



Facility Name & ID Number Abbington Rehab And Nursing

# 0039693 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	22	Skilled (SNF)	22	8,030	1
2		Skilled Pediatric (SNF/PED)			2
3	60	Intermediate (ICF)	60	21,900	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	82	TOTALS	82	29,930	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	8,067	701	420	9,188	8
9	SNF/PED					9
10	ICF	16,039	764		16,803	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,106	1,465	420	25,991	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.84%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 07/01/1994

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 07/01/1994 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 19 and days of care provided 420

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Abbingdon Rehab And Nursing # 0039693 Report Period Beginning: 01/01/18 Ending: 12/31/18

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	210,037	24,158	7,056	241,251		241,251	6,164	247,415		1
2	Food Purchase		137,810		137,810		137,810	(78)	137,732		2
3	Housekeeping	142,953	39,555		182,508		182,508		182,508		3
4	Laundry	30,949	6,438	31,865	69,252		69,252		69,252		4
5	Heat and Other Utilities			93,094	93,094		93,094	(3,087)	90,007		5
6	Maintenance	54,686	7,768	56,831	119,285		119,285	(8,069)	111,216		6
7	Other (specify):*							897	897		7
8	<b>TOTAL General Services</b>	<b>438,625</b>	<b>215,729</b>	<b>188,846</b>	<b>843,200</b>		<b>843,200</b>	<b>(4,173)</b>	<b>839,027</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,423,227	82,509	7,213	1,512,949		1,512,949		1,512,949		10
10a	Therapy	28,811		4,068	32,879		32,879		32,879		10a
11	Activities	68,947	891	880	70,718		70,718		70,718		11
12	Social Services	42,079		854	42,933		42,933		42,933		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,563,064</b>	<b>83,400</b>	<b>19,015</b>	<b>1,665,479</b>		<b>1,665,479</b>		<b>1,665,479</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	93,904		246,100	340,004		340,004	(170,241)	169,763		17
18	Directors Fees										18
19	Professional Services			70,773	70,773		70,773	(25,900)	44,873		19
20	Dues, Fees, Subscriptions & Promotions			21,655	21,655		21,655	(11,914)	9,741		20
21	Clerical & General Office Expenses	76,582	8,937	65,293	150,812		150,812	70,929	221,741		21
22	Employee Benefits & Payroll Taxes			319,350	319,350		319,350		319,350		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,858	1,858		1,858	183	2,041		24
25	Other Admin. Staff Transportation			3,258	3,258		3,258	1,677	4,935		25
26	Insurance-Prop.Liab.Malpractice			52,510	52,510		52,510	1,781	54,291		26
27	Other (specify):*							33,028	33,028		27
28	<b>TOTAL General Administration</b>	<b>170,486</b>	<b>8,937</b>	<b>780,797</b>	<b>960,220</b>		<b>960,220</b>	<b>(100,457)</b>	<b>859,763</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,172,175</b>	<b>308,066</b>	<b>988,658</b>	<b>3,468,899</b>		<b>3,468,899</b>	<b>(104,630)</b>	<b>3,364,269</b>		<b>29</b>

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

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

Facility Name & ID Number Abbington Rehab And Nursing

#0039693

Report Period Beginning:

01/01/18

Ending:

12/31/18

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			52,455	52,455		52,455	98,080	150,535			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,096	3,096		3,096	121,029	124,125			32
33	Real Estate Taxes			37,915	37,915		37,915	1,397	39,312			33
34	Rent-Facility & Grounds			588,000	588,000		588,000	(588,000)				34
35	Rent-Equipment & Vehicles							4,695	4,695			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			681,466	681,466		681,466	(362,799)	318,667			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		16,960	58,326	75,286		75,286		75,286			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			201,989	201,989		201,989		201,989			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		16,960	260,315	277,275		277,275		277,275			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,172,175	325,026	1,930,439	4,427,640		4,427,640	(467,429)	3,960,211			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 **Abbington Rehab And Nursing**

# **0039693**

Report Period Beginning:

**01/01/18**

Ending:

**12/31/18**

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(4,012)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	38,253	30		9
10	Interest and Other Investment Income	(14,869)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(78)	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				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	(5,723)	21		24
25	Fund Raising, Advertising and Promotional	(526)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(6,960)	20		28
29	Other-Attach Schedule	(33,017)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (26,932)		\$	30

<b>BHF USE ONLY</b>							
48		49		50		51	
							52

**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	
		<b>Amount</b>	<b>Reference</b>	
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)	(440,497)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (440,497)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (467,429)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Abbington Rehab And Nursing

ID# 0039693

Report Period Beginning: 01/01/18

Ending: 12/31/18

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Capitalized R&M (tax items)	\$ (12,250)	06	1
2	Miscellaneous Income	(87)	21	2
3	Sequestration	(4,002)	21	3
4	Building Co - Amortization	(2,828)	36	4
5	Building Co - Accounting Fees	(1,500)	19	5
6	Building Co - LLC Fees	(375)	20	6
7	Building Co - Replacement Tax	(5,725)	21	7
8	Non-Allowable Legal	(1,822)	19	8
9	PAC Dues	(4,428)	20	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(33,017)		49

Abbington Rehab And Nursing

Report Period Beginning: ID# 0039693  
 Ending: 01/01/18  
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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	<b>Total</b>		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Abbington Rehab And Nursing# 0039693

Report Period Beginning:

01/01/18

Ending:

12/31/18

## 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				6,164								6,164	1
2	Food Purchase	(78)											(78)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(4,012)		925									(3,087)	5
6	Maintenance	(12,250)		1,027	3,154								(8,069)	6
7	Other (specify):*				897								897	7
8	<b>TOTAL General Services</b>	<b>(16,340)</b>		<b>1,952</b>	<b>10,215</b>								<b>(4,173)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>													<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(227,097)	56,856								(170,241)	17
18	Directors Fees													18
19	Professional Services	(3,322)	1,500	(24,274)		196							(25,900)	19
20	Fees, Subscriptions & Promotions	(12,289)	375										(11,914)	20
21	Clerical & General Office Expenses	(15,537)	5,725	80,741									70,929	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			183									183	24
25	Other Admin. Staff Transportation			1,677									1,677	25
26	Insurance-Prop.Liab.Malpractice			1,449		332							1,781	26
27	Other (specify):*			29,317	3,711								33,028	27
28	<b>TOTAL General Administration</b>	<b>(31,148)</b>	<b>7,600</b>	<b>(138,004)</b>	<b>60,567</b>	<b>528</b>							<b>(100,457)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(47,488)</b>	<b>7,600</b>	<b>(136,052)</b>	<b>70,782</b>	<b>528</b>							<b>(104,630)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Abbington Rehab And Nursing

# 0039693

Report Period Beginning:

01/01/18

Ending:

Summary B

12/31/18

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	38,253	59,827										98,080	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(14,869)	135,033			865							121,029	32
33	Real Estate Taxes					1,397							1,397	33
34	Rent-Facility & Grounds		(588,000)	11,161		(11,161)							(588,000)	34
35	Rent-Equipment & Vehicles			4,695									4,695	35
36	Other (specify):*	(2,828)	2,828											36
37	<b>TOTAL Ownership</b>	<b>20,556</b>	<b>(390,312)</b>	<b>15,856</b>		<b>(8,899)</b>							<b>(362,799)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>(26,932)</b>	<b>(382,712)</b>	<b>(120,196)</b>	<b>70,782</b>	<b>(8,371)</b>							<b>(467,429)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 588,000	Abbington Health Care Associates, LLC	100.00%	\$	\$ (588,000)	1
2	V	32 Interest	92	Abbington Health Care Associates, LLC	100.00%	135,125	135,033	2
3	V	30 Depreciation		Abbington Health Care Associates, LLC	100.00%	59,827	59,827	3
4	V	36 Amortization		Abbington Health Care Associates, LLC	100.00%	2,828	2,828	4
5	V	19 Accounting Fees		Abbington Health Care Associates, LLC	100.00%	1,500	1,500	5
6	V	20 LLC Fees		Abbington Health Care Associates, LLC	100.00%	375	375	6
7	V	21 Replacement Tax		Abbington Health Care Associates, LLC	100.00%	5,725	5,725	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 588,092			\$ 205,380	\$ * (382,712)	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	5 UTILITIES	\$	STAYCARE MANAGEMENT, LTD.		\$ 925	\$ 925	15
16	V	6 REPAIRS AND MAINT.		STAYCARE MANAGEMENT, LTD.		1,027	1,027	16
17	V	17 ADMIN. SALARY		STAYCARE MANAGEMENT, LTD.		19,003	19,003	17
18	V	19 PROFESSIONAL FEES		STAYCARE MANAGEMENT, LTD.		2,851	2,851	18
19	V	21 CLERICAL & GENERAL - SALARIES		STAYCARE MANAGEMENT, LTD.		83,990	83,990	19
20	V	21 CLERICAL & GENERAL - OTHER		STAYCARE MANAGEMENT, LTD.		6,081	6,081	20
21	V	24 SEMINARS		STAYCARE MANAGEMENT, LTD.		183	183	21
22	V	25 ADMIN. STAFF TRAVEL		STAYCARE MANAGEMENT, LTD.		1,677	1,677	22
23	V	26 INSURANCE		STAYCARE MANAGEMENT, LTD.		1,449	1,449	23
24	V	27 EMPLOYEE BENEFITS		STAYCARE MANAGEMENT, LTD.		29,317	29,317	24
25	V	30 DEPRECIATION		STAYCARE MANAGEMENT, LTD.				25
26	V	34 BUILDING RENT		STAYCARE MANAGEMENT, LTD.		11,161	11,161	26
27	V	35 EQUIP. RENTAL-AUTO		STAYCARE MANAGEMENT, LTD.		4,695	4,695	27
28	V							28
29	V							29
30	V	17 MANAGEMENT FEE	246,100	STAYCARE MANAGEMENT, LTD.			(246,100)	30
31	V	19 ADMINISTRATIVE CONSULT.	13,520	STAYCARE MANAGEMENT, LTD.			(13,520)	31
32	V	21 ADMISSIONS DIRECTOR	9,330	STAYCARE MANAGEMENT, LTD.			(9,330)	32
33	V	19 REIMBURSEMENT CONSULT.	13,605	STAYCARE MANAGEMENT, LTD.			(13,605)	33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 282,555			\$ 162,359	\$ * (120,196)	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	1		DIETARY COMP - S. WEBSTER		\$ 1,553	\$ 1,553	15
16	V	1		DIETARY COMP - D. WENGROW		4,611	4,611	16
17	V	6		MAINTENANCE COMP.		3,154	3,154	17
18	V	7		EMP. BEN. - S. WEBSTER		156	156	18
19	V	7		EMP. BEN. - D. WENGROW		402	402	19
20	V	7		EMP. BEN. - MAINT. NON-OWNER		339	339	20
21	V	17		ADMIN. COMP - H. WENGROW		42,619	42,619	21
22	V	17		ADMIN. COMP - J. WEBSTER		14,237	14,237	22
23	V	27		EMP. BEN. - H. WENGROW		2,821	2,821	23
24	V	27		EMP. BEN. - J. WEBSTER		890	890	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		\$			\$ 70,782	\$ * 70,782	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	19 PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		196	\$	196	15
16	V	26 INSURANCE		DOUBLE YOU REALTY, LLC		332		332	16
17	V	30 DEPRECIATION		DOUBLE YOU REALTY, LLC					17
18	V	32 INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		865		865	18
19	V	33 REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		1,397		1,397	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V	34 RENT	11,161	DOUBLE YOU REALTY, LLC				(11,161)	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		\$ 11,161			\$ 2,790	\$ *	(8,371)	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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





Facility Name & ID Number Abbington Rehab And Nursing # 0039693 Report Period Beginning: 01/01/18 Ending: 12/31/18

## 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	Jeffrey Webster	Owner	Administrative	50.00%	See Attached	5	7.14%	Alloc. Salary	\$ 14,237	17-07	1
2	Howard Wengrow	Owner	Administrative	50.00%	See Attached	15	23.08%	Alloc. Salary	42,619	17-07	2
3	Ephraim Braunstein	Relative	Clerical		See Attached	4.76	11.90%	Alloc. Salary	11,995	21-07	3
4	Sara Webster	Relative	Dietary		See Attached	0.77	15.37%	Alloc. Salary	1,553	01-07	4
5	Deborah Wengrow	Relative	Dietary		See Attached	0.77	15.37%	Alloc. Salary	4,611	01-07	5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 75,015		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 Abbington Rehab And Nursing

# 0039693

Report Period Beginning:

01/01/18

Ending: 12/31/18

**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 Abbington Rehab And Nursing

# 0039693

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

STAYCARE MANAGEMENT, LTD.

Street Address

3737 W ARTHUR AVENUE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(847) 679-2121

Fax Number

(847) 679-2122

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	218,426	6	\$ 7,776	\$ 25,991	\$ 925	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	218,426	6	8,630	25,991	1,027	2
3	17	ADMIN. SALARY	PATIENT DAYS	218,426	6	159,698	159,698	25,991	19,003
4	19	PROFESSIONAL FEES	PATIENT DAYS	218,426	6	23,962	25,991	2,851	4
5	21	CLERICAL & GENERAL - SALA	PATIENT DAYS	218,426	6	705,841	705,841	25,991	83,990
6	21	CLERICAL & GENERAL - OTH	PATIENT DAYS	218,426	6	51,101	25,991	6,081	6
7	24	SEMINARS	PATIENT DAYS	218,426	6	1,541	25,991	183	7
8	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	218,426	6	14,095	25,991	1,677	8
9	26	INSURANCE	PATIENT DAYS	218,426	6	12,177	25,991	1,449	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	218,426	6	246,373	25,991	29,317	10
11	30	DEPRECIATION	PATIENT DAYS	218,426	6		25,991		11
12	34	BUILDING RENT	PATIENT DAYS	218,426	6	93,800	25,991	11,161	12
13	35	EQUIP. RENTAL-AUTO	PATIENT DAYS	218,426	6	39,457	25,991	4,695	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					\$ 1,364,451	\$ 865,539	\$ 162,359	25

Facility Name & ID Number Abbington Rehab And Nursing

# 0039693

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

STAYCARE MANAGEMENT, LTD.

Street Address

3737 W ARTHUR AVENUE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(847) 679-2121

Fax Number

(847) 679-2122

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY COMP - S. WEBSTER	AVG. HOURS WORKED	5	4	10,104	10,104	1	1,553	1
2	1	DIETARY COMP - D. WENGRO	AVG. HOURS WORKED	5	4	30,000	30,000	1	4,611	2
3	6	MAINTENANCE COMP.	AVG. HOURS WORKED	40	6	26,510	26,510	5	3,154	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	1,013		1	156	4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	2,618		1	402	5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	2,848		5	339	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	184,684	184,684	15	42,619	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	199,324	199,324	5	14,237	8
9	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	12,223		15	2,821	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	12,458		5	890	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					\$ 481,782	\$ 450,622		\$ 70,782	25

Facility Name & ID Number Abbington Rehab And Nursing

# 0039693

Report Period Beginning:

01/01/18

Ending: 12/31/18

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

DOUBLE YOU REALTY, LLC

Street Address

3737 W. ARTHUR AVENUE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(847) 679-2121

Fax Number

(847) 679-2122

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	218,426	6	1,650	25,991	196	1
2	26	INSURANCE	PATIENT DAYS	218,426	6	2,791	25,991	332	2
3	30	DEPRECIATION	PATIENT DAYS	218,426	6		25,991		3
4	32	INTEREST EXPENSE	PATIENT DAYS	218,426	6	7,271	25,991	865	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	218,426	6	11,737	25,991	1,397	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				\$ 23,449	\$		\$ 2,790	25

Facility Name & ID Number Abbington Rehab And Nursing

# 0039693

Report Period Beginning:

01/01/18

Ending: 12/31/18

**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 Abbington Rehab And Nursing

# 0039693

Report Period Beginning:

01/01/18

Ending: 12/31/18

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 Abbington Rehab And Nursing

# 0039693

Report Period Beginning:

01/01/18

Ending: 12/31/18

**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 Abbington Rehab And Nursing

# 0039693

Report Period Beginning:

01/01/18

Ending: 12/31/18

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

Facility Name & ID Number Abbington Rehab And Nursing

# 0039693

Report Period Beginning:

01/01/18

Ending: 12/31/18

**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 Abbington Rehab And Nursing

# 0039693

Report Period Beginning:

01/01/18

Ending: 12/31/18

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

Abbington Rehab And Nursing

# 0039693

Report Period Beginning:

01/01/18

Ending:

12/31/18

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	MB Financial		X	Mortgage			\$	\$ 3,285,136		\$ 135,125	1									
2											2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	Miscellaneous		X							3,096	6									
7	Allocated from Double You Realty		X							865	7									
8											8									
9	<b>TOTAL Facility Related</b>						\$	\$ 3,285,136		\$ 139,086	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X							(14,869)	10									
11	Interest Income - Bldg Co.		X							(92)	11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ (14,961)	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 3,285,136		\$ 124,124	15									

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

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

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



**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Abbingdon Rehab And Nursing COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0039693

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(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>02-03-303-029</u>	<u>Long Term Care Property</u>	\$ <u>36,756.96</u>	\$ <u>36,756.96</u>
2. <u>10-35-329-014-0000</u>	<u>Home Office Allocation</u>	\$ <u>24,601.06</u>	\$ <u>2,927.34</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>61,358.02</u></u>	\$ <u><u>39,684.30</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? X YES        NO

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

**C. Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

**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.**

**IMPORTANT NOTICE**

**TO: Long Term Care Facilities with Real Estate Tax Rates**  
**RE: 2017 REAL ESTATE TAX COST DOCUMENTATION**

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 real estate tax bill.

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

**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Abbington Rehab And Nursing COUNTY Dupage  
 FACILITY IDPH LICENSE NUMBER 0039693  
 CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_  
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 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 2017.

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

**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 Abbington Rehab And Nursing

# 0039693

Report Period Beginning:

01/01/18 Ending:

12/31/18

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 20,478 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>41,400</u>	<u>1994</u>	<u>\$ 100,000</u>	<u>1</u>
2	<u>Allocated from Double You Realty LLC</u>			<u>5,950</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 105,950</b>	<b>3</b>

Facility Name & ID Number Abbington Rehab And Nursing

# 0039693

Report Period Beginning:

01/01/18

Ending:

12/31/18

**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	82	1994	1976	\$ 2,293,000	\$ 59,827	35	\$ 65,514	\$ 5,687	\$ 1,579,169	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		1994	7,258		20			7,258	9
10	Various		1995	41,235		20			34,660	10
11	Various		1996	14,284		20			13,722	11
12	Various		1997	19,228		20			19,227	12
13	Various		1998	8,781		20	87	87	8,779	13
14	Various		1999	74,013		20	2,105	2,105	40,350	14
15	Various		2000	16,733		20	837	837	15,315	15
16	Various		2001	3,412		20	171	171	3,031	16
17	Various		2002	100,056		20			100,056	17
18	Various		2003	172,044		20	1,554	1,554	165,437	18
19	Various		2004	17,406		20	870	870	12,475	19
20	Various		2005	31,352		20			31,352	20
21	Various		2006	1,000		20			1,000	21
22	Various		2007	23,100		20			23,100	22
23	Various		2008	15,797		20	788	788	15,797	23
24	Various		2009	6,310		20	631	631	6,038	24
25	Various		2010	27,030		20	2,184	2,184	18,195	25
26	Various		2011	74,494		20	4,988	4,988	40,942	26
27	Various		2012	18,109		20	892	892	5,922	27
28	Various		2013	158,448		20	15,485	15,485	82,820	28
29	Various		2014	42,333		20	2,117	2,117	9,281	29
30										30
31										31
32										32
33										33
34										34
35										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



**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12A, Carried Forward</b>	\$ 3,228,022	\$ 112,282		\$ 99,966	\$ (12,316)	\$ 2,259,660		1
2	Elevator Shunt Trip	2015 5,000		20	250	250	938		2
3	Load Center Circuit Breaker For Backup Generator	2015 10,000		20	500	500	2,000		3
4	14 Square Of Sidewalk With New Concrete	2015 5,600		20	280	280	863		4
5	Replacement Of Front Concrete Ramp	2016 2,750		20	138	138	286		5
6	Electrical Feeder For 1St Floor Boiler Room	2017 15,000		20	750	750	1,375		6
7	New Trane Hvac Unit - Pump Room	2017 14,000		20	700	700	992		7
8	Construction,Electrical,Flooring,Millwork,Plumbing,Wall Surfaces	2017 459,383		20	22,969	22,969	36,368		8
9	Installed Ceiling Lighting In Lobby	2017 36,075		20	1,804	1,804	2,856		9
10	Howard Bernath Heating - Water Heater	2018 10,693		20	312	312	312		10
11	Walk-In Freezer Compressor	2018 4,688		20	137	137	137		11
12	Rising Development - Roof Work	2018 4,390		20	183	183	183		12
13	Rising Development - Water Damage Roof	2018 3,955		20	132	132	132		13
14	Re-Cover Awning	2018 5,990		20	25	25	25		14
15	Johnstone/Bernath - Pump/Parts	2018 3,905		20	16	16	16		15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ 3,809,451	\$ 112,282		\$ 128,161	\$ 15,879	\$ 2,306,143		34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,809,451	\$ 112,282		\$ 128,161	\$ 15,879	\$ 2,306,143	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,809,451	\$ 112,282		\$ 128,161	\$ 15,879	\$ 2,306,143	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,809,451	\$ 112,282		\$ 128,161	\$ 15,879	\$ 2,306,143	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
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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)		\$ 3,809,451	\$ 112,282		\$ 128,161	\$ 15,879	\$ 2,306,143	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,809,451	\$ 112,282		\$ 128,161	\$ 15,879	\$ 2,306,143	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,809,451	\$ 112,282		\$ 128,161	\$ 15,879	\$ 2,306,143	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company</b>		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								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	<b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	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
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16									16
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Double You Realty LLC	2003	56,870		35	1,458	1,458	23,272	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Staycare Management	2016	3,094		20	155	155	413	9
10	Allocated from Staycare Management	2003	2,634		20	132	132	2,049	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 62,598	\$		\$ 1,745	\$ 1,745	\$ 25,734	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 62,598	\$		\$ 1,745	\$ 1,745	\$ 25,734	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 62,598	\$		\$ 1,745	\$ 1,745	\$ 25,734	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	\$ 175,195	\$	\$ 21,675	\$ 21,675	10	\$ 82,805	71
72	Current Year Purchases	3,575		209	209	10	209	72
73	Fully Depreciated Assets	104,552				10	104,552	73
74								74
75	TOTALS	\$ 283,322	\$	\$ 21,883	\$ 21,883		\$ 187,565	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		Allocated from Staycare Mgmt	2018	\$ 4,027	\$	\$ 491	\$ 491	5	\$ 3,598	76
77										77
78										78
79										79
80	TOTALS			\$ 4,027	\$	\$ 491	\$ 491		\$ 3,598	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)	\$ 4,202,750	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 112,282	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 150,535	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 38,253	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,497,306	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	_____/2019	\$ _____
13.	_____/2020	\$ _____
14.	_____/2021	\$ _____

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	<u>Allocated from Staycare Management</u>		\$ _____	\$ <u>4,695</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ <u>4,695</u>	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Abbington Rehab And Nursing # 0039693 Report Period Beginning: 01/01/18 Ending: 12/31/18  
 XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs		\$			\$	24,504	\$			\$		24,504	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs						2,345						2,345	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs						31,477						31,477	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							16,960					16,960	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):															13
14	TOTAL				\$			\$	58,326	\$	16,960		\$		75,286	14

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

Facility Name & ID Number **Abbington Rehab And Nursing**

# **0039693**

Report Period Beginning: **01/01/18**

Ending: **12/31/18**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/18**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 258,119	\$ 442,169	1
2	Cash-Patient Deposits	20,015	20,015	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	448,161	448,161	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,813	69,813	6
7	Other Prepaid Expenses	3,974	3,974	7
8	Accounts Receivable (owners or related parties)	31,536	31,536	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 831,618	\$ 1,015,668	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		101,756	13
14	Buildings, at Historical Cost		2,333,258	14
15	Leasehold Improvements, at Historical Cost	1,179,480	1,179,480	15
16	Equipment, at Historical Cost	245,060	352,060	16
17	Accumulated Depreciation (book methods)	(754,208)	(2,288,995)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	120,000	141,208	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 790,332	\$ 1,818,767	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,621,950	\$ 2,834,435	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 163,690	\$ 163,690	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,015	20,015	28
29	Short-Term Notes Payable	571,448		29
30	Accrued Salaries Payable	171,657	171,657	30
31	Accrued Taxes Payable (excluding real estate taxes)	663	663	31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,860	37,860	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	18,158	138,158	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 983,491	\$ 532,043	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,285,136	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 3,285,136	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 983,491	\$ 3,817,179	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 638,459	\$ (982,744)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,621,950	\$ 2,834,435	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>661,491</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>661,491</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(23,032)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (23,032)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>638,459</b>	<b>24</b> *

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

Facility Name & ID Number **Abbington Rehab And Nursing**# **0039693**Report Period Beginning: **01/01/18**Ending: **12/31/18****XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,261,529	1
2	Discounts and Allowances for all Levels	(103,542)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,157,987	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	118,940	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 118,940	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	17,174	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	486	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,435	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 19,095	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	14,869	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 14,869	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See Supplemental Schedule</b>	93,717	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 93,717	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,404,608	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	843,200	31
32	Health Care	1,665,479	32
33	General Administration	960,220	33
<b>B. Capital Expense</b>			
34	Ownership	681,466	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	75,286	35
36	Provider Participation Fee	201,989	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,427,640	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(23,032)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (23,032)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,766,065	44
45	Private Pay - Net Inpatient Revenue	281,945	45
46	Medicare - Net Inpatient Revenue	109,977	46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,157,987	49

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

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

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

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

Facility Name & ID Number **Abbington Rehab And Nursing**

# **0039693**

Report Period Beginning:

**01/01/18**

Ending:

**12/31/18**

**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	1,962	2,098	\$ 82,355	\$ 39.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,657	11,019	333,012	30.22	3
4	Licensed Practical Nurses	9,275	9,999	280,276	28.03	4
5	CNAs & Orderlies	35,725	41,438	586,186	14.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,736	2,116	28,811	13.62	8
9	Activity Director	2,008	2,080	33,536	16.12	9
10	Activity Assistants	2,826	2,988	35,411	11.85	10
11	Social Service Workers	2,200	2,312	42,079	18.20	11
12	Dietician					12
13	Food Service Supervisor	2,043	2,223	41,097	18.49	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,600	13,221	168,940	12.78	15
16	Dishwashers					16
17	Maintenance Workers	2,461	2,734	54,686	20.00	17
18	Housekeepers	10,595	11,614	142,953	12.31	18
19	Laundry	2,048	2,288	30,949	13.53	19
20	Administrator	1,968	2,080	93,904	45.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,531	6,974	76,582	10.98	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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	3,945	4,292	141,398	32.95	33
34	TOTAL (lines 1 - 33)	106,580	119,476	\$ 2,172,175 *	\$ 18.18	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 7,056	01-03	35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Per Visit	110	10-03	38
39	Pharmacist Consultant	Monthly	7,103	10-03	39
40	Physical Therapy Consultant	65	3,046	10a-03	40
41	Occupational Therapy Consultant	26	1,022	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	880	11-03	44
45	Social Service Consultant	16	854	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	122	\$ 26,071		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 Abbington Rehab And Nursing# 0039693

Report Period Beginning:

01/01/18Ending: 12/31/18**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. Health Care Council of Illinois \$8,856
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 38,023 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES 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. \$ 201,989  
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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14  
d. Have vehicle usage logs been maintained? 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