FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0051144

Facility Name: Oak Lawn Respiratory & Rehab

Address: 9525 South Mayfield (Number) Oaklawn (City) 60453 (Zip Code)

County: Cook

Telephone Number: 708 449-1900 **Fax #** 708 449-1500

HFS ID Number:

Date of Initial License for Current Owners: 9/1/10

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Daniel S. Gaafar **Telephone Number:** 317 237-5500
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/15 to 12/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Flora Reznik
(Title) CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Daniel S. Gaafar, Partner
(Firm Name & Address) Bradley Associates, 201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225
(Telephone) 317 237-5500 Fax # 317 235-5503

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/15 Ending: 12/31/15

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,010		2,544	16,554	8
9	SNF/PED					9
10	ICF	12,701		254	12,955	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,711		2,798	29,509	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.54%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold 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 [X]

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

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 [X] Date NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 54 and days of care provided 2,264

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 1/1/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	222,147		27,395	249,542		249,542	(1,286)	248,256			1
2	Food Purchase		130,648		130,648		130,648		130,648			2
3	Housekeeping	175,159	21,513		196,672		196,672		196,672			3
4	Laundry	28,219	21,821		50,040		50,040		50,040			4
5	Heat and Other Utilities			161,649	161,649		161,649	1,671	163,320			5
6	Maintenance	41,485	30,082	73,158	144,725		144,725	1,150	145,875			6
7	Other (specify):*											7
8	TOTAL General Services	467,010	204,064	262,202	933,276		933,276	1,535	934,811			8
	B. Health Care and Programs											
9	Medical Director			34,600	34,600		34,600		34,600			9
10	Nursing and Medical Records	2,351,202	673,095	27,346	3,051,643		3,051,643	1,275	3,052,918			10
10a	Therapy	532,533		406,115	938,648		938,648		938,648			10a
11	Activities	72,542	20,825		93,367		93,367		93,367			11
12	Social Services	41,441		4,346	45,787		45,787		45,787			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consult			8,437	8,437		8,437		8,437			15
16	TOTAL Health Care and Programs	2,997,718	693,920	480,844	4,172,482		4,172,482	1,275	4,173,757			16
	C. General Administration											
17	Administrative	101,722			101,722		101,722	(40,000)	61,722			17
18	Directors Fees											18
19	Professional Services			285,354	285,354		285,354	(229,167)	56,187			19
20	Dues, Fees, Subscriptions & Promotions			6,305	6,305		6,305		6,305			20
21	Clerical & General Office Expenses	142,639	48,696	188,476	379,811		379,811	76,534	456,345			21
22	Employee Benefits & Payroll Taxes			942,553	942,553		942,553	21,775	964,328			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,534	4,534		4,534	1,111	5,645			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			359,375	359,375		359,375	41,567	400,942			26
27	Other (specify):*											27
28	TOTAL General Administration	244,361	48,696	1,786,597	2,079,654		2,079,654	(128,180)	1,951,474			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,709,089	946,680	2,529,643	7,185,412		7,185,412	(125,370)	7,060,042			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:** 1/1/15 **Ending:** 12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			42,654	42,654		42,654	98,032	140,686			30
31	Amortization of Pre-Op. & Org.							33,336	33,336			31
32	Interest			441,345	441,345		441,345	161,725	603,070			32
33	Real Estate Taxes							259,399	259,399			33
34	Rent-Facility & Grounds			1,083,048	1,083,048		1,083,048	(1,078,860)	4,188			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,567,047	1,567,047		1,567,047	(526,368)	1,040,679			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			(60)	(60)		(60)		(60)			38
39	Ancillary Service Centers		165,764		165,764		165,764		165,764			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			244,726	244,726		244,726		244,726			42
43	Other (specify):* **Bad Debt**			690,663	690,663		690,663	(690,663)				43
44	**TOTAL Special Cost Centers**		165,764	935,329	1,101,093		1,101,093	(690,663)	410,430			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,709,089	1,112,444	5,032,019	9,853,552		9,853,552	(1,342,401)	8,511,151			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: 1/1/15 Ending: 12/31/15

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 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	(238,976)	30		9
10	Interest and Other Investment Income	(6,066)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(7,987)	21		18
19	Entertainment				19
20	Contributions	(100)	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	(690,663)	43		24
25	Fund Raising, Advertising and Promotional	(7,920)	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	(13,427)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (965,139)		$	30

BHF USE ONLY								
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 Amount	2 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)	(377,262)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (377,262)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,342,401)		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 Yes	2 No	3 Amount	4 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

Oak Lawn Respiratory & Rehab

ID# 0051144

Report Period Beginning: 1/1/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (12,028)	21	1
2	Vending Income	(1,399)	1	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				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**	(13,427)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,399)	113	0	0	0	0	0	0	0	0	0	(1,286)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,671	0	0	0	0	0	0	0	0	0	1,671	5
6	Maintenance	0	1,150	0	0	0	0	0	0	0	0	0	1,150	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,399)	2,934	0	0	0	0	0	0	0	0	0	1,535	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	1,275	0	0	0	0	0	0	0	0	0	1,275	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	1,275	0	0	0	0	0	0	0	0	0	1,275	16
	C. General Administration													
17	Administrative	0	(40,000)	0	0	0	0	0	0	0	0	0	(40,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(257,306)	28,139	0	0	0	0	0	0	0	0	(229,167)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(28,035)	104,293	276	0	0	0	0	0	0	0	0	76,534	21
22	Employee Benefits & Payroll Taxes	0	21,775	0	0	0	0	0	0	0	0	0	21,775	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,111	0	0	0	0	0	0	0	0	0	1,111	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	1,971	39,596	0	0	0	0	0	0	0	0	41,567	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(28,035)	(168,156)	68,011	0	0	0	0	0	0	0	0	(128,180)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(29,434)	(163,947)	68,011	0	0	0	0	0	0	0	0	(125,370)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oak Lawn Respiratory & Rehab **#** 0051144 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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	(238,976)	0	337,008	0	0	0	0	0	0	0	0	98,032	30
31	Amortization of Pre-Op. & Org.	0	0	33,336	0	0	0	0	0	0	0	0	33,336	31
32	Interest	(6,066)	0	167,791	0	0	0	0	0	0	0	0	161,725	32
33	Real Estate Taxes	0	2,898	256,501	0	0	0	0	0	0	0	0	259,399	33
34	Rent-Facility & Grounds	0	4,188	(1,083,048)	0	0	0	0	0	0	0	0	(1,078,860)	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	(245,042)	7,086	(288,412)	0	0	0	0	0	0	0	0	(526,368)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(690,663)	0	0	0	0	0	0	0	0	0	0	(690,663)	43
44	TOTAL Special Cost Centers	(690,663)	0	0	0	0	0	0	0	0	0	0	(690,663)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(965,139)	(156,861)	(220,401)	0	0	0	0	0	0	0	0	(1,342,401)	45

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	Infinity Healthcare	Hillside	Management Co
GELP	20%	Belhaven Nursing & Rehab Center	Chicago			
A&F Realty	20%	City View Multicare Center	Cicero			
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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$ 6,886	Infinity Healthcare Management		$ 6,999	$ 113	1
2	V	10	Nursing Wages	31,840	Infinity Healthcare Management		33,115	1,275	2
3	V	21	Office Wages		Infinity Healthcare Management		136,585	136,585	3
4	V	5	Utilities		Infinity Healthcare Management		1,671	1,671	4
5	V	6	Maintenance		Infinity Healthcare Management		1,150	1,150	5
6	V	19	Professional Services	258,025	Infinity Healthcare Management		719	(257,306)	6
7	V	21	Office Expense	44,116	Infinity Healthcare Management		11,824	(32,292)	7
8	V	22	Employee Benefit	3,416	Infinity Healthcare Management		25,191	21,775	8
9	V	24	Auto/Travel Expense	730	Infinity Healthcare Management		1,841	1,111	9
10	V	26	Insurance		Infinity Healthcare Management		1,971	1,971	10
11	V	33	Property Tax		Infinity Healthcare Management		2,898	2,898	11
12	V	34	Rent		Infinity Healthcare Management		4,188	4,188	12
13	V	17	Administrative	40,000	Infinity Healthcare Management			(40,000)	13
14	Total			$ 385,013			$ 228,152	$ * (156,861)	14

*** 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: 1/1/15 Ending: 12/31/15

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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	33	Property Tax	$	Oak Lawn Realty LLC		$ 256,501	$ 256,501	15
16	V	26	Insurance		Oak Lawn Realty LLC		39,596	39,596	16
17	V	31	Amortization		Oak Lawn Realty LLC		33,336	33,336	17
18	V	19	Professional Fees		Oak Lawn Realty LLC		28,139	28,139	18
19	V	21	Office Expense		Oak Lawn Realty LLC		276	276	19
20	V	30	Depreciation		Oak Lawn Realty LLC		337,008	337,008	20
21	V	32	Interest		Oak Lawn Realty LLC		167,791	167,791	21
22	V	34	Rent	1,083,048	Oak Lawn Realty LLC			(1,083,048)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,083,048			$ 862,647	$ * (220,401)	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: 1/1/15 Ending: 12/31/15

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 Center	Chicago				4
5			Southpoint Nursing & Rehab Center	Chicago				5
6			West Suburban Nursing & Rehab Center	Bloomingdale				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: 1/1/15 Ending: 12/31/15

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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: 1/1/15 Ending: 12/31/15

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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: 1/1/15 Ending: 12/31/15

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Hud Loan		x	mortgage	$21,117.00	9/24/14	$ 4,587,800	$ 4,488,224	10/1/44	3.7000	$ 167,791	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capital One		x	working capital	none	8/31/14	26,000,000	926,383	8/31/18	various	73,999	6
7	Infinity Funding	x		working capital	none	various	various	4,598,789	various	various	367,346	7
8												8
9	TOTAL Facility Related				$21,117.00		$ 30,587,800	$ 10,013,396			$ 609,136	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	$ 10,013,396			$ 609,136	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 29,866 **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.)**

Facility Name & ID Number Oak Lawn Respiratory & Rehab **#** 0051144 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 88,886	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.)		$ 331,492	2
3. Under or (over) accrual (line 2 minus line 1).		$ 242,606	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 16,793	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.		$ 259,399	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	236,607	8
	2011	271,403	9
	2012	253,105	10
	2013	258,880	11
	2014	331,492	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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:

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

2014 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 #: 317 235-5503

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-08-201-007-0000	NURSING HOME	$ 331,491.70	$ 331,491.70
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 331,491.70	$ 331,491.70

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 1/1/15 Ending: 12/31/15

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 [X] (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? [X] (a) Own the Equipment [X] (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? [X] 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.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		2010	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	143		2010	1960	$ 2,000,000	$ 51,288	39	$ 51,282	$ (6)	$ 239,340	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Painting			2010	1,981	51	39	51		275	9
10	Drywall			2010	1,500	38	39	38		208	10
11	Roofing			2010	40,500	1,038	39	1,038		5,625	11
12	Signs			2010	3,102	80	39	80		431	12
13	Windows			2010	16,500	423	39	423		2,292	13
14	Walls, Wallpaper, Flooring, Doors			2010	88,500	2,270	39	2,269	(1)	12,291	14
15	Signs			2010	6,298	161	39	161		874	15
16	Windows			2010	50,630	1,299	39	1,298	(1)	7,032	16
17	Concrete and Asphalt for driveway			2010	38,000	974	39	974		5,277	17
18	Concrete and Asphalt for driveway			2010	17,490	448	39	448		2,429	18
19	Air conditioner			2011	753	19	39	19		96	19
20	Chair mats			2011	346	9	39	9		44	20
21	Fire alarm system			2011	16,210	416	39	416		2,079	21
22	Drywall			2011	1,696	43	39	43		217	22
23	Electrical Outlets			2011	3,200	82	39	82		410	23
24	Subpanel in 2nd floor med room			2011	3,500	90	39	90		449	24
25	remove & install new shingle roof			2010	20,490	525	39	525		2,627	25
26	Mirrors, Vanity Lights, Ceiling Painting			2011	45,280	1,160	39	1,161	1	5,805	26
27	Signage permit for mirros, vanitity, etc.			2010	450	12	39	12		58	27
28	Window permit for mirrors, vanity, etc.			2010	900	23	39	23		115	28
29	Air conditioner			2011	3,620	93	39	93		464	29
30	Tables and Chairs			2010	5,525	142	39	142		709	30
31	Mirrors, Vanity Lights, Ceiling Painting			2010	67,919	1,741	39	1,742	1	8,708	31
32	Aluminum and glass store front, wiring, sidewalk, sprinkler			2010	39,750	1,019	39	1,019		5,096	32
33	Sprinkler system			2011	9,500	244	39	244		1,218	33
34	Shower Door Frame			2011	550	14	39	14		70	34
35	Granite shelf			2011	300	8	39	8		39	35
36	Drywall soffit for sprinkler pipe enclosure			2011	650	17	39	17		84	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: 1/1/15 Ending: 12/31/15

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	
37	Profile cove base	2011	$ 1,350	$ 35	39	$ 35	$	$ 173	37
38	Laminate column covers	2011	945	24	39	24		121	38
39	Drywall for spinkler pipe enclosure	2011	500	13	39	13		64	39
40	Hallway & Shower room walls, tiles, wander board, lighting, grab l	2011	66,717	1,710	39	1,711	1	8,554	40
41	build new closet	2011	1,100	28	39	28		141	41
42	Plumbing for lobby bathroom	2011	1,600	41	39	41		205	42
43	Drywall and insulation for dining room & hallway	2011	5,344	137	39	137		685	43
44	Granite countertop and wood front	2011	8,500	218	39	218		1,090	44
45	Profile cove base	2011	1,350	35	39	35		173	45
46	Bathroom doors and frames	2011	1,200	31	39	31		154	46
47	Bathroom doors and frames	2011	1,200	31	39	31		154	47
48	Office walls, rewiring, lighting, doors	2011	3,900	100	39	100		500	48
49	Door and frame	2011	1,450	37	39	37		186	49
50	Bulletin boards	2011	1,256	32	39	32		161	50
51	Foundation, tiles, exit signs, lighting	2011	8,160	209	39	209		1,046	51
52	Shower room plumbing, drain, door, drywall	2011	2,050	53	39	53		263	52
53	Room repair for canopy, steel column, wood cover	2011	11,450	294	39	294		1,468	53
54	Elevator new valve (Maxton UC 4)	2011	3,650	94	39	94		468	54
55	Fire dampers and smoke detectors	2011	2,125	54	39	54		272	55
56	Fire dampers and smoke detectors	2011	2,125	54	39	54		272	56
57	Plumbing	2011	2,800	72	39	72		359	57
58	Lights	2011	3,165	81	39	81		406	58
59	Ejector pumps and control panel	2011	1,385	36	39	36		178	59
60	Replace ventor motor on stove	2012	2,318	59	39	59		237	60
61	Ceiling tiles	2012	1,833	47	39	47		188	61
62	Fire sprinkler for elevator pit and hallway	2012	4,100	105	39	105		420	62
63	Painting of resident rooms	2012	1,920	49	39	49		197	63
64	Painting of resident rooms	2012	7,600	195	39	195		780	64
65	Painting of resident rooms	2012	10,950	282	39	281	(1)	1,122	65
66	Painting of resident rooms	2012	4,300	110	39	110		441	66
67	Painting of resident rooms	2012	3,350	86	39	86		344	67
68	Painting of resident rooms	2012	5,200	133	39	133		533	68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,660,032	$ 68,212		$ 68,206	$ (6)	$ 325,717	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: 1/1/15 Ending: 12/31/15

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 12A, Carried Forward		$ 2,660,032	$ 68,212		$ 68,206	$ (6)	$ 325,717	1
2	Priming/Sanding/painting on 1st floor	2013	4,599	118	39	118		295	2
3	Laminate walls panels - 1st floor nurse station	2013	1,850	47	39	47		118	3
4	Shutters	2013	1,900	49	39	49		122	4
5	Cement Board panels - exterior columns	2013	1,500	38	39	38		96	5
6	Drywall	2013	1,421	36	39	36		91	6
7	Air ducts - 1st floor	2013	2,895	74	39	74		185	7
8	Air ducts - 2nd floor	2013	3,250	83	39	83		208	8
9	Bathroom exhaust - 2nd floor	2013	4,467	115	39	115		287	9
10	Fire dampers / exhaust - 1st floor	2013	7,850	201	39	201		503	10
11	Outlets - 2nd flor	2013	7,800	200	39	200		500	11
12	Outlets - 1st floor	2013	2,750	70	39	71	1	177	12
13	Outlets - basement	2013	4,680	120	39	120		300	13
14	Ceiling - basement	2013	1,315	34	39	34		85	14
15	Electrical switches	2013	1,755	45	39	45		112	15
16	Ceiling patch	2013	1,860	48	39	48		120	16
17	Electrical wiring - nurse stations	2013	11,200	287	39	287		718	17
18									18
19	Danny Golmayo - repair exit doors	2014	3,750	96	39	96		144	19
20	Precision Heating - work on RTU	2013	3,925	101	39	101		151	20
21	Superior Const.- drywall, electrical, paint near fire exit door	2014	3,857	99	39	99		148	21
22	Repair door frames & install outlets all resident rms 2nd flr	2014	6,837	175	39	175		263	22
23	Superior Const. - Replace drywall & insulation in 2 hallways	2014	7,161	184	39	184		276	23
24	Pegasus Custom Furn - beds, wardrobes, dressers	2014	3,130	80	39	80		120	24
25	Alliance Construction - plumbing / sewer line diverted	2014	5,700	146	39	146		219	25
26	New wander guard system for the dementia unit	2014	3,522	90	39	90		135	26
27	Charles Equipment Energy Systems - inspect/repaid Generac	2014	2,054	53	39	53		79	27
28	Five Star - replaces asphalt, removed debris	2014	2,375	61	39	61		91	28
29	Cement boards on ext. columns/handrails 1st flr nrse station	2014	4,006	103	39	103		154	29
30	Remove asbestos from boiler room	2014	7,244	186	39	186		279	30
31	On-Line Communications, Inc. - cable installation	2014	28,465	730	39	730		1,095	31
32	OTIS - Door restrictor down payment	2014	3,313	85	39	85		127	32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,806,463	$ 71,966		$ 71,961	$ (5)	$ 332,915	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: 1/1/15 Ending: 12/31/15

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		$ 2,806,463	$ 71,966		$ 71,961	$ (5)	$ 332,915	1
2	Precision Heating - replace 1st floor furnace	2014	3,250	83	39	83		125	2
3	Precision Heating - replace fan motors and contactors	2014	2,191	56	39	56		84	3
4	Precision Heating - install new a/c compressor/unit	2014	3,665	94	39	94		141	4
5	Precision Heating - new high efficient 10-ton RTU	2014	12,550	322	39	322		483	5
6	Superior Construction - basement kitchen doors	2014	2,963	76	39	76		114	6
7	Superior Construction - remove/repair chair rail/hinges	2014	5,915	152	39	152		228	7
8	Superior Construction - install approx. 50 locks, closet door	2014	4,108	105	39	105		158	8
9	Superior Construction - drywall / painting / wiring	2014	1,666	43	39	43		64	9
10	Superior Construction - new outlets, electrical work	2014	3,497	90	39	90		135	10
11	Superior Construction - replace ceiling tiles, paint	2014	2,549	65	39	65		98	11
12	Superior Construction - repair walls / install new flooring / ceiling	2014	4,291	110	39	110		165	12
13	Various - test all outlets, plumbing/clog issue	2014	15,640	401	39	401		602	13
14									14
15	Hot Water Heater Repair	2015	2,598	67	39	67		67	15
16	Hot Water Heater Repair	2015	8,000	205	39	205		205	16
17	Paint/Repair Walls/Replace Ceiling Light on 2nd floor	2015	4,319	111	39	111		111	17
18	Life Safety Code Repairs	2015	4,861	125	39	125		125	18
19	Inspection of Sprinkler System/Additional Sprinkler Head	2015	2,572	66	39	66		66	19
20	New Fire Doors	2015	2,920	75	39	75		75	20
21	New Doors	2015	4,047	104	39	104		104	21
22	Rewired Lights/Repaired Walls in 1st Floor Med Room	2015	5,534	142	39	142		142	22
23	Repaired Bed Lights/Walls in Patient Rooms on 1st Floor	2015	3,988	102	39	102		102	23
24	Repaired Bed Lights/Walls in Patient Rooms on 1st Floor	2015	4,735	121	39	121		121	24
25	Installed Additional Outlets in Patient Rooms on 1st Floor	2015	8,309	213	39	213		213	25
26	New Boiler	2015	42,887	1,100	39	1,100		1,100	26
27	Electrical and Lighting Repairs in Boiler Room	2015	18,500	474	39	474		474	27
28	Installed New Doors	2015	4,387	112	39	112		112	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,986,404	$ 76,580		$ 76,575	$ (5)	$ 338,329	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: 1/1/15 Ending: 12/31/15

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	$ 2,274,865	$ 294,348	$ 45,104	$ (249,244)	5	$ 1,538,627	71
72	Current Year Purchases	95,036	8,734	19,007	10,273	5	8,734	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,369,901	$ 303,082	$ 64,111	$ (238,971)		$ 1,547,361	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)	$ 5,456,305	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 379,662	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 140,686	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (238,976)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,885,690	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: 1/1/15 Ending: 12/31/15

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

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: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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.

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/15 Ending: 12/31/15

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-3	hrs	$	2,830	$ 139,169	$	2,830	$ 139,169	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,323	96,120		1,323	96,120	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		2,608	164,826		2,608	164,826	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 prescrpts				149,617		149,617	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Laboratory/Xray	39-2					16,147		16,147	12
13	Other (specify):									13
14	TOTAL			$	6,761	$ 400,115	$ 165,764	6,761	$ 565,879	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.

STATE OF ILLINOIS

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (202,101)	$ 153,510	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,992,984	2,992,984	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	200,983	200,983	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		181,164	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,991,866	$ 3,528,641	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	986,404	986,404	15
16	Equipment, at Historical Cost	369,900	2,369,900	16
17	Accumulated Depreciation (book methods)	(360,614)	(1,885,691)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		510,505	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(155,566)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		132,699	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 995,690	$ 4,058,251	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,987,556	$ 7,586,892	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,001,422	$ 1,129,516	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,867	30,867	28
29	Short-Term Notes Payable		88,836	29
30	Accrued Salaries Payable	125,406	125,406	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,961	16,961	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		13,839	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Line of Credit	926,383	926,383	36
37	Due to Infinity	4,598,789	4,598,789	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,699,828	$ 6,930,597	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,399,388	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)**	$	$ 4,399,388	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,699,828	$ 11,329,985	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,712,272)	$ (3,743,093)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,987,556	$ 7,586,892	48

***(See instructions.)**

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,476,642)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,476,642)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,285,633)	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) Capital Contribution	50,003	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,235,630)	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)**	$ (2,712,272)	24 *

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

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,528,492	1
2	Discounts and Allowances for all Levels	628,544	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,157,036	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	328,313	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 328,313	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	64,413	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,497	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 65,910	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,233	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,233	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Income	13,427	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,427	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,567,919	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	933,276	31
32	Health Care	4,172,482	32
33	General Administration	2,079,654	33
	B. Capital Expense		
34	Ownership	1,567,047	34
	C. Ancillary Expense		
35	Special Cost Centers	165,704	35
36	Provider Participation Fee	244,726	36
	D. Other Expenses (specify):		
37	Bad Debt	690,663	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,853,552	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,285,633)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,285,633)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,611,960	44
45	Private Pay - Net Inpatient Revenue	77,453	45
46	Medicare - Net Inpatient Revenue	690,311	46
47	Other-(specify)	777,312	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,157,036	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: 1/1/15 Ending: 12/31/15

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,984	2,092	$ 92,379	$ 44.16	1
2	Assistant Director of Nursing	3,909	4,347	146,663	33.74	2
3	Registered Nurses	18,409	20,589	576,836	28.02	3
4	Licensed Practical Nurses	23,687	27,453	725,833	26.44	4
5	CNAs & Orderlies	73,641	84,216	1,254,002	14.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,610	6,197	72,542	11.71	9
10	Activity Assistants					10
11	Social Service Workers	2,059	2,235	41,441	18.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,509	18,304	222,147	12.14	15
16	Dishwashers					16
17	Maintenance Workers	1,773	1,914	41,485	21.67	17
18	Housekeepers	14,328	15,559	175,159	11.26	18
19	Laundry	2,769	2,939	28,219	9.60	19
20	Administrator	2,161	2,231	101,722	45.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,017	10,753	196,404	18.27	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	2,363	2,363	34,257	14.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	179,219	201,192	$ 3,709,089 *	$ 18.44	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	197	$ 6,886	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	781	27,346	10-3	38
39	Pharmacist Consultant	169	8,437	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	124	4,346	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,271	$ 47,015		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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: 1/1/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sherrilyn Harris	Administrator		$ 1,859
Leola Mixon	Administrator		56,903
Carrie Dipaolo	Administrator		42,960
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 101,722

B. Administrative - Other

Description	Amount
	$
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	$ 8,861
Johnson, Goldburg, & Brown	Accounting	2,500
Swanson Martin & Bell	Legal	10,231
Infinity	Mgmt/Professional	263,762
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 285,354

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 125,011
Unemployment Compensation Insurance	156,717
FICA Taxes	265,916
Employee Health Insurance	235,085
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniform Expense	7,019
Pension Expense	128,788
Employee Expense	45,792
TOTAL (agree to Schedule V, line 22, col.8)	$ 964,328

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Illinois Dept. of Health	3,980
Village of Oak Lawn	1,634
Illinois Office of the State	350
various	341
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,305

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
mileage	3,083
Seminar Expense	
seminars	2,562
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,645

**See instructions.

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/15 Ending: 12/31/15

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/15 Ending: 12/31/15

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? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **30,857** 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. $ **244,726**
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.