses	28,475	30,856	801,083	25.96	4
5	CNAs & Orderlies	67,377	73,207	888,998	12.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,533	7,487	131,974	17.63	8
9	Activity Director	1,866	2,066	33,649	16.29	9
10	Activity Assistants	5,661	6,320	72,025	11.40	10
11	Social Service Workers	11,471	12,309	221,297	17.98	11
12	Dietician					12
13	Food Service Supervisor	1,867	2,071	47,354	22.87	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,148	18,020	208,417	11.57	15
16	Dishwashers					16
17	Maintenance Workers	5,969	6,578	116,538	17.72	17
18	Housekeepers	15,134	16,385	186,329	11.37	18
19	Laundry	3,562	4,060	47,858	11.79	19
20	Administrator	2,045	2,206	156,067	70.75	20
21	Assistant Administrator	2,045	2,206	96,208	43.61	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,236	13,207	393,452	29.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,138	2,305	31,127	13.50	31
32	Other Health Care(specify)					32
33	Other(specify)	6,466	6,984	234,010	33.51	33
34	TOTAL (lines 1 - 33)	204,231	222,742	\$ 4,220,303 *	\$ 18.95	34

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 11,359	01 - 03	35
36	Medical Director	9,000	09 - 03	36
37	Medical Records Consultant	1,898	10 - 03	37
38	Nurse Consultant	25,970	10 - 03	38
39	Pharmacist Consultant	10,579	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	2,262	11 - 03	44
45	Social Service Consultant	2,016	12 - 03	45
46	Other(specify)			46
47	See Supplemental			47
48				48
49	TOTAL (lines 35 - 48)	\$ 63,084		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

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	
Yechiel Mashiach	Administrator	15.20%	\$ 156,067	Workers' Compensation Insurance	\$ 121,709	IDPH License Fee	\$ 1,990	
Cynthia Staine	Asst. Admin.	0.00%	96,208	Unemployment Compensation Insurance	59,065	Advertising: Employee Recruitment	9,276	
				FICA Taxes	304,468	Health Care Worker Background Check	6,031	
				Employee Health Insurance	237,645	(Indicate # of checks performed)		
				Employee Meals		<u>Patient Background Checks</u>		
				Illinois Municipal Retirement Fund (IMRF)*		<u>Dues and Subscriptions</u>	20,639	
				<u>Retirement Contributions</u>	56,889	<u>Licenses and Fees</u>	1,297	
				<u>Other</u>	3,842	<u>Advertising and Promotion</u>	9,405	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 252,275			<u>Alloc. - Extended Care Consulting</u>	841	
(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				Description	Line #	Amount	Description	Amount
							Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	2,608
							<u>Alloc. - Extended Care Consulting</u>	36
							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)							TOTAL	\$ 40,074
C. Professional Services								
Vendor/Payee	Type							
Extended Care Consulting, LLC	Home Office	\$	134,400					
Plante & Moran, PLLC	Accounting		3,593					
Personnel Planners, Inc.	Unemployment Consultant		1,131					
Ability Network	Data Processing / IT		5,298					
MatrixCare	Data Processing / IT		18,183					
ProPay	Data Processing / IT		20,827					
National Datacare Corporation	Data Processing / IT		3,211					
Relias Learning	Data Processing / IT		4,179					
Comcast	Data Processing / IT		2,519					
Other	Data Processing / IT		335					
Ronald Cournaya	Accounting		2,500					
See Supplemental Schedule			35,500					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 231,676					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Kensington Place Nursing & Rehabilitation Center, LLC

Medicaid Cost Report

01/01/17 - 12/31/17

Page 21 Supplemental Schedule - Legal Invoice Detail

Vendor	Service Description	Invoice Date		Amount	Non-Allowable	Allowable	
Finkel, Martwick & Colson, P.C.	RE Tax Appeal (Pg. 3 / 4 Reclass)	01/18/17		4,167		4,167	
Generation Law, Ltd.	Resident Guardianship	07/14/17		963		963	
Generation Law, Ltd.	Resident Guardianship	09/26/17		4,918		4,918	
Other	Non-Allowable	Various		16,524	16,524	-	
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
Total				26,571	16,524	10,047	

Facility Name & ID Number Kensington Place Nursing & Rehabilitation Center, LLC# 0052712

Report Period Beginning:

01/01/17Ending: 12/31/17**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC - \$16,233
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 - 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10 - 02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 381,753
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 0
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? Ln 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT