FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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: 0047241

Facility Name: CLARIDGE HEALTHCARE CENTER

Address: 700 JENKISSON (Number) LAKE BLUFF (City) 60044 (Zip Code)

County: LAKE

Telephone Number: (847) 295-3900 **Fax #** (847) 295-3989

HFS ID Number:

Date of Initial License for Current Owners: 07/01/2005

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: SANFORD BOKOR **Telephone Number:** (847) 675-3585
Email Address: kvanstockum@kbkbcpa.com

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2017 to 12/31/2017 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) SCOTT O'BRIEN
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KBKB, LTD, 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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 CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 _____

	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	160	Skilled (SNF)	160	58,400	1
2		Skilled Pediatric (SNF/PED)			2
3	71	Intermediate (ICF)	71	25,915	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,315	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	398		3,163	3,561	8
9	SNF/PED					9
10	ICF	28,597	1,609		30,206	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,995	1,609	3,163	33,767	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 40.05%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 07/01/05

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/05 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 42 and days of care provided 3,163

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	218,668	15,549	14,625	248,842		248,842		248,842			1
2	Food Purchase		187,477		187,477		187,477		187,477			2
3	Housekeeping	244,358	39,866		284,224		284,224		284,224			3
4	Laundry	5,132	10,866	1,015	17,013		17,013		17,013			4
5	Heat and Other Utilities			125,683	125,683		125,683		125,683			5
6	Maintenance	36,462	34,555	50,801	121,818		121,818		121,818			6
7	Other (specify):*			18,538	18,538		18,538		18,538			7
8	**TOTAL General Services**	504,620	288,313	210,662	1,003,595		1,003,595		1,003,595			8
	B. Health Care and Programs											
9	Medical Director			42,000	42,000		42,000		42,000			9
10	Nursing and Medical Records	1,011,748	99,935	809,714	1,921,397		1,921,397		1,921,397			10
10a	Therapy											10a
11	Activities	71,651	3,125	2,640	77,416		77,416		77,416			11
12	Social Services	38,455		1,024	39,479		39,479		39,479			12
13	CNA Training											13
14	Program Transportation			6,762	6,762		6,762		6,762			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,121,854	103,060	862,140	2,087,054		2,087,054		2,087,054			16
	C. General Administration											
17	Administrative	81,429			81,429		81,429		81,429			17
18	Directors Fees											18
19	Professional Services			45,966	45,966		45,966	11,110	57,076			19
20	Dues, Fees, Subscriptions & Promotions			9,720	9,720		9,720	(5,150)	4,570			20
21	Clerical & General Office Expenses	116,998	9,077	114,390	240,465		240,465		240,465			21
22	Employee Benefits & Payroll Taxes			205,153	205,153		205,153		205,153			22
23	Inservice Training & Education			4,222	4,222		4,222		4,222			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			2,426	2,426		2,426		2,426			25
26	Insurance-Prop.Liab.Malpractice			114,379	114,379		114,379	9,223	123,602			26
27	Other (specify):*											27
28	**TOTAL General Administration**	198,427	9,077	496,256	703,760		703,760	15,183	718,943			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,824,901	400,450	1,569,058	3,794,409		3,794,409	15,183	3,809,592			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#: CLARIDGE HEALTHCARE CENTER **#0047241** **Report Period Beginning: 01/01/2017** **Ending: 12/31/2017**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	11,668	
	REPAIRS & MAINTENANCE		2,957	
				14,625
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,015	
				1,015
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		37,056	
	ELECTRICITY		55,271	
	WATER		33,356	
	CABLE TV - LOBBY		0	
				125,683
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,152	
	PAINTING & DECORATING		2,168	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		25,728	
	ELEVATOR MAINTENANCE & REPAIR		2,608	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,275	
	FIRE SERVICE		14,870	
				50,801
7	**OTHER**			
	SCAVENGER		18,538	
	SECURITY SERVICE		0	
				18,538
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	42,000	42,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	803,051	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	6,663	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
				809,714
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,640	
				2,640
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,024	
				1,024
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER **#0047241** **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		6,762	
				6,762
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	16,120	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	29,846	
				45,966
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	5,150	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	59	
	LICENSES & PERMITS	XIX F	2,371	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	1,090	
	PATIENT BACKGROUND CHECKS	XIX F	1,050	
				9,720
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		40	
	EQUIPMENT REPAIR & MAINTENANCE		1,148	
	OUTSIDE CLERICAL SERVICES		50,363	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		14,528	
	MESSENGER SERVICE		0	
	COMPUTER SUPPORT CHARGES		48,311	114,390

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	139,104	
	UNEMPLOYMENT COMPENSATION	XIX D	17,557	
	WORKERS COMPENSATION INSURANC	XIX D	39,354	
	HOSPITALIZATION INSURANCE	XIX D	9,068	
	EMPLOYEE BENEFITS - OTHER	XIX D	70	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				205,153
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,222	
				4,222
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,426	
				2,426
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		114,379	
				114,379
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **1,569,058**

CLARIDGE HEALTHCARE CENTER
SCHEDULES
12/31/2017

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	187,477
LESS SALES TAX	0
NET FOOD	187,477
TOTAL PATIENT CENSUS	33,767
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	101,301
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	58,400
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	101,301
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	101,301
NET FOOD	187,477
DIVIDE TOTAL MEALS/YEAR	101,301
COST PER MEAL	1.85
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER #0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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			56,760	56,760		56,760	176,425	233,185			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,756	2,756		2,756	438,059	440,815			32
33	Real Estate Taxes							87,301	87,301			33
34	Rent-Facility & Grounds			1,200,000	1,200,000		1,200,000	(1,200,000)				34
35	Rent-Equipment & Vehicles			6,763	6,763		6,763		6,763			35
36	Other (specify):*							26,308	26,308			36
37	**TOTAL Ownership**			1,266,279	1,266,279		1,266,279	(471,907)	794,372			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,941	313,255	371,196		371,196		371,196			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			312,171	312,171		312,171		312,171			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		57,941	625,426	683,367		683,367		683,367			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,824,901	458,391	3,460,763	5,744,055		5,744,055	(456,724)	5,287,331			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 CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	(22,782)	30		9
10	Interest and Other Investment Income	(553)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(5,150)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PG 5A				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (28,485)		$	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)	(428,239)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (428,239)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (456,724)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

CLARIDGE HEALTHCARE CENTER

ID# 0047241

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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
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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	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	0	11,110	0	0	0	0	0	0	0	0	0	11,110	19
20	Fees, Subscriptions & Promotions	(5,150)	0	0	0	0	0	0	0	0	0	0	(5,150)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	9,223	0	0	0	0	0	0	0	0	0	9,223	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(5,150)	20,333	0	0	0	0	0	0	0	0	0	15,183	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,150)	20,333	0	0	0	0	0	0	0	0	0	15,183	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER # 0047241 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	(22,782)	199,207	0	0	0	0	0	0	0	0	0	176,425	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(553)	438,612	0	0	0	0	0	0	0	0	0	438,059	32
33	Real Estate Taxes	0	87,301	0	0	0	0	0	0	0	0	0	87,301	33
34	Rent-Facility & Grounds	0	(1,200,000)	0	0	0	0	0	0	0	0	0	(1,200,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	26,308	0	0	0	0	0	0	0	0	0	26,308	36
37	**TOTAL Ownership**	(23,335)	(448,572)	0	0	0	0	0	0	0	0	0	(471,907)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(28,485)	(428,239)	0	0	0	0	0	0	0	0	0	(456,724)	45

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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
MRS CHOON CHI	96			CLARIDGE REAL		
RICHARD SCOTT O'BRIEN	4			ESTATE, LLC	LAKE BLUFF	REAL ESTATE

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	$ 1,200,000	CLARIDGE REAL ESTATE LLC	100.00%	$	$ (1,200,000)	1
2	V	26	INSURANCE				9,223	9,223	2
3	V	33	REAL ESTATE TAXES				87,301	87,301	3
4	V	32	INTEREST				438,612	438,612	4
5	V	36	MIP INSURANCE				26,308	26,308	5
6	V	30	SL DEPORECIATION				199,207	199,207	6
7	V	19	PROFESSIONAL FEES				11,110	11,110	7
8	V								8
9	V								9
10	V								10
11	V	10	CONTRACT NURSING	803,051	PNI	100.00%	803,051		11
12	V								12
13	V								13
14	Total			$ 2,003,051			$ 1,574,812	$ * (428,239)	14

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

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	MRS CHOON CHI	ADMINISTRATIVE							$		1
2											2
3	RICHARD SCOTT O'BRIEN	CFO									3
4											4
5											5
6	ALEXANDER CHI	ASST ADMINISTR.				40	100.00	SALARY	81,429	17-1	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 81,429		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 CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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 CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: CLARIDGE REAL ESTATE, LLC						$	$			$	1
2	HEARTLAND BANK	X		MORTGAGE	$72,149.00	05/27/94	8,192,800	5,274,224	06/01/29	8.1250	438,612	2
3												3
4												4
5												5
	Working Capital											
6		X		INSURANCE FINANCING							2,756	6
7												7
8												8
9	TOTAL Facility Related						$ 8,192,800	$ 5,274,224			$ 441,368	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,192,800	$ 5,274,224			$ 441,368	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 26,308 Line # 36

* 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 CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		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.)	$	87,301	2
3. Under or (over) accrual (line 2 minus line 1).	$	87,301	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	88,000	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.	$	175,301	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	77,545	8
	2013	65,177	9
	2014	85,233	10
	2015	83,607	11
	2016	87,301	12

THE PAYMENT ON LINE 2 APPLIES TO THE 2016 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CLARIDGE HEALTHCARE CENTER COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0047241

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-18-400-003	NURSING HOME	$ 2,606.11	$ 2,606.11
2.	12-18-400-010	NURSING HOME	$ 84,695.36	$ 84,695.36
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 87,301.47	$ 87,301.47

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,545 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

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

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

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

N/A

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	NURSING HOME		2005	$ 885,703	1
2					2
3	TOTALS			$ 885,703	3

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	231			2005	$ 7,552,808	$ 193,662	39	$ 193,662	$	$	4
5				2005	515,849		10				5
6											6
7											7
8											8
	Improvement Type**										
9	PAINTING; TILE & WALLPAPER COVERING; CEILING TILE			2005	52,239	1,900	27.5	1,900		23,545	9
10	FLOORING, COVE BASE, CARPETING			2005	57,519	2,091	27.5	2,091		25,703	10
11	STEEL DOORS			2005	16,319	593	27.5	593		7,289	11
12	PLUMBING REPAIRS; PUMPS, VALUES, MOTORS			2005	19,662	715	27.5	715		8,789	12
13	SPRINKLER SYS;SMOKE DET; FIRE DAMPER;TEMP CONTR			2005	25,043	911	27.5	911		11,195	13
14	LOBBY COUNTER & NURSES STATION			2005	10,758	391	27.5	391		4,806	14
15	WINDOW TREATMENT; CUBICLE CURTAINS			2005	19,636	714	27.5	714		8,776	15
16	NEW SERVICES SIDEWALK			2005	2,400	87	27.5	87		1,070	16
17	INSULATION			2005	7,194	262	27.5	262		3,219	17
18	HANDRAILS			2006	15,358	558	27.5	558		6,394	18
19	CEILING TILES			2006	4,309	157	27.5	157		1,799	19
20	FIRE INSULATIONS			2006	4,400	160	27.5	160		1,833	20
21	FIRE ALARM SYSTEM			2007	31,590	1,149	27.5	1,149		12,017	21
22	HEATING AND AIR CONDITIONER REPAIRS			2007	26,295	956	27.5	956		9,999	22
23	WATER MAIN AND PARKING LOT REPAIR			2009	9,915	361	27.5	361		3,023	23
24	INSTALL NEW SEWER PIPE			2010	6,000	218	27.5	218		1,626	24
25	SPRINKLER SYS;SMOKE DET; FIRE DAMPER;TEMP CONTR			2010	8,570	312	27.5	312		2,327	25
26	REPLACED GFI OUTLETS;ELECTRIC BREAKERS IN PANEL			2010	4,398	160	27.5	160		1,193	26
27	REPLACED FLAME SAFEGUARDS ON BOILERS			2011	12,403	451	27.5	451		3,138	27
28	ROOF-PARAPET WALL;FLASHING;ROOF CEMENT;AWNING			2011	7,535	274	27.5	274		1,792	28
29	INSTALLED THE NEW GENERATOR CONTROLLER			2011	4,757	173	27.5	173		1,088	29
30	REPLACE VALVES ON TRANSFER PUMPS IN BOILER ROOM			2011	4,172	152	27.5	152		944	30
31	INSTALLED TWO HEADS AT THE TOP AND TWO HEADS AT			2013	4,100	149	27.5	149		652	31
32	THWE BOTTOM OF ELEVATOR SHAFT										32
33	LAUNDRY ROOM-INSTALL NEW FIRE RATED DOORS &			2013	10,388	378	27.5	378		1,622	33
34	FRAME WITH SET OF HEAVY DUTY HINGES										34
35	ELEVATOR "B"-INSTALL HYDRAULIC OIL CONTAMI-			2013	14,350	522	27.5	522		2,197	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 CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	2ND AND 3RD FLOOR-INSTALLATION OF BLINDS	2014	$ 4,699	$ 541	5	$ 541	$	$ 3,887	37
38	2ND, 3RD FLOOR, BASEMENT ELEVATOR, FRONT LOBBY-								38
39	DOORS AND HALLWAY RAILS PAINTING	2014	6,900	795	5	795		5,708	39
40	REPACK 1000GPM FIRE PUMP, REPACK OS&Y VALVES ON								40
41	THE WET SPRINKLER SYSTEMS	2017	10,340	172	27.5	172		172	41
42	INSTALL MODIFY 2 PIT LADDER, SET OF CONTROLLER								42
43	PRINTS, ADJUST PUMP V-BELTS ON ELEVATOR 1	2017	8,241	88	27.5	88		88	43
44	INSTALL SHUNT BREAKER FOR EACH OF TWO ELEVATO	2017	6,175	28	27.5	28		28	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56	CLARIDGE REAL ESTATE, LLC								56
57	MODERNIZATION OF TWO PASSENGER ELEVATORS:	2012	45,000	2,250	20	2,250			57
58	REPLACE EXISTING ELEVATOR CONTROLERS; INSTALL								58
59	NEW CAR OPERATING PANELS, HALL FIXTURES, DOOR								59
60	OPERATORS,SAFETY EDGES, TRAVELING CABLES								60
61	FIRE ALARM PROGRAMMING: REPLACEING THE	2012	24,300	2,430	10	2,430			61
62	EXISTING FIRE LITE MS9200; INSTALL SMORE DETECTORS								62
63	INSTALL HVAC SYSTEM INDOOR AND OUTDOOR UNIT	2013	8,650	865	10	865			63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,562,272	$ 214,625		$ 214,625	$	$ 155,919	70

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

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 137,575	$ 12,122	$ 15,649	$ 3,527	3-10	$ 51,423	71
72	Current Year Purchases	48,219	28,932	2,411	(26,521)		2,411	72
73	Fully Depreciated Assets	259,307					259,307	73
74								74
75	TOTALS	$ 445,101	$ 41,054	$ 18,060	$ (22,994)		$ 313,141	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	MAINTENANCE	JEEP CHEROKEE 1994	2013	$ 2,500	$ 288	$ 500	$ 212	5	$ 2,125	76
77										77
78										78
79										79
80	TOTALS			$ 2,500	$ 288	$ 500	$ 212		$ 2,125	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)	$ 9,895,576	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 255,967	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 233,185	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (22,782)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 471,185	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 CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

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.		$
13.		$
14.		$

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: $ 6,763 Description: INTEGRA-NURSING EQUIPMENT
(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			N/A		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 CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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.

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	39-3	hrs	$		$ 167,445	$		$ 167,445	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			225			225	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			145,585			145,585	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				52,990		52,990	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-2					4,951		4,951	13
14	TOTAL			$		$ 313,255	$ 57,941		$ 371,196	14

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

STATE OF ILLINOIS

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (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	$ (431,578)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 508,750)	3,339,220		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	73,479		6
7	Other Prepaid Expenses	104,613		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,085,734	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	415,665		15
16	Equipment, at Historical Cost	447,601		16
17	Accumulated Depreciation (book methods)	(567,010)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 296,256	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,381,990	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,385,887	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	41,520		30
31	Accrued Taxes Payable (excluding real estate taxes)	28,218		31
32	Accrued Real Estate Taxes(Sch.IX-B)			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)**	$ 2,455,625	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO RELATED PARTY	3,567,844		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,567,844	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,023,469	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,641,479)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,381,990	$	48

*(See instructions.)

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,733,280)	1
2	Restatements (describe):		2
3	ROUNDING	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,733,277)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,250,468	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	(150,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES	(8,670)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,091,798	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,641,479)	24 *

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

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 6,993,520	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,993,520	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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	450	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 450	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	553	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 553	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)**	$ 6,994,523	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,003,595	31
32	Health Care	2,087,054	32
33	General Administration	703,760	33
	B. Capital Expense		
34	Ownership	1,266,279	34
	C. Ancillary Expense		
35	Special Cost Centers	371,196	35
36	Provider Participation Fee	312,171	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,744,055	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,250,468	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,250,468	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,797,455	44
45	Private Pay - Net Inpatient Revenue	386,121	45
46	Medicare - Net Inpatient Revenue	1,809,944	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,993,520	49

**TAX RETURN PREPARED ON CASH BASIS

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO** 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 CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	2,206	2,206	$ 90,114	$ 40.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,477	21,057	604,170	28.69	3
4	Licensed Practical Nurses	5,693	5,862	148,528	25.34	4
5	CNAs & Orderlies	9,524	10,179	134,332	13.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,950	2,100	29,909	14.24	9
10	Activity Assistants	4,155	4,274	41,742	9.77	10
11	Social Service Workers	2,571	2,587	38,455	14.86	11
12	Dietician					12
13	Food Service Supervisor	7,119	7,763	109,178	14.06	13
14	Head Cook	5,815	5,876	70,232	11.95	14
15	Cook Helpers/Assistants	3,847	3,954	39,258	9.93	15
16	Dishwashers					16
17	Maintenance Workers	2,501	2,609	36,462	13.98	17
18	Housekeepers	22,647	24,092	244,358	10.14	18
19	Laundry	570	570	5,132	9.00	19
20	Administrator					20
21	Assistant Administrator	1,985	2,466	81,429	33.02	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,859	8,116	116,998	14.42	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	1,897	2,018	34,604	17.15	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	100,816	105,729	$ 1,824,901 *	$ 17.26	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	M	$ 11,668	1-3	35
36	Medical Director	O	42,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,663	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,640	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 62,971		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides	41,150	803,051	10-3	52
53	TOTAL (lines 50 - 52)	41,150	$ 803,051		53

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ALEXANDER CHI	ASST ADMIN	0	$ 81,429
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 81,429

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
ZIRMED, INC	DATA PROCESSING	$ 2,188
HEALTH DATA SYSTEM	DATA PROCESSING	8,271
ABILITY NETWORK	DATA PROCESSING	1,356
POINTCLICKCARE	DATA PROCESSING	3,697
KBKB, LTD	ACCOUNTING	11,700
WIPFLI, LLP	MEDICARE CONSULTANT	3,750
LEGAT ARCHITECTS	DESIGN CONSULTING	2,835
LEGAL FEES	SEE SCHEDULE ATTACHED	12,169
SEE LEGAL SCHEDULE ATTACHED		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 45,966

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,354
Unemployment Compensation Insurance	17,557
FICA Taxes	139,104
Employee Health Insurance	9,068
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	70
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 205,153

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	$ 1,990
Advertising: Employee Recruitment	0
Health Care Worker Background Check	1,090
(Indicate # of checks performed 109)	
Patient Background Checks 105	1,050
TRUST/FRANCHISE/CONTRIB/ETC	0
MARKETING/ADV/PROMO	5,150
LICENSES/DUES/SUBSCRIPTIONS	440
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(5,150)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,570

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
Seminar Expense	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

CLARIDGE HEALTHCARE CENTER
SCHEDULE-LEGAL
12/31/2017

INVOICE DATE	FIRM NAME	AMOUNT	DESCRIPTION OF SERVICES
5/4/2017	SALVI, SALVI & WIFLER, P.C.	1,725	GUARDIANSHIP
6/2/2017	SALVI, SALVI & WIFLER, P.C.	1,312	GUARDIANSHIP
7/6/2017	SALVI, SALVI & WIFLER, P.C.	713	GUARDIANSHIP
7/6/2017	SALVI, SALVI & WIFLER, P.C.	219	GUARDIANSHIP
7/6/2017	SALVI, SALVI & WIFLER, P.C.	219	GUARDIANSHIP
8/2/2017	SALVI, SALVI & WIFLER, P.C.	215	GUARDIANSHIP
8/3/2017	SALVI, SALVI & WIFLER, P.C.	2,356	GUARDIANSHIP
8/3/2017	SALVI, SALVI & WIFLER, P.C.	246	GUARDIANSHIP
8/29/2017	SALVI, SALVI & WIFLER, P.C.	75	GUARDIANSHIP
9/7/2017	SALVI, SALVI & WIFLER, P.C.	650	GUARDIANSHIP
9/7/2017	SALVI, SALVI & WIFLER, P.C.	650	GUARDIANSHIP
10/3/2017	SALVI, SALVI & WIFLER, P.C.	37	GUARDIANSHIP
10/5/2017	LESSER LUTREY PASQUESI & HOWE, LLP	1,346	ESTATE OF RESIDENT
11/1/2017	SALVI, SALVI & WIFLER, P.C.	563	GUARDIANSHIP
11/1/2017	SALVI, SALVI & WIFLER, P.C.	400	GUARDIANSHIP
12/1/2017	SALVI, SALVI & WIFLER, P.C.	756	GUARDIANSHIP
12/31/2017	SALVI, SALVI & WIFLER, P.C.	687	GUARDIANSHIP
	TOTAL	12,169	

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

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

(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?

(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 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **32,330** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(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 fo 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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen during this cost report period. $ **312,171**
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 tc the Department, in addition to the daily rate, been properly classifiec 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 fo 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, attacl a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe 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:

(18) Have all costs which do not relate to the provision of long term care been adjusted ou 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