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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0039693

Facility Name: Abbington Rehab & Nrsing Ctr

Address: 31 West Central (Number) Roselle (City) 60172 (Zip Code)

County: Dupage

Telephone Number: (630) 894-5058 **Fax #** (630) 894-5070

HFS ID Number:

Date of Initial License for Current Owners: 7/1/1994

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 01/01/16 to 12/31/16 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)
(Title)

Paid Preparer

(Signed) * (Date)
** Subject to the attached Accountants Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	22	Skilled (SNF)	22	8,052	1
2		Skilled Pediatric (SNF/PED)			2
3	60	Intermediate (ICF)	60	21,960	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	82	TOTALS	82	30,012	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	4,674	575	653	5,902	8
9	SNF/PED					9
10	ICF	16,785	1,533		18,318	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,459	2,108	653	24,220	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.70%

D. How many bed-hold days during this year were paid by the Department?
None (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 07/01/1994

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 653

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	173,280	27,440	7,116	207,836		207,836	6,164	214,000			1
2	Food Purchase		111,861		111,861	(7,796)	104,065	(97)	103,968			2
3	Housekeeping	125,006	28,287		153,293		153,293		153,293			3
4	Laundry	27,619	6,260	31,215	65,094		65,094		65,094			4
5	Heat and Other Utilities			82,225	82,225		82,225	(5,687)	76,538			5
6	Maintenance	51,985	2,425	37,564	91,974		91,974	2,709	94,683			6
7	Other (specify):*							847	847			7
8	TOTAL General Services	377,890	176,273	158,120	712,283	(7,796)	704,487	3,936	708,423			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,288,166	75,271	5,260	1,368,697		1,368,697		1,368,697			10
10a	Therapy	35,481		2,776	38,257		38,257		38,257			10a
11	Activities	56,675	362	1,096	58,133		58,133		58,133			11
12	Social Services	36,046		2,459	38,505		38,505		38,505			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,416,368	75,633	17,591	1,509,592		1,509,592		1,509,592			16
	C. General Administration											
17	Administrative	90,459		285,775	376,234		376,234	(213,562)	162,672			17
18	Directors Fees											18
19	Professional Services			54,404	54,404	(167)	54,237	574	54,811			19
20	Dues, Fees, Subscriptions & Promotions			26,683	26,683		26,683	(13,451)	13,232			20
21	Clerical & General Office Expenses	58,945	8,424	43,707	111,076		111,076	24,517	135,593			21
22	Employee Benefits & Payroll Taxes			314,494	314,494	7,796	322,290		322,290			22
23	Inservice Training & Education											23
24	Travel and Seminar			806	806		806	120	926			24
25	Other Admin. Staff Transportation			471	471		471	2,415	2,886			25
26	Insurance-Prop.Liab.Malpractice			79,636	79,636		79,636	1,516	81,152			26
27	Other (specify):*							30,068	30,068			27
28	TOTAL General Administration	149,404	8,424	805,976	963,804	7,629	971,433	(167,803)	803,629			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,943,662	260,330	981,687	3,185,679	(167)	3,185,512	(163,867)	3,021,645			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 Abbington Rehab & Nrsing Ctr #0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			18,962	18,962		18,962	98,246	117,208			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			202	202		202	69,921	70,123			32
33	Real Estate Taxes			31,994	31,994	167	32,161	2,920	35,081			33
34	Rent-Facility & Grounds			588,000	588,000		588,000	(588,000)				34
35	Rent-Equipment & Vehicles							3,184	3,184			35
36	Other (specify):*											36
37	TOTAL Ownership			639,158	639,158	167	639,325	(413,730)	225,595			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		15,923	86,532	102,455		102,455		102,455			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			188,175	188,175		188,175		188,175			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		15,923	274,707	290,630		290,630		290,630			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,943,662	276,253	1,895,552	4,115,467		4,115,467	(577,597)	3,537,870			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 & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	(6,585)	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	33,953	30		9
10	Interest and Other Investment Income	(671)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(97)	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	(2,252)	20		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	(11,251)	21		24
25	Fund Raising, Advertising and Promotional	(1,032)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,418)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(6,420)	20		28
29	Other-Attach Schedule	(29,389)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (25,162)		$	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)	(552,435)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (552,435)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (577,597)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Abbington Rehab & Nrsing Ctr

ID# 0039693

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MCA Sequester Reduction	$ (6,659)	21	1
2	Building Co. - Accounting Fees	(1,325)	19	2
3	Building Co. - LLC Fees	(250)	20	3
4	Builidng Co. - Illinois Replacement Tax	(7,791)	21	4
5	Building Co. - Amortization	(1,414)	36	5
6	PAC Dues	(3,747)	20	6
7	Building Co. - Legal Fees	(4,614)	19	7
8	Additional R&M	1,607	06	8
9	Capitalized R&M	(2,750)	06	9
10	Non-Allowable Legal Fees	(2,446)	19	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**	(29,389)		49

Abbington Rehab & Nrsing Ctr

ID# 0039693

Report Period Beginning: 01/01/16

Ending: 12/31/16

	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	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary				6,164								6,164	1
2	Food Purchase	(97)											(97)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(6,585)		898									(5,687)	5
6	Maintenance	(1,143)		900	2,952								2,709	6
7	Other (specify):*				847								847	7
8	TOTAL General Services	(7,825)		1,798	9,963								3,936	8
	B. Health Care and Programs													
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	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative			(268,384)	54,822								(213,562)	17
18	Directors Fees													18
19	Professional Services	(8,385)	5,939	2,669		351							574	19
20	Fees, Subscriptions & Promotions	(13,701)	250										(13,451)	20
21	Clerical & General Office Expenses	(27,119)	7,791	43,845									24,517	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			120									120	24
25	Other Admin. Staff Transportation			2,415									2,415	25
26	Insurance-Prop.Liab.Malpractice			1,239		277							1,516	26
27	Other (specify):*			26,485	3,583								30,068	27
28	TOTAL General Administration	(49,205)	13,980	(191,611)	58,405	628							(167,803)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(57,030)	13,980	(189,813)	68,368	628							(163,867)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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	33,953	59,827	3,101		1,365							98,246	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(671)	69,598	17		977							69,921	32
33	Real Estate Taxes					2,920							2,920	33
34	Rent-Facility & Grounds		(588,000)	8,218		(8,218)							(588,000)	34
35	Rent-Equipment & Vehicles			3,184									3,184	35
36	Other (specify):*	(1,414)	1,414											36
37	TOTAL Ownership	31,868	(457,161)	14,520		(2,957)							(413,730)	37
	Ancillary Expense													
	E. Special Cost Centers													
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	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(25,162)	(443,181)	(175,293)	68,368	(2,329)							(577,597)	45

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [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	34	Rent Income	$ 588,000	Abbington Health Care Associates, LLC		$	$ (588,000)	1
2	V	32	Interest Income	1,820	Abbington Health Care Associates, LLC			(1,820)	2
3	V	32	Mortgage Interest		Abbington Health Care Associates, LLC		71,418	71,418	3
4	V	30	Depreciation		Abbington Health Care Associates, LLC		59,827	59,827	4
5	V	36	Amortization		Abbington Health Care Associates, LLC		1,414	1,414	5
6	V	19	Accounting Fees		Abbington Health Care Associates, LLC		1,325	1,325	6
7	V	19	Legal Fees		Abbington Health Care Associates, LLC		4,614	4,614	7
8	V	20	LLC Fees		Abbington Health Care Associates, LLC		250	250	8
9	V	21	ILL. RT		Abbington Health Care Associates, LLC		7,791	7,791	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 589,820			$ 146,639	$ * (443,181)	14

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	5	UTILITIES	$	STAYCARE MANAGEMENT, LTD.	100.00%	$ 898	$ 898	15
16	V	6	REPAIRS AND MAINT.				900	900	16
17	V	17	ADMIN. SALARY				17,391	17,391	17
18	V	19	PROFESSIONAL FEES				2,669	2,669	18
19	V	21	CLERICAL & GENERAL				43,845	43,845	19
20	V	24	SEMINARS				120	120	20
21	V	25	ADMIN. STAFF TRAVEL				2,415	2,415	21
22	V	26	INSURANCE				1,239	1,239	22
23	V	27	EMPLOYEE BENEFITS				26,485	26,485	23
24	V	30	DEPRECIATION				3,101	3,101	24
25	V	32	INTEREST EXPENSE				17	17	25
26	V	34	BUILDING RENT				8,218	8,218	26
27	V	35	EQUIP. RENTAL-AUTO				3,184	3,184	27
28	V								28
29	V								29
30	V	17	MANAGEMENT FEES	285,775				(285,775)	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			$ 285,775			$ 110,482	$ * (175,293)	39

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1	DIET. COMP - S. WEBSTER	$	STAY CARE MANAGEMENT, LTD.	100.00%	$ 1,553	$ 1,553	15
16	V	1	DIET. COMP - D. WENGROW				4,611	4,611	16
17	V	6	MAINT. COMP.				2,952	2,952	17
18	V	7	EMP. BEN. - S. WEBSTER				143	143	18
19	V	7	EMP. BEN. - D. WENGROW				390	390	19
20	V	7	EMP. BEN. - MAINT. NON-OWNER				314	314	20
21	V	17	ADMIN. COMP - H. WENGROW				41,105	41,105	21
22	V	17	ADMIN. COMP - J. WEBSTER				13,717	13,717	22
23	V	27	EMP. BEN. - H. WENGROW				2,723	2,723	23
24	V	27	EMP. BEN. - J. WEBSTER				860	860	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			$			$ 68,368	$ * 68,368	39

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			$		100.00%	$	$	15
16	V	19	PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		184	184	16
17	V	26	INSURANCE		DOUBLE YOU REALTY, LLC		277	277	17
18	V	30	DEPRECIATION		DOUBLE YOU REALTY, LLC		1,365	1,365	18
19	V	32	INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		977	977	19
20	V	19	RE TAX PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		167	167	20
21	V	33	REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		2,920	2,920	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	8,218	DOUBLE YOU REALTY, LLC			(8,218)	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			$ 8,218			$ 5,889	$ * (2,329)	39

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	HOWARD L. WENGROW	50.00%	ARBOUR HEALTH CARE CENTER, LTD.	CHICAGO	ABBINGTON HEALTH CARE AS	LINCOLNWOOD	BUILDING CO.	1
2	JEFFREY L. WEBSTER	50.00%	ATRIUM HEALTH CARE CENTER, LTD., THE	CHICAGO	DOUBLE YOU REALTY	LINCOLNWOOD	BUILDING COMPANY	2
3			HICKORY NURSING PAVILION, INC.	HICKORY HILLS	STAYCARE MANAGEMENT	LINCOLNWOOD	MANAGEMENT, BOOKKEEI	3
4			RIDGEVIEW REHAB & NURSING CENTER, LLC	CHICAGO				4
5			ZIKAINIM, INC. D/B/A ALL AMERICAN NURSING HOME	CHICAGO				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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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								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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Jeffrey Webster	Owner	Administrative	50.00%	See Attached	5	7.14%	Alloc. Salary	$ 13,717	17-07	1
2	Howard Wengrow	Owner	Administrative	50.00%	See Attached	15	23.08%	Alloc. Salary	41,105	17-07	2
3	Ephraim Braunstein	Relative	Clerical		See Attached	4.45	11.13%	Alloc. Salary	8,672	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	$ 69,658		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 & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [X] NO [ ]

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

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

	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	5	UTILITIES	PATIENT DAYS	217,497	6	$ 8,067	$	24,220	$ 898	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	217,497	6	8,079		24,220	900	2
3	17	ADMIN. SALARY	PATIENT DAYS	217,497	6	156,174	156,174	24,220	17,391	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	217,497	6	23,970		24,220	2,669	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	217,497	6	393,729	339,385	24,220	43,845	5
6	24	SEMINARS	PATIENT DAYS	217,497	6	1,079		24,220	120	6
7	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	217,497	6	21,689		24,220	2,415	7
8	26	INSURANCE	PATIENT DAYS	217,497	6	11,124		24,220	1,239	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	217,497	6	237,834		24,220	26,485	9
10	30	DEPRECIATION	PATIENT DAYS	217,497	6	27,851		24,220	3,101	10
11	32	INTEREST	PATIENT DAYS	217,497	6	155		24,220	17	11
12	34	BUILDING RENT	PATIENT DAYS	217,497	6	73,800		24,220	8,218	12
13	35	EQUIP. RENTAL-AUTO	PATIENT DAYS	217,497	6	28,591		24,220	3,184	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					$ 992,142	$ 495,559		$ 110,482	25

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [X] NO [ ]

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

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

	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	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	5	4	10,104	10,104	1	1,553	1
2	1	DIET. COMP - D. WENGROW	AVG. HOURS WORKED	5	4	30,000	30,000	1	4,611	2
3	6	MAINT. COMP.	AVG. HOURS WORKED	40	6	26,510	26,510	4	2,952	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	932		1	143	4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	2,537		1	390	5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	2,822		4	314	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	178,120	178,120	15	41,105	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	192,042	192,042	5	13,717	8
9	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	11,798		15	2,723	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	12,046		5	860	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					$ 466,911	$ 436,776		$ 68,368	25

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [X] 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 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	19	PROFESSIONAL FEES	PATIENT DAYS	217,497	6	1,650		24,220	184	2
3	26	INSURANCE	PATIENT DAYS	217,497	6	2,487		24,220	277	3
4	30	DEPRECIATION	PATIENT DAYS	217,497	6	12,254		24,220	1,365	4
5	32	INTEREST EXPENSE	PATIENT DAYS	217,497	6	8,771		24,220	977	5
6	19	RE TAX PROFESSIONAL FEES	PATIENT DAYS	217,497	6	1,500		24,220	167	6
7	33	REAL ESTATE TAXES	PATIENT DAYS	217,497	6	26,220		24,220	2,920	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					$ 52,882	$		$ 5,889	25

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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 Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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 Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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 Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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 Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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 Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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 Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	MB Financial		X	Mortgage			$	$ 3,458,397			$ 71,418	1
2												2
3	Allocated from Double You Realty		X	Mortgage							977	3
4												4
5					-							5
	Working Capital											
6	Miscellaneous		X								202	6
7	Allocated from Staycare Management		X								17	7
8					-							8
9	TOTAL Facility Related						$	$ 3,458,397			$ 72,614	9
	B. Non-Facility Related*											
10	Interest Income										(671)	10
11	Interest Income - Bldg Co.										(1,820)	11
12												12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (2,491)	14
15	TOTALS (line 9+line14)						$	$ 3,458,397			$ 70,123	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.)

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 33,653	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.)		$ 35,258	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,605	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 33,308	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.)		$ 167	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.		$ 35,080	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	26,671	8
	2012	31,395	9
	2013	32,298	10
	2014	32,672	11
	2015	32,338	12

2016 Accrual: $32,338 x 1.03 = $33,308

Allocated from Double You Realty = $2,920

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Abbington Rehab & Nrsing Ctr COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0039693

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-03-303-029	Long Term Care Facility	$ 32,338.26	$ 32,338.26
2.	10-35-329-014-0000	Home Office	$ 26,219.28	$ 2,919.72
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 58,557.54	$ 35,257.98

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Abbington Rehab & Nrsing Ctr COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0039693

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [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? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	41,400	1994	$ 100,000	1
2	Allocated from Double You Realty			5,568	2
3	TOTALS	41,400		$ 105,568	3

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	82		1994	1976	$ 2,293,000	$ 59,827	35	$ 65,514	$ 5,687	$ 1,448,141	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1994	7,258		20			7,258	9
10	Various			1995	41,235		20			34,660	10
11	Various			1996	14,284		20	317	317	13,722	11
12	Various			1997	19,228		20	960	960	18,703	12
13	Various			1998	8,781		20	439	439	8,253	13
14	Various			1999	74,013		20	2,105	2,105	36,140	14
15	Various			2000	16,733		20	837	837	13,642	15
16	Various			2001	3,412		20	171	171	2,690	16
17	Various			2002	100,056		20			100,056	17
18	Various			2003	172,044		20	1,645	1,645	162,239	18
19	Various			2004	17,406		20	870	870	10,734	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	2,310	2,310	21,514	22
23	Various			2008	15,797		20	1,580	1,580	13,429	23
24	Various			2009	6,310		20	631	631	4,776	24
25	Various			2010	27,030		20	2,184	2,184	13,826	25
26	Various			2011	74,494		20	5,446	5,446	30,967	26
27	Various			2012	18,109		20	892	892	4,139	27
28											28
29											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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		58,582	4,260		1,585	(2,675)	20,817	68
69	Financial Statement Depreciation			22,816			(22,816)		69
70	TOTAL (lines 4 thru 69)		$ 3,023,225	$ 86,903		$ 87,485	$ 582	$ 1,998,057	70

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 3,023,225	$ 86,903		$ 87,485	$ 582	$ 1,998,057	1
2	Water Heater For Kitchen	2013	8,215		20	685	685	2,738	2
3	Ventilation System	2013	32,000		20	3,200	3,200	10,667	3
4	Walk-In Freezer	2013	6,699		20	447	447	1,712	4
5	Set Back East Elevation 2Nd Floor, Replaced Brick, Tuck Point El	2013	18,783		20	1,878	1,878	6,261	5
6	Installed Sprinkler System In Entire Facility	2013	75,000		20	7,500	7,500	25,000	6
7	Installed Drywall In Rooms And Bathrooms 101-105, 109-112, 114	2013	17,750		20	1,775	1,775	5,473	7
8	Dining Rm-Millwork Base, Cornice, Sheers, Wallcovering, Crashr	2014	17,720		20	886	886	2,141	8
9	Reroof Dining Area, Waterproof Walls & Windows	2014	13,950		20	698	698	1,511	9
10	Critical Panel Installation	2014	3,150		20	158	158	341	10
11	Install Condenser Outside For Walk-In Freezer	2014	5,000		20	250	250	688	11
12	Domestic Water Mixing Valve	2014	2,513		20	126	126	366	12
13	Elevator Shunt Trip	2015	5,000		20	250	250	438	13
14	Load Center Circuit Breaker For Backup Generator	2015	10,000		20	500	500	1,000	14
15	14 Square Of Sidewalk With New Concrete	2015	5,600		20	280	280	303	15
16	Replacement Of Front Concrete Ramp	2016	2,750		20	138	138	138	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)		$ 3,247,356	$ 86,903		$ 106,254	$ 19,351	$ 2,056,834	34

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 3,247,356	$ 86,903		$ 106,254	$ 19,351	$ 2,056,834	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)		$ 3,247,356	$ 86,903		$ 106,254	$ 19,351	$ 2,056,834	34

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 3,247,356	$ 86,903		$ 106,254	$ 19,351	$ 2,056,834	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)		$ 3,247,356	$ 86,903		$ 106,254	$ 19,351	$ 2,056,834	34

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 3,247,356	$ 86,903		$ 106,254	$ 19,351	$ 2,056,834	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)		$ 3,247,356	$ 86,903		$ 106,254	$ 19,351	$ 2,056,834	34

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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)		$	$		$	$	$	34

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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
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)		$	$		$	$	$	34

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2003	53,222	1,365	35	1,365		19,049	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Staycare Management	2003	2,465		20	123	123	1,671	9
10	Allocated from Staycare Management	2016	2,895	2,895	20	97	(2,798)	97	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)		$ 58,582	$ 4,260		$ 1,585	$ (2,675)	$ 20,817	34

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 58,582	$ 4,260		$ 1,585	$ (2,675)	$ 20,817	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
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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)		$ 58,582	$ 4,260		$ 1,585	$ (2,675)	$ 20,817	34

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 97,025	$	$ 14,082	$ 14,082	10	$ 59,401	71
72	Current Year Purchases	8,029		268	268	10	268	72
73	Fully Depreciated Assets	85,374				10	85,374	73
74								74
75	TOTALS	$ 190,428	$	$ 14,349	$ 14,349		$ 145,042	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	2012	$ 3,769	$ 206	$ 459	$ 253	5	$ 2,449	76
77										77
78										78
79										79
80	TOTALS			$ 3,769	$ 206	$ 459	$ 253		$ 2,449	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,547,121	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 87,109	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 121,062	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 33,953	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,204,325	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	LTC Interiors/Econocare	$ 85,000	92
93	LTC Interiors/Econocare	125,000	93
94			94
95		$ 210,000	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 Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 3,184 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	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 Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 41,343	$		$ 41,343	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			4,023			4,023	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			41,166			41,166	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 prescrpts				15,923		15,923	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			$		$ 86,532	$ 15,923		$ 102,455	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 & Nrsing Ctr **#** 0039693 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 142,472	$ 538,856	1
2	Cash-Patient Deposits	18,959	18,959	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	866,588	866,588	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	113,520	113,520	6
7	Other Prepaid Expenses	5,982	5,982	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,147,521	$ 1,543,905	10
	B. Long-Term Assets			
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	851,841	851,841	15
16	Equipment, at Historical Cost	226,104	333,104	16
17	Accumulated Depreciation (book methods)	(516,716)	(1,952,409)	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): See Attached Schedule	120,000	26,864	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 681,229	$ 1,694,414	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,828,750	$ 3,238,319	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 197,225	$ 197,225	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,959	18,959	28
29	Short-Term Notes Payable	316,448		29
30	Accrued Salaries Payable	127,179	127,179	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,792	1,792	31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,308	33,308	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,801	3,801	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	19,398	19,398	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 718,110	$ 401,662	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,458,397	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)**	$	$ 3,458,397	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 718,110	$ 3,860,059	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,110,640	$ (621,740)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,828,750	$ 3,238,319	48

***(See instructions.)**

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,188,851	1
2	Restatements (describe):		2
3	**Rounding**	4	3
4	**Prior Year Bad Debt**	87,562	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,276,417	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,777)	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	(164,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (165,777)	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)**	$ 1,110,640	24 *

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

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 4,056,369	1
2	Discounts and Allowances for all Levels	(147,966)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,908,403	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	185,905	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 185,905	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	16,148	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	800	19
20	Radiology and X-Ray	474	20
21	Other Medical Services	1,289	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 18,711	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	671	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 671	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,113,690	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	712,283	31
32	Health Care	1,509,592	32
33	General Administration	963,804	33
	B. Capital Expense		
34	Ownership	639,158	34
	C. Ancillary Expense		
35	Special Cost Centers	102,455	35
36	Provider Participation Fee	188,175	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,115,467	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,777)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,777)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,298,673	44
45	Private Pay - Net Inpatient Revenue	395,615	45
46	Medicare - Net Inpatient Revenue	214,115	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,908,403	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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 & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2,015	2,087	$ 82,186	$ 39.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,609	11,996	355,218	29.61	3
4	Licensed Practical Nurses	8,082	8,416	219,107	26.03	4
5	CNAs & Orderlies	34,524	39,376	501,138	12.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,025	2,258	35,481	15.71	8
9	Activity Director	1,849	1,937	29,123	15.04	9
10	Activity Assistants	2,639	2,781	27,552	9.91	10
11	Social Service Workers	1,840	2,080	36,046	17.33	11
12	Dietician					12
13	Food Service Supervisor	1,965	2,093	33,242	15.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,423	12,851	140,038	10.90	15
16	Dishwashers					16
17	Maintenance Workers	2,385	2,680	51,985	19.40	17
18	Housekeepers	10,476	11,910	125,006	10.50	18
19	Laundry	2,045	2,293	27,619	12.04	19
20	Administrator	1,880	2,080	90,459	43.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,036	5,438	58,945	10.84	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)	3,856	4,209	130,517	31.01	33
34	TOTAL (lines 1 - 33)	102,649	114,485	$ 1,943,662 *	$ 16.98	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	Monthly	$ 7,116	01-03	35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,260	10-03	39
40	Physical Therapy Consultant	35	1,652	10a-03	40
41	Occupational Therapy Consultant	28	1,124	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	20	1,096	11-03	44
45	Social Service Consultant	46	2,459	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	129	$ 24,707		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 Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janet Cantelo	Administrator	0	$ 90,459
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,459

B. Administrative - Other

Description	Amount
Staycare Management Fees	$ 285,775
TOTAL (agree to Schedule V, line 17, col. 3)	$ 285,775
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal Fees	$ 3,707
Marcum LLP	Accounting	18,491
Personnel Planners	Unemployment Consulting	377
Staycare Management	Reimbursement Consultant	14,625
KBC Computer Services, Ltd	Computer Service	4,245
E-Healthcare Solutions	E-Charting Expense	12,959
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 54,404

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,084
Unemployment Compensation Insurance	15,908
FICA Taxes	138,706
Employee Health Insurance	82,206
Employee Meals	7,796
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	1,235
Union Pension Expense	13,632
401K Employer	1,321
Christmas Expense	3,402
TOTAL (agree to Schedule V, line 22, col.8)	$ 322,290

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	586
Health Care Worker Background Check	1,610
(Indicate # of checks performed 161)	
Patient Background Checks	
Dues & Subscriptions	7,609
Licenses/Permits/Fees	3,427
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,232

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	806
Allocated from Staycare Management	120
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 926

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Abbington Rehab & Nrsing Ctr # 0039693 Report Period Beginning: 01/01/16 Ending: 12/31/16

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC: $11,356**

(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. $ **36,211** 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. $ **188,175**
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. $ **7,796** Has any meal income been offset against related costs? **No** 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? **None**
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