

Facility Name & ID Number Oak Lawn Respiratory & Rehab

0051144 Report Period Beginning: 1/1/17 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	75	Skilled (SNF)	75	27,375	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,820	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	143	TOTALS	143	52,195	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	11,966	201	3,842	16,009	8
9	SNF/PED					9
10	ICF	10,850	183	2,141	13,174	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,816	384	5,983	29,183	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.91%

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)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 9/1/10

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 54 and days of care provided 1,481

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

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

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/17 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	233,813	20,386	17,837	272,036		272,036	(3,281)	268,755		1
2	Food Purchase		135,895		135,895		135,895	1,041	136,936		2
3	Housekeeping	153,068	38,713		191,781		191,781	315	192,096		3
4	Laundry	59,847	19,836		79,683		79,683		79,683		4
5	Heat and Other Utilities			142,251	142,251		142,251	425	142,676		5
6	Maintenance	45,903	42,629	83,920	172,452		172,452	358	172,810		6
7	Other (specify):*										7
8	TOTAL General Services	492,631	257,459	244,008	994,098		994,098	(1,142)	992,956		8
	B. Health Care and Programs										
9	Medical Director			34,800	34,800		34,800		34,800		9
10	Nursing and Medical Records	2,368,652	580,548	51,508	3,000,708		3,000,708	(15,921)	2,984,787		10
10a	Therapy	535,306		408,315	943,621		943,621		943,621		10a
11	Activities	73,020	10,232		83,252		83,252		83,252		11
12	Social Services	41,745		8,254	49,999		49,999		49,999		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Pharmacy Consult			8,685	8,685		8,685	(159)	8,526		15
16	TOTAL Health Care and Programs	3,018,723	590,780	511,562	4,121,065		4,121,065	(16,080)	4,104,985		16
	C. General Administration										
17	Administrative	132,596			132,596		132,596	(36,000)	96,596		17
18	Directors Fees										18
19	Professional Services			592,138	592,138		592,138	(114,742)	477,396		19
20	Dues, Fees, Subscriptions & Promotions			26,156	26,156		26,156	75	26,231		20
21	Clerical & General Office Expenses	209,234	67,438	117,232	393,904		393,904	63,882	457,786		21
22	Employee Benefits & Payroll Taxes			786,186	786,186		786,186	24,950	811,136		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,696	6,696		6,696	3,049	9,745		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			248,841	248,841		248,841	35,049	283,890		26
27	Other (specify):*										27
28	TOTAL General Administration	341,830	67,438	1,777,249	2,186,517		2,186,517	(23,737)	2,162,780		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,853,184	915,677	2,532,819	7,301,680		7,301,680	(40,959)	7,260,721		29

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

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

Facility Name & ID Number

Oak Lawn Respiratory & Rehab

#0051144

Report Period Beginning:

1/1/17

Ending:

12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			61,161	61,161		61,161	466,638	527,799			30
31	Amortization of Pre-Op. & Org.							33,336	33,336			31
32	Interest			160,525	160,525		160,525	117,553	278,078			32
33	Real Estate Taxes							280,970	280,970			33
34	Rent-Facility & Grounds			1,083,048	1,083,048		1,083,048	(1,079,001)	4,047			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,304,734	1,304,734		1,304,734	(180,504)	1,124,230			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			149	149		149		149			38
39	Ancillary Service Centers		159,472		159,472		159,472	(2,762)	156,710			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			241,115	241,115		241,115		241,115			42
43	Other (specify):* Bad Debt Expense			174,895	174,895		174,895	(174,895)				43
44	TOTAL Special Cost Centers		159,472	416,159	575,631		575,631	(177,657)	397,974			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,853,184	1,075,149	4,253,712	9,182,045		9,182,045	(399,120)	8,782,925			45

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

Facility Name & ID Number Oak Lawn Respiratory & Rehab

0051144

Report Period Beginning:

1/1/17

Ending:

12/31/17

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	129,517	30		9
10	Interest and Other Investment Income	(43,399)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(7,142)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(174,895)	43		24
25	Fund Raising, Advertising and Promotional	(8,311)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(11,948)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (116,188)		\$	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)	(282,932)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (282,932)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (399,120)		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				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

Oak Lawn Respiratory & Rehab

ID# 0051144

Report Period Beginning: 1/1/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (1,706)	1	1
2	Miscellaneous Income	(6,576)	21	2
3	Lobbying	(475)	20	3
4	RP Profit	(270)	10	4
5	RP Profit	(159)	15	5
6	RP Profit	(2,762)	39	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	(11,948)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oak Lawn Respiratory & Rehab

0051144

Report Period Beginning:

1/1/17

Ending:

12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	(1,716)	(1,565)	0	0	0	0	0	0	0	0	0	(3,281)	1
2	Food Purchase	0	1,041	0	0	0	0	0	0	0	0	0	1,041	2
3	Housekeeping	0	315	0	0	0	0	0	0	0	0	0	315	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	425	0	0	0	0	0	0	0	0	0	425	5
6	Maintenance	0	358	0	0	0	0	0	0	0	0	0	358	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,716)	574	0	0	0	0	0	0	0	0	0	(1,142)	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	(270)	(15,651)	0	0	0	0	0	0	0	0	0	(15,921)	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):*	(159)	0	0	0	0	0	0	0	0	0	0	(159)	15
16	TOTAL Health Care and Programs	(429)	(15,651)	0	0	0	0	0	0	0	0	0	(16,080)	16
	C. General Administration													
17	Administrative	0	(36,000)	0	0	0	0	0	0	0	0	0	(36,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(141,136)	26,394	0	0	0	0	0	0	0	0	(114,742)	19
20	Fees, Subscriptions & Promotions	(475)	550	0	0	0	0	0	0	0	0	0	75	20
21	Clerical & General Office Expenses	(22,029)	85,376	535	0	0	0	0	0	0	0	0	63,882	21
22	Employee Benefits & Payroll Taxes	0	24,950	0	0	0	0	0	0	0	0	0	24,950	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,049	0	0	0	0	0	0	0	0	0	3,049	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	512	34,537	0	0	0	0	0	0	0	0	35,049	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(22,504)	(62,699)	61,466	0	(23,737)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(24,649)	(77,776)	61,466	0	(40,959)	29							

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

1/1/17

Ending:

12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	129,517	0	337,121	0	0	0	0	0	0	0	0	466,638	30
31	Amortization of Pre-Op. & Org.	0	0	33,336	0	0	0	0	0	0	0	0	33,336	31
32	Interest	(43,399)	0	160,952	0	0	0	0	0	0	0	0	117,553	32
33	Real Estate Taxes	0	0	280,970	0	0	0	0	0	0	0	0	280,970	33
34	Rent-Facility & Grounds	0	0	(1,079,001)	0	0	0	0	0	0	0	0	(1,079,001)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	86,118	0	(266,622)	0	(180,504)	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	(2,762)	0	0	0	0	0	0	0	0	0	0	(2,762)	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):*	(174,895)	0	0	0	0	0	0	0	0	0	0	(174,895)	43
44	TOTAL Special Cost Centers	(177,657)	0	0	0	0	0	0	0	0	0	0	(177,657)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(116,188)	(77,776)	(205,156)	0	(399,120)	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
Michael Blisko	20%	Ambassador Nursing & Rehab Center	Chicago	Inifinity Healthcare	Hillside	Management Co
GELP	20%	Belhaven Nursing & Rehab Center	Chicago	Oak Lawn Realty	Hillside	Property Co.
A&F Realty	20%	City View Multicare Center	Cicero	United Rx	Hillside	Pharmacy Co.
Rosie Schwartz	20%	Continental Nursing & Rehab Center	Chicago			
SYSNY	20%	Forest View Rehab & Nursing Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$ 3,587	Inifinity Healthcare Management		\$ 2,022	\$ (1,565)	1
2	V	2 Food Purchase		Inifinity Healthcare Management		1,041	1,041	2
3	V	3 Housekeeping		Inifinity Healthcare Management		315	315	3
4	V	5 Utilities		Inifinity Healthcare Management		425	425	4
5	V	6 Maintenance		Inifinity Healthcare Management		358	358	5
6	V	10 Nursing	51,508	Inifinity Healthcare Management		35,857	(15,651)	6
7	V	17 Administrator	36,000	Inifinity Healthcare Management			(36,000)	7
8	V	19 Activities	233,377	Inifinity Healthcare Management		92,241	(141,136)	8
9	V	20 Dues & Fees		Inifinity Healthcare Management		550	550	9
10	V	21 Office Expense	97,927	Inifinity Healthcare Management		183,303	85,376	10
11	V	22 Employee Benefits		Inifinity Healthcare Management		24,950	24,950	11
12	V	24 Travel Expense		Inifinity Healthcare Management		3,049	3,049	12
13	V	26 Insurance		Inifinity Healthcare Management		512	512	13
14	Total		\$ 422,399			\$ 344,623	\$ * (77,776)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	30 Depreciation	\$	Infinity Healthcare Management		\$ 113	\$	113	15
16	V	32 Interest		Infinity Healthcare Management		12		12	16
17	V	34 Rent		Infinity Healthcare Management		4,047		4,047	17
18	V								18
19	V	19 Professional Fees		Oak Lawn Realty LLC		26,394		26,394	19
20	V	21 Office Expense		Oak Lawn Realty LLC		535		535	20
21	V	26 Insurance		Oak Lawn Realty LLC		34,537		34,537	21
22	V	30 Depreciation		Oak Lawn Realty LLC		337,008		337,008	22
23	V	31 Amortization		Oak Lawn Realty LLC		33,336		33,336	23
24	V	32 Interest		Oak Lawn Realty LLC		160,940		160,940	24
25	V	33 Property Tax		Oak Lawn Realty LLC		280,970		280,970	25
26	V	34 Rent	1,083,048	Oak Lawn Realty LLC				(1,083,048)	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		\$ 1,083,048			\$ 877,892	\$ *	(205,156)	39

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

Facility Name & ID Number

Oak Lawn Respiratory & Rehab

0051144

Report Period Beginning:

1/1/17

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			Momence Meadows Nursing & Rehab Ctr	Momence				1
2			Niles Nursing & Rehab Center	Niles				2
3			Parker Nursing & Rehab Center	Streator				3
4			Parkshore Estates Nursing & Rehab Ctr	Chicago				4
5			Southpoint Nursing & Rehab Center	Chicago				5
6			West Suburban Nursing & Rehab Center	Bloomington				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/17 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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Oak Lawn Respiratory & Rehab

0051144

Report Period Beginning:

1/1/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Oak Lawn Respiratory & Rehab

0051144

Report Period Beginning:

1/1/17

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	HUD Loan		X	Mortgage	\$21,117.00	9/24/14	\$ 4,587,800	\$ 4,307,212	10/1/44	3.7000	\$ 160,940	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Capital One		X	Working Capital	None	8/31/14	26,000,000	7,683,118	8/31/15	various	160,046	6						
7	Infinity Funding	X		Working Capital	None	Various	Various	7,783	various	various	491	7						
8												8						
9	TOTAL Facility Related				\$21,117.00		\$ 30,587,800	\$ 11,998,113			\$ 321,477	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 30,587,800	\$ 11,998,113			\$ 321,477	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 28,471 Line # 26

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2016 report.		\$	23,762	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.)		\$	337,027	2
3. Under or (over) accrual (line 2 minus line 1).		\$	313,265	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	(32,295)	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	280,970	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2012	253,105	8	
	2013	258,880	9	
	2014	331,492	10	
	2015	334,468	11	
	2016	337,027	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oak Lawn Respiratory & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051144

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>24-08-201-007-0000</u>	<u>Nursing Home</u>	\$ <u>337,027.00</u>	\$ <u>337,027.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>337,027.00</u></u>	\$ <u><u>337,027.00</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 Oak Lawn Respiratory & Rehab

0051144

Report Period Beginning:

1/1/17

Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,070 B. General Construction Type: Exterior Brick Frame Number of Stories 3

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

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

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

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

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

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

Blank lines for listing other business entities.

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

If so, please complete the following:

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Oak Lawn Respiratory & Rehab

0051144

Report Period Beginning:

1/1/17

Ending:

12/31/17

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	143	2010	1960	\$ 2,000,000	\$ 51,288	39	\$ 51,282	\$ (6)	\$ 341,916	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Painting	2010		1,981	51	39	51		377	9
10	Drywall	2010		1,500	38	39	38		284	10
11	Roofing	2010		40,500	1,038	39	1,038		7,701	11
12	Signs	2010		3,102	80	39	80		591	12
13	Windows	2010		16,500	423	39	423		3,138	13
14	Walls, Wallpaper, Flooring, Doors	2010		88,500	2,269	39	2,269		16,829	14
15	Signs	2010		6,298	161	39	161		1,196	15
16	Windows	2010		50,630	1,298	39	1,298		9,628	16
17	Concrete and Asphalt for driveway	2010		38,000	974	39	974		7,225	17
18	Concrete and Asphalt for driveway	2010		17,490	448	39	448		3,325	18
19	Air conditioner	2011		753	19	39	19		134	19
20	Chair mats	2011		346	9	39	9		62	20
21	Fire alarm system	2011		16,210	416	39	416		2,911	21
22	Drywall	2011		1,696	43	39	43		303	22
23	Electrical Outlets	2011		3,200	82	39	82		574	23
24	Subpanel in 2nd floor med room	2011		3,500	90	39	90		629	24
25	remove & install new shingle roof	2010		20,490	525	39	525		3,677	25
26	Mirrors, Vanity Lights, Ceiling Painting	2011		45,280	1,161	39	1,161		8,127	26
27	Signage permit for mirros, vanity, etc.	2010		450	12	39	12		82	27
28	Window permit for mirrors, vanity, etc.	2010		900	23	39	23		161	28
29	Air conditioner	2011		3,620	93	39	93		650	29
30	Tables and Chairs	2010		5,525	142	39	142		993	30
31	Mirrors, Vanity Lights, Ceiling Painting	2010		67,919	1,742	39	1,742		12,192	31
32	Aluminum and glass store front, wiring, sidewalk, sprinkler	2010		39,750	1,019	39	1,019		7,134	32
33	Sprinkler system	2011		9,500	244	39	244		1,706	33
34	Shower Door Frame	2011		550	14	39	14		98	34
35	Granite shelf	2011		300	8	39	8		55	35
36	Drywall soffit for sprinkler pipe enclosure	2011		650	17	39	17		118	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Oak Lawn Respiratory & Rehab

0051144

Report Period Beginning:

1/1/17

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	Profile cove base	2011	\$ 1,350	\$ 35	39	\$ 35		\$ 243	37
38	Laminate column covers	2011	945	24	39	24		169	38
39	Drywall for spinkler pipe enclosure	2011	500	13	39	13		90	39
40	Hallway & Shower room walls, tiles, wander board, lighting, grab	2011	66,717	1,711	39	1,711		11,976	40
41	build new closet	2011	1,100	28	39	28		197	41
42	Plumbing for lobby bathroom	2011	1,600	41	39	41		287	42
43	Drywall and insulation for dining room & hallway	2011	5,344	137	39	137		959	43
44	Granite countertop and wood front	2011	8,500	218	39	218		1,526	44
45	Profile cove base	2011	1,350	35	39	35		243	45
46	Bathroom doors and frames	2011	1,200	31	39	31		216	46
47	Bathroom doors and frames	2011	1,200	31	39	31		216	47
48	Office walls, rewiring, lighting, doors	2011	3,900	100	39	100		700	48
49	Door and frame	2011	1,450	37	39	37		260	49
50	Bulletin boards	2011	1,256	32	39	32		225	50
51	Foundation, tiles, exit signs, lighting	2011	8,160	209	39	209		1,464	51
52	Shower room plumbing, drain, door, drywall	2011	2,050	53	39	53		369	52
53	Room repair for canopy, steel column, wood cover	2011	11,450	294	39	294		2,056	53
54	Elevator new valve (Maxton UC 4)	2011	3,650	94	39	94		656	54
55	Fire dampers and smoke detectors	2011			39				55
56	Fire dampers and smoke detectors	2011	4,250	109	39	109		762	56
57	Plumbing	2011	2,800	72	39	72		503	57
58	Lights	2011	3,165	81	39	81		568	58
59	Ejector pumps and control panel	2011	1,385	36	39	36		250	59
60	Replace ventor motor on stove	2012	2,318	59	39	59		355	60
61	Ceiling tiles	2012	1,833	47	39	47		282	61
62	Fire sprinkler for elevator pit and hallway	2012	4,100	105	39	105		630	62
63	Painting of resident rooms	2012	1,920	49	39	49		295	63
64	Painting of resident rooms	2012	7,600	195	39	195		1,170	64
65	Painting of resident rooms	2012	10,950	281	39	281		1,684	65
66	Painting of resident rooms	2012	4,300	110	39	110		661	66
67	Painting of resident rooms	2012	3,350	86	39	86		516	67
68	Painting of resident rooms	2012	5,200	133	39	133		799	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,660,032	\$ 68,213		\$ 68,207	\$ (6)	\$ 462,143	70

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

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

Report Period Beginning:

1/1/17

Ending:

12/31/17**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,660,032	\$ 68,213		\$ 68,207	\$ (6)	\$ 462,143	1
2	Priming/Sanding/painting on 1st floor	2013	4,599	118	39	118		531	2
3	Laminate walls panels - 1st floor nurse station	2013	1,850	47	39	47		212	3
4	Shutters	2013	1,900	49	39	49		220	4
5	Cement Board panels - exterior columns	2013	1,500	38	39	38		172	5
6	Drywall	2013	1,421	36	39	36		163	6
7	Air ducts - 1st floor	2013	2,895	74	39	74		333	7
8	Air ducts - 2nd floor	2013	3,250	83	39	83		374	8
9	Bathroom exhaust - 2nd floor	2013	4,467	115	39	115		517	9
10	Fire dampers / exhaust - 1st floor	2013	7,850	201	39	201		905	10
11	Outlets - 2nd floor	2013	7,800	200	39	200		900	11
12	Outlets - 1st floor	2013	2,750	71	39	71		319	12
13	Outlets - basement	2013	4,680	120	39	120		540	13
14	Ceiling - basement	2013	1,315	34	39	34		153	14
15	Electrical switches	2013	1,755	45	39	45		202	15
16	Ceiling patch	2013	1,860	48	39	48		216	16
17	Electrical wiring - nurse stations	2013	11,200	287	39	287		1,292	17
18									18
19	Danny Golmayo - repair exit doors	2014	3,750	96	39	96		336	19
20	Precision Heating - work on RTU	2013	3,925	101	39	101		353	20
21	Superior Const.- drywall, electrical, paint near fire exit door	2014	3,857	99	39	99		346	21
22	Repair door frames & install outlets all resident rms 2nd flr	2014	6,837	175	39	175		613	22
23	Superior Const. - Replace drywall & insulation in 2 hallways	2014	7,161	184	39	184		644	23
24	Pegasus Custom Furn - beds, wardrobes, dressers	2014	3,130	80	39	80		280	24
25	Alliance Construction - plumbing / sewer line diverted	2014	5,700	146	39	146		511	25
26	New wander guard system for the dementia unit	2014	3,522	90	39	90		315	26
27	Charles Equipment Energy Systems - inspect/repaid Generac	2014	2,054	53	39	53		185	27
28	Five Star - replaces asphalt, removed debris	2014	2,375	61	39	61		213	28
29	Cement boards on ext. columns/handrails 1st flr nrse station	2014	4,006	103	39	103		360	29
30	Remove asbestos from boiler room	2014	7,244	186	39	186		651	30
31	On-Line Communications, Inc. - cable installation	2014	28,465	730	39	730		2,555	31
32	OTIS - Door restrictor down payment	2014	3,313	85	39	85		297	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,806,463	\$ 71,968		\$ 71,962	\$ (6)	\$ 476,851	34

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

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

Report Period Beginning:

1/1/17

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		\$ 2,806,463	\$ 71,968		\$ 71,962	\$ (6)	\$ 476,851	1
2	Precision Heating - replace 1st floor furnace	2014	3,250	83	39	83		291	2
3	Precision Heating - replace fan motors and contactors	2014	2,191	56	39	56		196	3
4	Precision Heating - install new a/c compressor/unit	2014	3,665	94	39	94		329	4
5	Precision Heating - new high efficient 10-ton RTU	2014	12,550	322	39	322		1,127	5
6	Superior Construction - basement kitchen doors	2014	2,963	76	39	76		266	6
7	Superior Construction - remove/repair chair rail/hinges	2014	5,915	152	39	152		532	7
8	Superior Construction - install approx. 50 locks, closet door	2014	4,108	105	39	105		368	8
9	Superior Construction - drywall / painting / wiring	2014	1,666	43	39	43		150	9
10	Superior Construction - new outlets, electrical work	2014	3,497	90	39	90		315	10
11	Superior Construction - replace ceiling tiles, paint	2014	2,549	65	39	65		228	11
12	Superior Construction - repair walls / install new flooring / ceiling	2014	4,291	110	39	110		385	12
13	Various - test all outlets, plumbing/clog issue	2014	15,640	401	39	401		1,404	13
14									14
15	Hot Water Heater Repair	2015	2,598	67	39	67		203	15
16	Hot Water Heater Repair	2015	8,000	205	39	205		621	16
17	Paint/Repair Walls/Replace Ceiling Light on 2nd floor	2015	4,319	111	39	111		336	17
18									18
19	Safety Code Repairs - close hole in ceiling in med records &	2015	4,861	125	39	125		378	19
20	boiler rm, replace latches to rms 111&116, seal fire damper								20
21	b/w FL 1&2, replace locks, to therapy rms & stairwell FLs 1&2								21
22									22
23	Inspection of Sprinkler System/Additional Sprinkler Head	2015	2,572	66	39	66		200	23
24	New Fire Doors for Laundry Room	2015	2,920	75	39	75		227	24
25	New Linen Closet Doors for Floors 1-4 & Basement	2015	4,047	104	39	104		315	25
26	Rewired Lights/Repaired Walls in 1st Floor Med Room	2015	5,534	142	39	142		430	26
27	Repaired Bed Lights/Walls in Patient Rooms on 1st Floor	2015	3,988	102	39	102		309	27
28	Repaired Bed Lights/Walls in Patient Rooms on 1st Floor	2015	4,735	121	39	121		366	28
29	Installed Additional Outlets in Patient Rooms on 1st Floor	2015	8,309	213	39	213		645	29
30	New Boiler	2015	42,887	1,100	39	1,100		3,329	30
31	Electrical and Lighting Repairs in Boiler Room	2015	18,500	474	39	474		1,434	31
32	Install New Doors, Hinges, & Bolts on Floors 1-4 & Basement	2015	4,387	112	39	112		339	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,986,404	\$ 76,582		\$ 76,576	\$ (6)	\$ 491,574	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,986,404	\$ 76,582		\$ 76,576	\$ (6)	\$ 491,574	1
2	New Gibs for Elevator	2016	3,454	89	39	89		188	2
3	Paint 1st Floor Dining Room	2016	3,560	91	39	91		193	3
4	New Condenser Fan Motor & Blade for Chiller	2016	2,670	68	39	68		145	4
5	New Control Board for Chiller	2016	3,815	98	39	98		207	5
6	Install New Drwall & Paint Activity Room	2016	2,676	69	39	69		146	6
7	Laundry Room Fresh Air Duct	2016	2,950	76	39	76		161	7
8	New Floor for Shower Room	2016	2,998	77	39	77		163	8
9	New Bowl Since for 1st & 2nd Floor Utility Closets	2016	4,150	106	39	106		225	9
10	IDPH Capital Report Adjustments 6/30/16	2016	(63,866)						10
11					39				11
12	Room 213 Chilled/Hot Water Convector	2017	4,500	63	39	115	52	63	12
13	2nd Floor Dining Room HVAC System	2017	2,975	42	39	76	34	42	13
14	New Dry Wall-Room 110; Install New VCT Tiles & Paint	2017	2,640	37	39	68	31	37	14
15	Conference Room Basement								15
16	New Fire-Rated Doors for Delivery Door & Patio	2017	6,494	91	39	167	76	91	16
17	Remove Wall Paper & Paint Medical Records Room	2017	3,506	49	39	90	41	49	17
18	Fire Alarm Egress Doors for Room 113 & Room 103	2017	3,521	49	39	90	41	49	18
19	Condensor for 2nd Floor Dining Room AC	2017	6,545	92	39	168	76	92	19
20	Replace Dampers, Actuators & Controllers on 2nd Floor	2017	3,572	50	39	92	42	50	20
21	Dining Room AC Unit								21
22	Maglocks for Basement & First Floor Doors	2017	7,106	100	39	182	82	100	22
23	Seal Basement	2017	4,425	62	39	113	51	62	23
24	Door Operator, Clutch, Pick Ups & Locks for Elevator	2017	5,264	74	39	135	61	74	24
25	Install new Ejector Pumps & Electric Control Panel	2017	13,560	191	39	348	157	191	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,012,919	\$ 78,156		\$ 78,894	\$ 738	\$ 493,902	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,203,362	\$ 316,009	\$ 440,672	\$ 124,663	5	\$ 1,994,662	71
72	Current Year Purchases	41,163	4,117	8,233	4,116	5	4,117	72
73	Fully Depreciated Assets	188,243				5	188,243	73
74								74
75	TOTALS	\$ 2,432,768	\$ 320,126	\$ 448,905	\$ 128,779		\$ 2,187,022	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,545,687	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 398,282	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 527,799	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 129,517	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,680,924	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Oak Lawn Respiratory & Rehab

0051144

Report Period Beginning: 1/1/17

Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								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: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	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.

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	3,332	\$ 173,771	\$	3,332	\$ 173,771	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,014	54,292		1,014	54,292	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,286	180,252		3,286	180,252	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				150,383		150,383	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Laboratory/X-ray</u>	39-2					9,089		9,089	12
13	Other (specify): _____									13
14	TOTAL			\$	7,632	\$ 408,315	\$ 159,472	7,632	\$ 567,787	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.

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	\$ (96,242)	\$ 147,046	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,383,767	3,383,767	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	191,165	191,165	6
7	Other Prepaid Expenses	545	545	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Escrow</u>		197,066	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,479,235	\$ 3,919,589	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		2,000,000	14
15	Leasehold Improvements, at Historical Cost	1,076,785	1,076,785	15
16	Equipment, at Historical Cost	432,768	2,432,768	16
17	Accumulated Depreciation (book methods)	(481,831)	(2,680,924)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		510,505	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(222,238)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		164,853	22
23	Other(specify): <u>Insurance Exchange</u>	(7,134)	(7,134)	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,020,588	\$ 3,374,615	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,499,823	\$ 7,294,204	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,391,461	\$ 1,533,487	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,037	7,037	28
29	Short-Term Notes Payable		95,649	29
30	Accrued Salaries Payable	132,989	132,989	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,219	16,219	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		13,281	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Line of credit</u>	7,683,118	7,683,118	36
37	<u>Due to Infinity</u>	7,657	7,657	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,238,481	\$ 9,489,437	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,211,563	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,211,563	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,238,481	\$ 13,701,000	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,738,658)	\$ (6,406,796)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,499,823	\$ 7,294,204	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,128,177)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,128,177)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(610,481)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (610,481)	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)	\$ (4,738,658)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Oak Lawn Respiratory & Rehab

0051144

Report Period Beginning: 1/1/17

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,530,893	1
2	Discounts and Allowances for all Levels	626,288	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,157,181	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	283,586	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 283,586	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	70,142	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,138	19
20	Radiology and X-Ray	4,390	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 83,670	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	38,846	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 38,846	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Income	8,282	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,282	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,571,565	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	994,098	31
32	Health Care	4,121,066	32
33	General Administration	2,186,517	33
B. Capital Expense			
34	Ownership	1,304,734	34
C. Ancillary Expense			
35	Special Cost Centers	159,621	35
36	Provider Participation Fee	241,115	36
D. Other Expenses (specify):			
37	Bad Debt	174,895	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,182,046	40
41	Income before Income Taxes (line 30 minus line 40)**	(610,481)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (610,481)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 5,839,024	44
45	Private Pay - Net Inpatient Revenue	73,100	45
46	Medicare - Net Inpatient Revenue	883,555	46
47	Other-(specify)	1,361,502	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,157,181	49

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

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

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

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

Facility Name & ID Number Oak Lawn Respiratory & Rehab

0051144

Report Period Beginning:

1/1/17

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	2,366	2,457	\$ 120,307	\$ 48.96	1
2	Assistant Director of Nursing	1,906	2,095	81,302	38.81	2
3	Registered Nurses	8,859	9,635	310,255	32.20	3
4	Licensed Practical Nurses	27,921	29,648	935,147	31.54	4
5	CNAs & Orderlies	67,689	73,568	1,350,112	18.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,489	5,670	73,020	12.88	9
10	Activity Assistants					10
11	Social Service Workers	1,843	2,028	41,745	20.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,193	18,033	233,813	12.97	15
16	Dishwashers					16
17	Maintenance Workers	1,678	1,930	45,903	23.78	17
18	Housekeepers	11,918	12,837	153,068	11.92	18
19	Laundry	5,496	5,785	59,847	10.35	19
20	Administrator	2,249	2,350	132,596	56.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,502	13,165	209,234	15.89	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	2,022	2,182	43,443	19.91	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Admission Directo</u>	2,028	2,070	63,393	30.62	33
34	TOTAL (lines 1 - 33)	170,159	183,453	\$ 3,853,185 *	\$ 21.00	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	380	\$ 17,837	13	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,472	51,508	10-3	38
39	Pharmacist Consultant	174	8,685	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	89	5,519	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,115	\$ 83,549		49

C. CONTRACT NURSES

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

Facility Name & ID Number **Oak Lawn Respiratory & Rehab**

0051144

Report Period Beginning: **1/1/17**

Ending: **12/31/17**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Valerie Perkovic	Administrator		\$ 59,597	Workers' Compensation Insurance	\$ 128,570	IDPH License Fee	\$	
Michael Kaplan	Administrator		35,564	Unemployment Compensation Insurance	60,664	Advertising: Employee Recruitment		
Ambren Qureshi	Administrator		37,435	FICA Taxes	288,380	Health Care Worker Background Check		
				Employee Health Insurance	166,154	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		IHCA	8,131	
				Pension	154,644	Illinois Dept of Public Health	14,315	
				Employee Background	2,796	AHA	700	
				Employee expense	9,928	Village of Oak Lawn	1,634	
						Other dues	1,451	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 132,596			Less: Public Relations Expense	()	
(List each licensed administrator separately.)						Non-allowable advertising	()	
						Yellow page advertising	()	
B. Administrative - Other						TOTAL (agree to Sch. V,	\$ 26,231	
						line 20, col. 8)		
Description			Amount	E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
			\$	to Owners or Employees			Description	Amount
				Description	Line #	Amount	Out-of-State Travel	\$
							In-State Travel	
							Auto allowance	3,049
							Mileage	5,980
							Seminar Expense	
							Seminar and education	716
							Entertainment Expense	()
							(agree to Sch. V,	
							line 24, col. 8)	
				TOTAL		\$	TOTAL	\$ 9,745
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
Bradley Associates	Accounting		\$ 14,781					
Johnson, Goldburg	Accounting		3,900					
MTS Consulting	Professional		15,511					
Pinnacle Quality Insight	Professional		120					
Kitch Drutchas Wagner Valitutti	Legal		18,312					
New York Health Care	Legal		3,558					
SWANSON, MARTIN & BELL LLP	Legal		24,128					
Infinity Funding / Sedgwick	Legal		266,451					
Infinity	Mgmt		233,377					
Empire Risk	Professional		12,000					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 592,138					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council \$8,131
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 59,752 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 241,115
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 0
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees