FOR BHF USE

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

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.

I. IDPH License ID Number: 0052589

Facility Name: Elmhurst Extended Care Ctr

Address: 200 East Lake Street (Number) Elmhurst (City) 60126 (Zip Code)

County: DuPage

Telephone Number: (630) 516-5000 **Fax #** (630) 834-0480

HFS ID Number:

Date of Initial License for Current Owners: 1/1/2014

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: Andrew B. Cutler **Telephone Number:** (847) 940-3269
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2016 to 12/31/2016 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)
(Print Name and Title) Andrew B. Cutler, Managing Director
(Firm Name & Address) FGMK, LLC, 2801 Lakeside Drive 3rd Floor, Bannockburn, IL 60015
(Telephone) (847) 940-3269 Fax # (847) 564-5439

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 Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	108	Skilled (SNF)	108	39,528	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,528	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	467	3,577	3,672	7,716	8
9	SNF/PED					9
10	ICF	2,910	13,337		16,247	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,377	16,914	3,672	23,963	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.62%

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 [X] NO [ ]

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

I. On what date did you start providing long term care at this location?
Date started 12/31/2013

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/31/2013 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 39 and days of care provided 3,257

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	266,652	29,347		295,999		295,999	(9,883)	286,116			1
2	Food Purchase		172,201		172,201		172,201		172,201			2
3	Housekeeping	149,891	21,123		171,014		171,014		171,014			3
4	Laundry	32,388	7,457		39,845		39,845		39,845			4
5	Heat and Other Utilities			110,978	110,978		110,978		110,978			5
6	Maintenance	84,366		46,884	131,250		131,250		131,250			6
7	Other (specify):*											7
8	**TOTAL General Services**	533,297	230,128	157,862	921,287		921,287	(9,883)	911,404			8
	B. Health Care and Programs											
9	Medical Director			61,925	61,925		61,925	(5,952)	55,973			9
10	Nursing and Medical Records	2,217,155	171,341	57,199	2,445,695		2,445,695	(25,804)	2,419,891			10
10a	Therapy		5,986	146	6,132		6,132		6,132			10a
11	Activities	117,648	797	1,854	120,299		120,299		120,299			11
12	Social Services	70,570			70,570		70,570		70,570			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,405,373	178,124	121,124	2,704,621		2,704,621	(31,756)	2,672,865			16
	C. General Administration											
17	Administrative	89,836			89,836		89,836		89,836			17
18	Directors Fees											18
19	Professional Services			50,619	50,619		50,619	(6,388)	44,231			19
20	Dues, Fees, Subscriptions & Promotions			33,551	33,551		33,551	(25,664)	7,887			20
21	Clerical & General Office Expenses	293,821	3,166	228,705	525,692		525,692	(204,910)	320,782			21
22	Employee Benefits & Payroll Taxes			434,201	434,201		434,201		434,201			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,425	15,425		15,425	(687)	14,738			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			86,790	86,790		86,790		86,790			26
27	Other (specify):*											27
28	**TOTAL General Administration**	383,657	3,166	849,291	1,236,114		1,236,114	(237,649)	998,465			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,322,327	411,418	1,128,277	4,862,022		4,862,022	(279,288)	4,582,734			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 Elmhurst Extended Care Ctr #0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			24,348	24,348		24,348	613,707	638,055			30
31	Amortization of Pre-Op. & Org.							21,907	21,907			31
32	Interest			53,738	53,738		53,738	294,300	348,038			32
33	Real Estate Taxes			54,000	54,000		54,000	(5,719)	48,281			33
34	Rent-Facility & Grounds			1,048,379	1,048,379		1,048,379	(1,046,004)	2,375			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,180,465	1,180,465		1,180,465	(121,809)	1,058,656			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	314,178	176,124	53,841	544,143		544,143		544,143			39
40	Barber and Beauty Shops			8,632	8,632		8,632	(8,632)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			185,013	185,013		185,013		185,013			42
43	Other (specify):*	33,947		12,669	46,616		46,616		46,616			43
44	**TOTAL Special Cost Centers**	348,125	176,124	260,155	784,404		784,404	(8,632)	775,772			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,670,452	587,542	2,568,897	6,826,891		6,826,891	(409,729)	6,417,162			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 Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	155,815	30		9
10	Interest and Other Investment Income	(1,954)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,872)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(190,401)	21		24
25	Fund Raising, Advertising and Promotional	(15,415)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(7,574)	20		28
29	Other-Attach Schedule	(70,658)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (134,059)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (134,059)		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

Elmhurst Extended Care Ctr

ID# 0052589

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Expense	$ (9,883)	01	1
2	Barber & Beauty	(8,632)	40	2
3	Bank Charges	(74)	21	3
4	Misc. Income	(563)	21	4
5	Non-Allowable Legal	(6,388)	19	5
6	Dialysis Income Offset	(25,804)	10	6
7	Non-Allowable Dialysis Medical Director Fees	(5,952)	09	7
8	Non-Allowable Travel - Out of State	(687)	24	8
9	Offset Non-Allowable Lobbying Exp IHCA	(2,675)	20	9
10	Offset Non-Allowable Penalties	(10,000)	21	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**	(70,658)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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	(9,883)	0	0	0	0	0	0	0	0	0	0	(9,883)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,883)	0	0	0	0	0	0	0	0	0	0	(9,883)	8
	B. Health Care and Programs													
9	Medical Director	(5,952)	0	0	0	0	0	0	0	0	0	0	(5,952)	9
10	Nursing and Medical Records	(25,804)	0	0	0	0	0	0	0	0	0	0	(25,804)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(31,756)	0	0	0	0	0	0	0	0	0	0	(31,756)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,388)	0	0	0	0	0	0	0	0	0	0	(6,388)	19
20	Fees, Subscriptions & Promotions	(25,664)	0	0	0	0	0	0	0	0	0	0	(25,664)	20
21	Clerical & General Office Expenses	(204,910)	0	0	0	0	0	0	0	0	0	0	(204,910)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(687)	0	0	0	0	0	0	0	0	0	0	(687)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(237,649)	0	0	0	0	0	0	0	0	0	0	(237,649)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(279,288)	0	0	0	0	0	0	0	0	0	0	(279,288)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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	155,815	457,892	0	0	0	0	0	0	0	0	0	613,707	30
31	Amortization of Pre-Op. & Org.	0	21,907	0	0	0	0	0	0	0	0	0	21,907	31
32	Interest	(1,954)	296,254	0	0	0	0	0	0	0	0	0	294,300	32
33	Real Estate Taxes	0	(5,719)	0	0	0	0	0	0	0	0	0	(5,719)	33
34	Rent-Facility & Grounds	0	(1,046,004)	0	0	0	0	0	0	0	0	0	(1,046,004)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	153,861	(275,670)	0	0	0	0	0	0	0	0	0	(121,809)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(8,632)	0	0	0	0	0	0	0	0	0	0	(8,632)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(8,632)	0	0	0	0	0	0	0	0	0	0	(8,632)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(134,059)	(275,670)	0	0	0	0	0	0	0	0	0	(409,729)	45

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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
				N/A		
Love Dave	15%					
Madhsudan Dave	60%					
Diptu Dave	25%					

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)	
1	V	34	Rent	$ 1,046,004	LKNY, LLC		$	$ (1,046,004)	1
2	V	30	Depreciation Expense		LKNY, LLC		457,892	457,892	2
3	V	31	Amortization Expense		LKNY, LLC		21,907	21,907	3
4	V	32	Mortgage Interest		LKNY, LLC		265,206	265,206	4
5	V	33	Real Estate Taxes	54,000	LKNY, LLC		48,281	(5,719)	5
6	V	32	Interest Expense-LOC		LKNY, LLC		31,048	31,048	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,100,004			$ 824,334	$ * (275,670)	14

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

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	Love Dave	Owner	Administrative	15.00	None	40	100.00	Salary	$ 95,680	17-1	1
2	Madhusudan Dave	Owner	Administrative	60.00	None	40	100.00	Salary	64,180	21-1	2
3	Dipti Dave	Owner	Bookkeeping	25.00	None	40	100.00	Salary	97,200	21-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 257,060		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 Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

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 N/A
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		N/A								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 Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	Ridgestone Bank		X	Mortgage			$ 5,000,000	$ 4,729,608		Prime+2.5	$ 265,206	1
2	Seller Finance		X	Seller Finance			1,000,000	840,668	3/1/2019	0.0575	53,738	2
3												3
4												4
5												5
	Working Capital											
6	Ridgestone Bank		X	Working Capital - LOC			500,000	285,000		Prime +3%	31,048	6
7	Freemont Street		X	Working Capital - LOC				192,000				7
8												8
9	TOTAL Facility Related						$ 6,500,000	$ 6,047,276			$ 349,992	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,954)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,954)	14
15	TOTALS (line 9+line14)						$ 6,500,000	$ 6,047,276			$ 348,038	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A 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 Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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.**	$ 5,719	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.)		$ 54,000	2
3. Under or (over) accrual (line 2 minus line 1).		$ 48,281	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 48,281	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012		9
2013	51,033	10
2014	51,316	11
2015	48,281	12

No Real Estate Tax Accrual as provider pays real estate tax as part of rent.
Rent expense is fixed therefore no accrual is required.

	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 Elmhurst Extended Care Ctr COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0052589

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

TELEPHONE (847) 374-0400 FAX #: (847) 374-0420

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.	03-36-309-029	Long-Term Care Property	$ 48,112.00	$ 48,112.00
2.	03-36-309-020	Long-Term Care Property	$ 6,656.00	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 54,768.00	$ 48,112.00

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,019 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 [ ] (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).

Freemont Street Property - All Expenses related have ben adjusted from Cost Report

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

1. Total Amount Incurred: 222,344 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: 21,907 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	Resident Care	41,851	2013	$ 92,016	1
2	Parking Lot			6,950	2
3	TOTALS	41,851		$ 98,966	3

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	108		2013		$ 2,860,030	$	27	$ 115,311	$ 115,311	$ 349,700	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Elevator- Motor and Starter Replacement			2014	5,545		20	277	277	693	9
10	Parking Lot Pavement Repair			2014	4,166		20	208	208	520	10
11	Fire Alarm Repair			2014	3,916		20	196	196	441	11
12	Fire Panel/Damper			2014	64,700		20	3,235	3,235	7,009	12
13	Exhaust Fan			2014	6,111		20	306	306	918	13
14	Generator Repair			2015	3,888		20	194	194	339	14
15	Fire Sprinkler Repair			2015	3,012		20	151	151	176	15
16	Valve Repair			2015	2,504		20	125	125	146	16
17	Call Light System			2015	21,138		27.5	769	769	1,761	17
18	Fire Panel / Dampers			2015	34,338		20	1,717	1,717	3,291	18
19	2nd Fl new floors dining room, nurses station, corridor,			2015	22,850		7	3,264	3,264	1,415	19
20	3Bedrooms, 4 closets										20
21	New VMS security (Video Management System)			2015	11,763		5	2,353	2,353	784	21
22	Room Renovations 1 East, Patient Rooms, Painting, Flooring			2016	20,450		20				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	Current Book Deprciation					482,240					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 Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,064,411	$ 482,240		$ 128,106	$ 128,106	$ 367,193	70

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

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,556,119	$	$ 507,136	$ 507,136	5-7	$ 1,491,278	71
72	Current Year Purchases	38,541		2,813	2,813	5	2,813	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,594,660	$	$ 509,949	$ 509,949		$ 1,494,091	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,758,037	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 482,240	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 638,055	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 155,815	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,861,284	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	Office Storage Rental				2,375			5
6								6
7	TOTAL				$ 2,375 **			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: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	39-1	hrs	$ 132,903		$ 9,654	$		$ 142,557	1
2	Licensed Speech and Language Development Therapist		hrs			12,000			12,000	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	181,275		19,903			201,178	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				176,124		176,124	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab &X-Ray					12,284			12,284	13
14	TOTAL			$ 314,178		$ 53,841	$ 176,124		$ 544,143	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 Elmhurst Extended Care Ctr **#** 0052589 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	$ 346,064	$ 903,449	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (19,740))	432,077	792,500	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,021	9,021	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,000	3,000	8
9	Other(specify): See Attached	800	800	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 790,962	$ 1,708,770	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		493,227	13
14	Buildings, at Historical Cost		2,486,821	14
15	Leasehold Improvements, at Historical Cost	181,349	554,558	15
16	Equipment, at Historical Cost	96,534	2,594,659	16
17	Accumulated Depreciation (book methods)	(41,312)	(2,315,733)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		42,879	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(65,723)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached		179,465	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 236,571	$ 3,970,153	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,027,533	$ 5,678,923	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 434,032	$ 434,032	26
27	Officer's Accounts Payable	6,470	6,470	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	77,230	77,230	29
30	Accrued Salaries Payable	372,477	372,477	30
31	Accrued Taxes Payable (excluding real estate taxes)	49,341	49,341	31
32	Accrued Real Estate Taxes(Sch.IX-B)		50,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 939,550	$ 989,550	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	865,674	1,341,965	39
40	Mortgage Payable		4,729,608	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)**	$ 865,674	$ 6,071,573	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,805,224	$ 7,061,123	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (777,691)	$ (1,382,200)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,027,533	$ 5,678,923	48

***(See instructions.)**

Elmhurst Extended Care Center
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	A. Current Assets	Operating	After Consolidation
9	Due from Employees	800.00	800.00
		800.00	800.00

	B. Long-Term Assets	Amount	
23	Loan Fees	-	179,465.00
		-	179,465.00

	Other Current Liabilities	Amount	
36		-	-
		-	-

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (63,659)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (63,659)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(714,032)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (714,032)	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)**	$ (777,691)	24 *

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

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,465,161	1
2	Discounts and Allowances for all Levels	(2,641,027)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,824,134	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	748,584	6
7	Oxygen	22,322	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 770,906	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	11,618	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	156,887	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,685	19
20	Radiology and X-Ray	6,704	20
21	Other Medical Services	309,281	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 492,175	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,954	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,954	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc. Income/Vending Income/3rd Party Settlement	23,690	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 23,690	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,112,859	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	921,287	31
32	Health Care	2,704,621	32
33	General Administration	1,236,114	33
	B. Capital Expense		
34	Ownership	1,180,465	34
	C. Ancillary Expense		
35	Special Cost Centers	599,391	35
36	Provider Participation Fee	185,013	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,826,891	40
41	**Income before Income Taxes (line 30 minus line 40)****	(714,032)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (714,032)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 493,624	44
45	Private Pay - Net Inpatient Revenue	3,680,126	45
46	Medicare - Net Inpatient Revenue	604,438	46
47	Other-(specify)	45,946	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,824,134	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash 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 Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	2,016	2,160	$ 92,071	$ 42.63	1
2	Assistant Director of Nursing	2,016	2,160	60,011	27.78	2
3	Registered Nurses	17,892	19,111	608,177	31.82	3
4	Licensed Practical Nurses	13,810	15,054	407,705	27.08	4
5	CNAs & Orderlies	68,412	73,481	1,014,007	13.80	5
6	CNA Trainees					6
7	Licensed Therapist	6,917	7,341	314,178	42.80	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,971	2,155	60,133	27.90	9
10	Activity Assistants	4,202	4,497	57,515	12.79	10
11	Social Service Workers	2,016	2,160	70,570	32.67	11
12	Dietician	2,096	2,160	48,709	22.55	12
13	Food Service Supervisor					13
14	Head Cook	2,147	2,451	50,139	20.46	14
15	Cook Helpers/Assistants	7,761	8,604	109,214	12.69	15
16	Dishwashers	5,222	5,609	58,590	10.45	16
17	Maintenance Workers	2,244	2,508	84,366	33.64	17
18	Housekeepers	12,010	12,940	149,891	11.58	18
19	Laundry	2,636	2,934	32,388	11.04	19
20	Administrator	2,080	2,160	89,836	41.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,343	8,735	293,821	33.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,057	2,120	35,184	16.60	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing Dir.	1,128	1,168	33,947	29.06	33
34	TOTAL (lines 1 - 33)	166,976	179,508	$ 3,670,452 *	$ 20.45	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		$		35
36	Medical Director	Monthly	61,925	9-3	36
37	Medical Records Consultant	24	1,350	10-3	37
38	Nurse Consultant	Monthly	7,182	10-3	38
39	Pharmacist Consultant	Monthly	7,843	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	880	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	40	$ 79,180		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 368	10-3	50
51	Licensed Practical Nurses	8	336	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	16	$ 704		53

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Love Dave	Administrator	15%	$ 89,836
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 89,836

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Keith Goldgerg	Legal	$ 6,388
Michigan Peer Review	Legal	605
Polsinelli	Legal	10,012
Keep It Safe	Data Storage	3,146
FGMK	Accounting	26,467
Aldrich Tech Solutions	Data Processing	4,001
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 50,619

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,064
Unemployment Compensation Insurance	26,775
FICA Taxes	271,968
Employee Health Insurance	58,319
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k Match	21,109
Employee Physicals	966
TOTAL (agree to Schedule V, line 22, col.8)	$ 434,201

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	75
Health Care Worker Background Check	
(Indicate # of checks performed 10)	350
Patient Background Checks 131	1,310
Marketing/Advertsing & Promotion	14,503
Yellow Page Advertising	7,574
IHCA Dues	6,152
Less: Public Relations Expense	(14,503)
Non-allowable advertising	( )
Yellow page advertising	(7,574)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,887

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	898
Seminar Expense	13,838
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,736

* Attach copy of IMRF notifications

**See instructions.

Elmhurst Extended Care Center
0052589
SEMINAR EXPENSE
FYE:1/1/2016-12/31/2016

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE
1/6/16	TNS Life Safety	In-Services	Various	All Staff	Elmhurst, IL	1,890
1/27/16	PESI Healthcare	Treatment of Diff. Wounds	Stefanowicz, Bartkowicz	DON, PT	Web	200
2/9/16	Lyf Savers	CPR Training	Various	Nursing	Elmhurst, IL	1,320
2/23/16	Skill Path	HR Law	Maher	Bookkeeper	Oak Brook, IL	179
2/29/16	CARF	CARF Manuals	Various	Various	Elmhurst, IL	300
4/21/16	CE Solutions	On-Line Training	Various	Various	Elmhurst, IL	1,770
7/22/16	Triton	Tuition - CNA	Maria Guadarrama	CNA	Melrose Park, IL	1,235
8/6/16	NFPA	Life Safety Code	Various	Various	Elmhurst, IL	180
8/30/16	Melissa Stefanowicz	Tuition	Melissa Stefanowicz	DON	Melrose Park, IL	2,500
3/7/16	IHCA	Public Policy Forum	Love Dave	Administrator	Web	50
8/23/16	IHCA	Convention	Love Dave	Administrator	Web	375
4/11/16	INHAA	Conference	Love Dave	Administrator	Springfield, IL	95
9/23/16	Cynthia Chow	2016 Seminar	Jessica Parran	Dietician	Elmhurst, IL	130
10/3/16	Leading Age	DNS-CT, DON Workshop	Melissa Stefanowicz	DON	Rosemont, IL	949
9/29/16	IHCA	Quality Reporting - Section GG	Love Dave	Administrator	Web	90
12/6/16	IHCA	Requirements of Participation	Love Dave	Administrator	Springfield, IL	75
12/29/16	Melissa Stefanowicz	Tuition	Melissa Stefanowicz	DON	Melrose Park, IL	2,500
					Total	13,838

Elmhurst Extended Care Center
0052589
AUTO & TRAVEL
FYE:1/1/2016-12/31/2016

DATE	EMPLOYEE NAME	JOB DESCRIPTION	DESTINATION	PURPOSE OF TRIP	FOOD	AIRFARE	HOTEL	TOTAL	
2/9/16	Love Dave	Administrator	Springfield	Seminar	72		163	235	
4/15/16	Love Dave	Administrator	Springfield	Seminar			99	99	
6/13/16	Love Dave	Administrator	Springfield	Seminar	73		491	563	
8/31/16	Love Dave	Administrator	Tennesse	Seminar		502	187	689	ADJ

Total	1,586
Adjustmer	(689)
Total	898

Elmhurst Extended Care Center
0052589
LEGAL SERVICES
FYE:1/1/2016-12/31/2016

DATE	G/L ACCT	PAYEE/VENDOR	AMOUNT	
1/28/16	64-4485	Keith Goldberg	2,259	ADJ
1/29/16	64-4485	Polsinelli	1,980	
2/23/16	64-4485	Keith Goldberg	2,129	ADJ
2/29/16	64-4485	Polsinelli	1,723	
3/23/16	64-4485	Keith Goldberg	2,701	ADJ
4/26/16	64-4485	Keith Goldberg	1,143	ADJ
4/30/16	64-4485	Polsinelli	621	
5/26/16	64-4485	Keith Goldberg	185	ADJ
6/27/16	64-4485	Keith Goldberg	185	ADJ
6/1/16	64-4485	Polsinelli	150	
7/31/16	64-4485	Keith Goldberg	235	ADJ
9/6/16	64-4485	Keith Goldberg	185	ADJ
9/28/16	64-4485	Keith Goldberg	579	ADJ
10/18/16	64-4485	Polsinelli	2,133	
10/25/16	64-4485	Keith Goldberg	660	ADJ
11/29/16	64-4485	Keith Goldberg	860	ADJ
12/1/16	64-4485	Michigan Peer Review Organization	605	
12/1/16	64-4485	Polsinelli	3,199	
12/21/16	64-4485	Polsinelli	207	
12/31/16	64-4485	Keith Goldberg	560	ADJ
	64-4485	Legal Fees Billed to Residents	(5,292)	ADJ
		TOTAL	17,005	
		ADJUSTMENTS	(6,388)	
		TOTAL:	10,617	

Facility Name & ID Number Elmhurst Extended Care Ctr # 0052589 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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. **IHCA - $6,772**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-7 Yr**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **24,642** 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. $ **185,013**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **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? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees