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: 0050807

Facility Name: Courtyard Healthcare

Address: 3601 S. Harlem Ave (Number) Berwyn (City) 60402 (Zip Code)

County: Cook

Telephone Number: (708)749-4160 **Fax #** (708)749-7696

HFS ID Number:

Date of Initial License for Current Owners: 2009

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: Larry Templin **Telephone Number:** (630) 361-2868
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 1/1/2017 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)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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	145	Skilled (SNF)	145	52,925	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	145	TOTALS	145	52,925	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			7,189	7,189	8
9	SNF/PED					9
10	ICF	33,727	1,257		34,984	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,727	1,257	7,189	42,173	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.68%

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] Non-allowable costs have been eliminated in Schedule V, Column 7

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 2009

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2009 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 145 and days of care provided 5,296

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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	333,224	27,843	39,618	400,685		400,685		400,685			1
2	Food Purchase		262,537		262,537		262,537		262,537			2
3	Housekeeping	7,956	10,820	165,150	183,926		183,926		183,926			3
4	Laundry		16,735	139,810	156,545		156,545		156,545			4
5	Heat and Other Utilities			94,628	94,628		94,628	636	95,264			5
6	Maintenance	76,723		60,395	137,118		137,118	2,173	139,291			6
7	Other (specify):* Waste Removal			40,449	40,449		40,449		40,449			7
8	TOTAL General Services	417,903	317,935	540,050	1,275,888		1,275,888	2,809	1,278,697			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,839,934	292,424	41,061	3,173,419		3,173,419	68,158	3,241,577			10
10a	Therapy	152,303	1,581	56,918	210,802		210,802	(32,918)	177,884			10a
11	Activities	113,958		3,561	117,519		117,519		117,519			11
12	Social Services	88,743		3,527	92,270		92,270		92,270			12
13	CNA Training											13
14	Program Transportation			1,376	1,376		1,376		1,376			14
15	Other (specify):* Mgmt Co Benefits Alloc							13,595	13,595			15
16	TOTAL Health Care and Programs	3,194,938	294,005	118,443	3,607,386		3,607,386	48,835	3,656,221			16
	C. General Administration											
17	Administrative	147,335		523,881	671,216		671,216	(420,993)	250,223			17
18	Directors Fees											18
19	Professional Services			231,171	231,171		231,171	6,187	237,358			19
20	Dues, Fees, Subscriptions & Promotions			46,319	46,319		46,319	123	46,442			20
21	Clerical & General Office Expenses	281,217	25,476	124,784	431,477		431,477	120,048	551,525			21
22	Employee Benefits & Payroll Taxes			670,938	670,938		670,938		670,938			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,153	2,153		2,153	177	2,330			24
25	Other Admin. Staff Transportation			20,309	20,309		20,309	(929)	19,380			25
26	Insurance-Prop.Liab.Malpractice			178,912	178,912		178,912	2,102	181,014			26
27	Other (specify):* Mgmt Co Benefits Alloc							35,080	35,080			27
28	TOTAL General Administration	428,552	25,476	1,798,467	2,252,495		2,252,495	(258,205)	1,994,290			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,041,393	637,416	2,456,960	7,135,769		7,135,769	(206,561)	6,929,208			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 Courtyard Healthcare #0050807 **Report Period Beginning:** 1/1/2017 **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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							456,587	456,587			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,884	51,884		51,884	1,166,723	1,218,607			32
33	Real Estate Taxes							312,000	312,000			33
34	Rent-Facility & Grounds			1,532,329	1,532,329		1,532,329	(1,519,727)	12,602			34
35	Rent-Equipment & Vehicles			36,505	36,505		36,505	1,430	37,935			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,620,718	1,620,718		1,620,718	417,013	2,037,731			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		284,715	956,641	1,241,356		1,241,356	(100,594)	1,140,762			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			303,316	303,316		303,316		303,316			42
43	Other (specify):* **Disallowed Costs**	55,107	5,401	234,643	295,151		295,151	(295,151)				43
44	**TOTAL Special Cost Centers**	55,107	290,116	1,494,600	1,839,823		1,839,823	(395,745)	1,444,078			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,096,500	927,532	5,572,278	10,596,310		10,596,310	(185,293)	10,411,017			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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	453,845	30		9
10	Interest and Other Investment Income	(6,684)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(634)	20		17
18	Fines and Penalties	(23,092)	43		18
19	Entertainment				19
20	Contributions	(17,300)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,573)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(155,911)	43		24
25	Fund Raising, Advertising and Promotional	(626)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(99,709)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 141,316		$	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)	(326,609)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (326,609)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (185,293)		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		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Courtyard Healthcare

ID# 0050807

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (55,107)	43	1
2	Marketing Expense	(43,115)	43	2
3	Expense Repair under $2,500	2,090	6	3
4	Disallow Marketing Travel	(3,577)	25	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**	(99,709)		49

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	Interest		Courtyard Realty at Berwyn	100.00%	$ 1,162,870	$ 1,162,870	1
2	V	33	Real Estate Taxes		Courtyard Realty at Berwyn	100.00%	312,000	312,000	2
3	V	34	Rent-Facility & Grounds	1,532,329	Courtyard Realty at Berwyn	100.00%		(1,532,329)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,532,329			$ 1,474,870	$ * (57,459)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Heat and Other Utilities	$	Premier Healthcare Management, LLC	100.00%	$ 636	$ 636	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	100.00%	83	83	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	81,314	81,314	17
18	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	0		18
19	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	13,595	13,595	19
20	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	0		20
21	V	17	Administrative	523,881	Premier Healthcare Management, LLC	100.00%	82,641	(441,240)	21
22	V	17	Administrative		Premier Healthcare Management, LLC	100.00%	20,247	20,247	22
23	V	17	Administrative		Premier Healthcare Management, LLC	100.00%	0		23
24	V	19	Professional Services		Premier Healthcare Management, LLC	100.00%	4,861	4,861	24
25	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	477	477	25
26	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	113,945	113,945	26
27	V	24	Travel and Seminar		Premier Healthcare Management, LLC	100.00%	177	177	27
28	V	25	Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	1,485	1,485	28
29	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	31,695	31,695	29
30	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	3,385	3,385	30
31	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	0		31
32	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	12,602	12,602	32
33	V	35	Equipment Rental		Premier Healthcare Management, LLC	100.00%	1,430	1,430	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 523,881			$ 368,573	$ * (155,308)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 21,162	Premier Healthcare Supplies, LLC	100.00%	$ 8,006	$ (13,156)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,162			$ 8,006	$ * (13,156)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	Therapy	$ 32,918	REX Therapeutics	100.00%	$	$ (32,918)	15
16	V	19	Professional Services		REX Therapeutics	100.00%	9,899	9,899	16
17	V	20	Fees and Subscriptions		REX Therapeutics	100.00%	280	280	17
18	V	21	Clerical & General Office Exp		REX Therapeutics	100.00%	6,103	6,103	18
19	V	25	Other Admin Staff Transp		REX Therapeutics	100.00%	1,163	1,163	19
20	V	26	Insurance-Prop.Liab.Malp		REX Therapeutics	100.00%	2,102	2,102	20
21	V	30	Depreciation		REX Therapeutics	100.00%	2,742	2,742	21
22	V	32	Interest Expense		REX Therapeutics	100.00%	10,537	10,537	22
23	V	39	Therapy Consultant		REX Therapeutics	100.00%	7,840	7,840	23
24	V	39	Therapy Management Wages		REX Therapeutics	100.00%	24,054	24,054	24
25	V	39	Allocated Employee Benefits		REX Therapeutics	100.00%	75,077	75,077	25
26	V								26
27	V	39	Therapy Wages		REX Therapeutics	100.00%	497,180	497,180	27
28	V	39	Contract Therapy	868,432	REX Therapeutics	100.00%	163,687	(704,745)	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 901,350			$ 800,664	$ * (100,686)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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	Joseph Knopf	3.00%	Gilman Healthcare Center	Gilman	Premier Healthcare	Skokie	Management Co.	1
2	Ayelet Knopf	3.00%	Champaign Urbana Nursing & Rehab	Savoy	Management, LLC			2
3	Naomi Lopin	3.00%	Winfield Woods Healthcare Center	Winfield	Premier Healthcare	Skokie	Medical Supply	3
4	Yisroel Lopin	3.00%	Pershing Gardens Healthcare Center	Stickney	Supplies, LLC			4
5	Harry Schayer	3.00%	Gardenview Manor	Danville	Courtyard Realty	Berwyn	Lessor	5
6	Michael & Carol Knopf - Class B	3.45%	Norridge Gardens	Norridge	at Berwyn			6
7	Isaac & Rachel Knopf - Class B	2.07%	Premier Healthcare of Fort Wayne, LLC	Fort Wayne, IN	REX Therapeutics	Skokie	Therapy	7
8	Joseph Knopf - Class B	1.72%	Premier Healthcare of North Vernon, LLC	North Vernon, IN				8
9	Ayelet Knopf - Class B	1.72%	Premier Healthcare of Sheridan, LLC	Sheridan, IN				9
10	Naomi Lopin - Class B	1.72%	Premier Healthcare of Connersville, LLC	Connersville, IN				10
11	Yisroel Lopin - Class B	1.72%						11
12	Orsheve Enterprises Class B	4.83%						12
13	Jerry & Deena Cheplowitz Class B	0.69%						13
14	Barak Baver	33.53%						14
15	David Cheplowitz	33.53%						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 Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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	David Cheplowitz	Shareholder	Administrative	33.53%	See Att Sch 7A	3.93	10%	Alloc Salary	$ 17,312	17-7	1
2	Barak Baver	Shareholder	Administrative	33.53%	See Att Sch 7A	3.93	10%	Alloc Salary	17,312	17-7	2
3	Sara Baver	Relative	Clerical	0	See Att Sch 7A	3.93	10%	Alloc Salary	4,347	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 38,971		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 Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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 [X] NO [ ]

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

Name of Related Organization: Premier Healthcare Management, LLC
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Census Days	428,856	12	$ 6,472	$	42,173	$ 636	1
2	6	Maintenance	Census Days	428,856	12	843		42,173	83	2
3	10	Nursing and Medical Records	Illinois Census Days	307,749	7	593,374	593,374	42,173	81,314	3
4	10	Nursing and Medical Records	Indiana Census Days	121,107	5	239,535	239,535		0	4
5	15	Emp Benefit Alloc-Healthcare	Illinois Census Days	307,749	7	99,203		42,173	13,595	5
6	15	Emp Benefit Alloc-Healthcare	Indiana Census Days	121,107	5	40,047			0	6
7	17	Administrative	Census Days	428,856	12	840,373	840,373	42,173	82,641	7
8	17	Administrative	Illinois Census Days	307,749	7	147,750	147,750	42,173	20,247	8
9	17	Administrative	Indiana Census Days	121,107	5	133,577	133,577		0	9
10	19	Professional Services	Census Days	428,856	12	49,430		42,173	4,861	10
11	20	Dues, Fees, Subs & Promo	Census Days	428,856	12	4,850		42,173	477	11
12	21	Clerical & Gen Office Expenses	Census Days	428,856	12	1,158,702	1,087,471	42,173	113,945	12
13	24	Travel and Seminar	Census Days	428,856	12	1,803		42,173	177	13
14	25	Other Admin. Staff Trans	Census Days	428,856	12	15,107		42,173	1,485	14
15	27	Emp Benefit Alloc-Gen Admin	Census Days	428,856	12	322,307		42,173	31,695	15
16	27	Emp Benefit Alloc-Gen Admin	Illinois Census Days	307,749	7	24,702		42,173	3,385	16
17	27	Emp Benefit Alloc-Gen Admin	Indiana Census Days	121,107	5	22,332			0	17
18	34	Rent-Facility & Grounds	Census Days	428,856	12	128,146		42,173	12,602	18
19	35	Equipment Rental	Census Days	428,856	12	14,538		42,173	1,430	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,843,091	$ 3,042,080		$ 368,573	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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 [X] NO [ ]

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

Name of Related Organization: Premier Healthcare Supplies, LLC
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	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	10	Nursing and Medical Records	Revenue	161,406	12	$ 65,860	$	19,622	$ 8,006	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					$ 65,860	$		$ 8,006	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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 [X] NO [ ]

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

Name of Related Organization: REX Therapeutics
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	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	19	Professional Services	Therapy Revenue	5,071,121	7	$ 55,562	$	903,562	$ 9,899	1
2	20	Fees and Subscriptions	Therapy Revenue	5,071,121	7	1,569		903,562	280	2
3	21	Clerical & General Office Exp	Therapy Revenue	5,071,121	7	34,248		903,562	6,103	3
4	25	Other Admin Staff Transp	Therapy Revenue	5,071,121	7	6,528		903,562	1,163	4
5	26	Insurance-Prop.Liab.Malp	Therapy Revenue	5,071,121	7	11,796		903,562	2,102	5
6	30	Depreciation	Therapy Revenue	5,071,121	7	15,390		903,562	2,742	6
7	32	Interest Expense	Therapy Revenue	5,071,121	7	59,135		903,562	10,537	7
8	39	Therapy Consultant	Therapy Revenue	5,071,121	7	44,000		903,562	7,840	8
9	39	Therapy Management Wages	Therapy Revenue	5,071,121	7	135,002	135,002	903,562	24,054	9
10	39	Allocated Employee Benefits	Therapy Revenue	5,071,121	7	421,361		903,562	75,077	10
11										11
12	39	Therapy Wages	Direct Allocation	3,215,952	4	3,215,952	3,215,952	497,180	497,180	12
13	39	Contract Therapy	Direct Allocation	396,932	4	396,932		163,687	163,687	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					$ 4,397,475	$ 3,350,954		$ 800,664	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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	AP MA Funding		X	Mortgage		8/1/2014		12,000,000	8/1/2017	variable	1,162,870	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit		8/1/2016		1,282,752	8/1/2017	variable	51,202	6
7												7
8												8
9	TOTAL Facility Related						$	$ 13,282,752			$ 1,214,072	9
	B. Non-Facility Related*											
10												10
11								Other Interest Expense			682	11
12								Offset Interest Income			(6,684)	12
13								Allocated from REX Therapeutics			10,537	13
14	TOTAL Non-Facility Related						$	$			$ 4,535	14
15	TOTALS (line 9+line14)						$	$ 13,282,752			$ 1,218,607	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Courtyard Healthcare # 0050807 **Report Period Beginning:** 1/1/2017 **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.**		$	780,907	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.)	2016	$		2
3. Under or (over) accrual (line 2 minus line 1).		$	(780,907)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$	1,092,907	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.		$	312,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	303,015	8
	2013	319,164	9
	2014	456,618	10
	2015	473,463	11
	2016	483,001	12

Accrual based on prior year 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 Courtyard Healthcare COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050807

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #: ( )

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.	16-31-308-001-0000	Long Term Care Property	$ 104,184.50	$ 104,184.50
2.	16-31-308-002-0000	Long Term Care Property	$ 98,045.30	$ 98,045.30
3.	16-31-308-003-0000	Long Term Care Property	$ 30,399.43	$ 30,399.43
4.	16-31-308-004-0000	Long Term Care Property	$ 102,024.44	$ 102,024.44
5.	16-31-308-005-0000	Long Term Care Property	$ 98,045.30	$ 98,045.30
6.	16-31-308-006-0000	Long Term Care Property	$ 29,288.77	$ 29,288.77
7.	16-31-308-007-0000	Long Term Care Property	$ 7,067.31	$ 7,067.31
8.	16-31-308-008-0000	Long Term Care Property	$ 6,819.62	$ 6,819.62
9.	16-31-308-009-0000	Long Term Care Property	$ 7,126.25	$ 7,126.25
10.			$	$
		TOTALS	$ 483,000.92	$ 483,000.92

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 Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,431 B. General Construction Type: Exterior Brick Frame Concrete 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? [X] (a) Own the Equipment [X] (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).

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2012	$ 690,291	1
2					2
3	TOTALS			$ 690,291	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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	145		2012	1964	$ 6,826,214	$	35	$ 195,035	$ 195,035	$ 840,715	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	6,852		20	343	343	2,912	9
10	Various			2010	37,295		20	1,865	1,865	13,986	10
11	Various			2011	47,920		20	2,396	2,396	15,574	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

*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 Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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	Cast Iron For Stair Railing	2012	$ 3,750	$	20	$ 188	$ 188	$ 1,064	37
38	75' Retaining Wall	2012	4,200		20	210	210	1,155	38
39	New Wall Sign With Flood Lights; New Monument Style Sign	2012	9,695		20	485	485	2,666	39
40	Cable Wiring	2013	14,828		20	741	741	3,336	40
41	Condenser & Air Handler	2013	5,566		20	278	278	1,252	41
42	New A/C Unit	2013	16,200		20	810	810	3,645	42
43	New Railings	2013	3,590		20	180	180	808	43
44	Permit Fees	2013	11,034		20	552	552	2,483	44
45	1st Floor Corridor & Dining Rm:Remove Cove Base, Install New	2013	25,047		20	1,252	1,252	5,009	45
46	1st Floor Corridor: Remove & Replace Light Fixtures, New Handr	2013	40,699		20	2,035	2,035	8,140	46
47	1st Floor Dining Room: Remove & Replace Light Fixtures, New W	2013	5,198		20	260	260	1,040	47
48	1st Floor Family Lounge: Remove Cove Base, New Carpeting, Wa	2013	3,741		20	187	187	748	48
49	1st Floor Resident Rooms: Remove & Replace Case Base, New Vir	2013	47,749		20	2,387	2,387	9,549	49
50	1st Floor Resident Bathrooms: New Vinyl Flooring,New Wall Tile,	2013	34,649		20	1,732	1,732	6,929	50
51	1st Floor Guest Bathrooms: Remove & Replace Flooring, New Wa	2013	4,464		20	223	223	892	51
52	Shower Rm 2: Floor Tile, Shower Fixture,Sink,Faucet,Grab Bars,	2013	36,320		20	1,816	1,816	7,264	52
53	Shower Rm 1: Floor Tile, Shower Fixture,Sink,Faucet,Grab Bars,	2013	38,117		20	1,906	1,906	7,624	53
54	2nd Floor Corridor & Dining Room: Remove Cove Base, New Vin	2013	41,528		20	2,076	2,076	8,305	54
55	2nd Floor Corridor & Dining Room: New Handrails, Wallcoverin	2013	27,159		20	1,358	1,358	5,432	55
56	2nd Floor Resident Room:Remove Cove Base, New Vinyl Flooring	2013	30,277		20	1,514	1,514	6,056	56
57	2nd Floor Resident Bathroom: Remove And Replace Flooring, Ne	2013	25,681		20	1,284	1,284	5,136	57
58	Basement Corridor:New Flooring	2013	8,166		20	408	408	1,333	58
59	Basement Therapy Room: Remove & Replace Light Fixtures, New	2013	21,125		20	1,056	1,056	4,225	59
60	Various Areas: Structural Engineering Service	2013	7,958		20	398	398	1,592	60
61	Lobby: New Flooring, Dividing Wall,Wallcovering,Wall Panels, Li	2013	48,735		20	2,437	2,437	9,748	61
62	Design And Build New Smoking Patio- Demo Current Area	2013	48,428		20	2,421	2,421	9,685	62
63	Admissions Office: New Flooring, New Panels	2013	4,072		20	204	204	815	63
64	1st Floor Corridor:One Side Door Lamination, Lighting,Roller Sh	2013	8,732		20	437	437	1,447	64
65	Administrators Office: New Flooring, Wallcovering, Stationary Pa	2013	5,359		20	268	268	1,072	65
66	1st Floor Nurses Station: Remove Current Nurses Station, Install I	2013	30,124		20	1,506	1,506	6,024	66
67	1st Floor Family Lounge & Resident Rooms: Loundge-New Floori	2013	20,527		20	1,026	1,026	4,105	67
68	1st Floor-Various-Remove Existing Wallcovering, Prep Walls, Inst	2013	42,621		20	2,131	2,131	8,524	68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,593,620	$		$ 233,405	$ 233,405	$ 1,010,290	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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	
1	Totals from Page 12A, Carried Forward		$ 7,593,620	$		$ 233,405	$ 233,405	$ 1,010,290	1
2	2nd Floor Corridor: Remove & Replace Light Fixtures, New Nurs	2013	31,320		20	1,566	1,566	6,264	2
3	2nd Floor Nurses Station: Installation Of Pure Vinyl Tile And Mil	2013	4,263		20	213	213	852	3
4	2nd Floor Dining Room: New Lighting, Chair Rail, Stationary Par	2013	7,749		20	387	387	1,549	4
5	2nd Floor Family Lounge: New Lighting, New Carpet Flooring, St	2013	15,802		20	790	790	3,160	5
6	2nd Floor Resident Room: Upholstered Cornice, Roller Shades, Cu	2013	32,580		20	1,629	1,629	6,516	6
7	2nd Floor Shower Room:Labor To Remove Old Bathroom And Re	2013	34,568		20	1,728	1,728	6,913	7
8	3rd Floor Corridor & Dining Room: Remove Cove Base, Install Ne	2013	16,234		20	812	812	3,247	8
9	3rd Floor Corridor:Handrails, Lighting,Refinish Nurses Station,R	2013	46,607		20	2,330	2,330	9,321	9
10	3rd Floor Dining Room & Nurses Station: New Flooring, Dining R	2013	9,580		20	479	479	1,916	10
11	3rd Floor Family Room:Carpeting,Panels,Acrylic Panels	2013	13,892		20	695	695	2,779	11
12	3rd Floor Activity Room:New Flooring, Decorative Panels	2013	4,580		20	229	229	916	12
13	3rd Floor Resident Rooms:Remove &Replace Cove Base,Roller Sh	2013	78,085		20	3,904	3,904	15,617	13
14	3rd Floor Resident Bathrooms;Flooring,Fixtures,Toilet,Sinks,Fauc	2013	46,307		20	2,315	2,315	9,261	14
15	Basement Corridor:Sinage,Handrails,Corner Guards	2013	2,928		20	146	146	585	15
16	Basement Therapy Room:Demo Wall Between Room & Staff Lour	2013	3,423		20	171	171	684	16
17	Beauty Salon:Flooring, Roller Shades	2013	3,308		20	165	165	661	17
18	Locker Room:Plumbing, Flooring-Bathroom:Flooring & Wall Tile	2013	8,386		20	419	419	1,677	18
19	Basement Office:Flooring; Elevator:Replace Interior	2013	9,634		20	482	482	1,927	19
20	Vestibule: Remove Existing Structure, New Doors, Walls,Flooring	2013	56,868		20	2,843	2,843	11,373	20
21	1st Floor Dining Room:Fireplace Panels And Drywall	2013	9,289		20	464	464	1,857	21
22	1st Floor Guest &2nd Floor Resident Bathrooms: Flooring, Finish	2013	10,687		20	534	534	2,137	22
23	Various Areas: Remove Existing Wallcovering,Prep Walls & Insta	2013	68,516		20	3,426	3,426	13,704	23
24	Various Bathroom Change Orders:Flooring, Toilets, Drain	2013	3,412		20	171	171	683	24
25	3rd Floor Office:Change Order-Flooring, New Wall, Door	2013	6,791		20	340	340	1,359	25
26	Vestibule, Lobby & Admissions Office Change Order:Structural E	2013	14,963		20	748	748	2,992	26
27	1st Floor Corridor Change Order:Outside Edge Protectors	2013	6,532		20	327	327	1,307	27
28	1st Floor Dining Room Change Order: Crown Molding, Cornice	2013	3,668		20	183	183	733	28
29	1st Floor Nurses Station & Various Areas Chang Order: Roller Sh	2013	5,982		20	299	299	1,196	29
30	1st Floor Resident Rooms Chang Order: Demo Closet & Relocate	2013	7,478		20	374	374	1,496	30
31	2nd Floor Dining Room Change Order: Malamine Panels Around	2013	10,076		20	504	504	2,016	31
32	2nd Floor Family Lounge & Beauty Salon Change Order: Remove	2013	3,881		20	194	194	776	32
33	2nd Floor Resident Room Change Order: Demo Closet	2013	7,478		20	374	374	1,496	33
34	TOTAL (lines 1 thru 33)		$ 8,178,487	$		$ 262,646	$ 262,646	$ 1,127,260	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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	
1	Totals from Page 12B, Carried Forward		$ 8,178,487	$		$ 262,646	$ 262,646	$ 1,127,260	1
2	New Backflow Preventer For Existing Sewers	2013	7,700		20	385	385	1,540	2
3	Hardscaping, Lighting, Install Irrigation	2014	50,000		20	2,500	2,500	10,000	3
4	4 New Led Light Fixtures	2014	3,135		20	157	157	628	4
5	Shunt Trip Breakers For Both North And South Elevators	2014	15,500		20	775	775	3,100	5
6	Mixing Valve Replacement For Domestic In Boiler Room	2014	3,722		20	186	186	744	6
7	Sump Pump	2014	15,500		20	775	775	3,100	7
8	New Electricals For Controls For New Service To Fire Pump	2014	17,170		20	859	859	3,435	8
9	New Fire Alarm System	2014	32,617		20	1,631	1,631	6,524	9
10	New Security System	2014	15,510		20	776	776	3,134	10
11	Change Order:Concrete Sidewalk, Custom Baseboard Heater Cov	2014	24,991		20	1,250	1,250	4,999	11
12	Service To Install Lighting	2014	4,000		20	200	200	800	12
13	Service To Restore Power And Lighting	2014	3,000		20	150	150	600	13
14	Plumbing Work For The Bathroom	2014	5,350		20	268	268	1,071	14
15	Install 63 Fire Dampers In Bathrooms	2014	11,500		20	575	575	2,300	15
16	Remove 23 Dilapidated Fluorescent Fixtures	2014	8,750		20	438	438	1,751	16
17	Bathroom Exhaust System Correction	2014	7,700		20	385	385	1,540	17
18	Install Water Filtration System & New Steamer/Hoses/Pvc Drain &	2015	2,630		20	131	131	393	18
19	Install New Floor Tile/Painting/Piping In Kitchen/Halls/Conf. Roo	2015	6,335		20	317	317	951	19
20	Install Conduit Sleeve Basement To 3Rd Floor/Junction Box Each	2015	3,000		20	150	150	450	20
21	Damper Test/Replace 68X Fire Damper Links Throughout Facilit	2015	6,122		20	306	306	918	21
22	Rose Planting/Fix Retaining Walls/Ground Covers/Weed Killer	2015	2,710		20	136	136	408	22
23	Install Code Compliant Toe Guards On Front/Back Of North Elev	2015	3,599		20	180	180	540	23
24	Install Tv Outlets First/Second Floor Day/Dining/Dialysis Rooms	2015	3,685		20	184	184	552	24
25	Remodel Toilet/Shower/Tub Room/Flooring/Masonry/Painting/Ele	2015	35,891		20	1,795	1,795	5,385	25
26	Upgrade Fire Recall/Pressure Test/Door Restrictors/Pit Ladder Nc	2015	45,549		20	2,277	2,277	6,831	26
27	Install New Transfer Switch/Wiring And Panel For Life Safety Fo	2015	36,500		20	1,825	1,825	5,475	27
28	Install LED Fixtures and Wall Switches - 1st and 2nd Floor Rms	2016	82,125		20	4,106	4,106	6,159	28
29	Install 3" RPZ Valves w/ Pipings & Expansion Tank in Kitchen	2016	10,083		20	504	504	756	29
30	Install LED Fixtures and Wall Switches - 2nd Floor Rms	2017	24,700		20	618	618	618	30
31	Boiler Repair	2017	3,121		20	78	78	78	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,670,682	$		$ 286,563	$ 286,563	$ 1,202,040	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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	
1	Totals from Page 12C, Carried Forward		$ 8,670,682	$		$ 286,563	$ 286,563	$ 1,202,040	1
2									2
3									3
4									4
5	Leasehold Improvements:								5
6	New 6' Water Main	2013	334,170		20	16,709	16,709	83,545	6
7									7
8									8
9									9
10									10
11	Allocated from Premier Healthcare Management, LLC	2013	2,447		20	122	122	513	11
12									12
13									13
14	Allocated from REX Therapeutics					2,742	2,742		14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,007,299	$		$ 306,136	$ 306,136	$ 1,286,098	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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	$ 1,496,917	$	$ 149,691	$ 149,691	10	$ 686,669	71
72	Current Year Purchases	15,208		760	760	10	760	72
73	Fully Depreciated Assets	7,677				10	7,677	73
74								74
75	TOTALS	$ 1,519,802	$	$ 150,451	$ 150,451		$ 695,106	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)	$ 11,217,392	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 456,587	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 456,587	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,981,204	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	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		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 Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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	Allocated from Management Co.				12,602			5
6								6
7	TOTAL				$ 12,602 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 28,201 Description: See Attached Schedule 14A
(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	Facility	2013 Ford Elkhart	$ 692.00	$ 8,304	17
18					18
19	Allocated from Management Co.			1,430	19
20					20
21	TOTAL		$ 692.00	$ 9,734	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Courtyard Healthcare**
IDPH License ID Number: **0050807**
Fiscal Year End: **12/31/2017**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Nursing Equipment	26,450
Dietary Equipment	883
Office Equipment	868
Total - Line 16	**28,201**

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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.

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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Courtyard Healthcare

STATE OF ILLINOIS
0050807 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(7)	5036	hrs	$ 195,443		$ 61,376	$	5,036	$ 256,819	1
2	Licensed Speech and Language Development Therapist	39(7)	1723	hrs	66,872		21,000		1,723	87,872	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10(2), 39(7)	6671	hrs	258,919		81,310	1,581	6,671	341,810	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				284,715		284,715	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Respiratory Therapy										12
13	Other (specify): See Attached Scheule 16A						171,126			171,126	13
14	TOTAL				$ 521,234		$ 334,812	$ 286,296	13,430	$ 1,142,342	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Courtyard Healthcare**
IDPH License ID Number: **0050807**
Fiscal Year End: **12/31/2017**

Schedule 16A

XIV. Special Services
Line 13 Other Services

Description	Schedule V Line & Column Reference	Amount
Lab & Xray	39(3)	2,482
Dialysis	39(3)	85,727
Therapy Consultant	39(7)	7,840
Employee Benefits Allocated fro	39(7)	75,077
Total - Line 13		**171,126**

STATE OF ILLINOIS

Facility Name & ID Number Courtyard Healthcare # 0050807 **Report Period Beginning:** 1/1/2017 **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	$ (84,150)	$ (84,150)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 867,093)	2,077,168	2,077,168	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,783	26,783	6
7	Other Prepaid Expenses	(109,249)	(109,249)	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,910,552	$ 1,910,552	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		690,291	13
14	Buildings, at Historical Cost		6,826,214	14
15	Leasehold Improvements, at Historical Cost	2,019,774	2,181,085	15
16	Equipment, at Historical Cost	1,145,954	1,519,802	16
17	Accumulated Depreciation (book methods)	(1,138,826)	(1,981,204)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule 17A	5,500	3,826,871	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,032,402	$ 13,063,059	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,942,954	$ 14,973,611	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,945,425	$ 1,945,425	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	60	60	28
29	Short-Term Notes Payable	1,112,121	1,112,121	29
30	Accrued Salaries Payable	172,543	172,543	30
31	Accrued Taxes Payable (excluding real estate taxes)	551,030	551,030	31
32	Accrued Real Estate Taxes(Sch.IX-B)		1,092,907	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	1,475,718	1,475,718	36
37	Due to Related Parties	7,738,466	5,941,997	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 12,995,363	$ 12,291,801	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	170,631	170,631	39
40	Mortgage Payable		12,000,000	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)**	$ 170,631	$ 12,170,631	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 13,165,994	$ 24,462,432	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (9,223,040)	$ (9,488,821)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,942,954	$ 14,973,611	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Courtyard Healthcare**
IDPH License ID Number: **0050807**
Fiscal Year End: **12/31/2017**

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
Intangible Assets & Loan Co	5,500	2,813,856
Reserve/Escrow Accounts		1,013,015
Total - Line 23	**5,500**	**3,826,871**

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Accrued MDS Tax	93,947	93,947
Accrued Expenses	282,792	282,792
Accrued Bed Tax	28,089	28,089
Payroll Withholdings	1,070,890	1,070,890
Total - Line 36	**1,475,718**	**1,475,718**

Facility Name & ID Number Courtyard Healthcare # 0050807 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (6,275,025)	1
2	Restatements (describe):		2
3	**Post closing adjustment - Addl Bad Debts**	(1,833,427)	3
4	**Post closing adjustment - Addl Depreciation Exp**	(753,052)	4
5	**Post closing adjustment - Addl PR Tax/Mgmt Fees**	(250,307)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (9,111,811)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(111,229)	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)**	$ (111,229)	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)**	$ (9,223,040)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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	$ 9,482,507	1
2	Discounts and Allowances for all Levels	718,405	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,200,912	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	276,556	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 276,556	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	(10,761)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	11,690	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 929	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,684	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,684	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)**	$ 10,485,081	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,275,888	31
32	Health Care	3,607,386	32
33	General Administration	2,252,495	33
	B. Capital Expense		
34	Ownership	1,620,718	34
	C. Ancillary Expense		
35	Special Cost Centers	1,536,507	35
36	Provider Participation Fee	303,316	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,596,310	40
41	**Income before Income Taxes (line 30 minus line 40)****	(111,229)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (111,229)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,088,441	44
45	Private Pay - Net Inpatient Revenue	295,214	45
46	Medicare - Net Inpatient Revenue	3,640,630	46
47	Other-(specify) Insurance	176,627	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,200,912	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 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	2,222	2,454	$ 119,966	$ 48.89	1
2	Assistant Director of Nursing	2,162	2,418	99,611	41.20	2
3	Registered Nurses	15,898	16,675	505,794	30.33	3
4	Licensed Practical Nurses	34,695	36,979	994,608	26.90	4
5	CNAs & Orderlies	69,378	73,237	988,596	13.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,048	7,795	152,303	19.54	8
9	Activity Director					9
10	Activity Assistants	7,093	7,584	113,958	15.03	10
11	Social Service Workers	3,367	3,701	76,142	20.57	11
12	Dietician					12
13	Food Service Supervisor	2,572	2,708	55,808	20.61	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,446	24,543	277,416	11.30	15
16	Dishwashers					16
17	Maintenance Workers	4,896	5,158	76,723	14.87	17
18	Housekeepers	612	616	7,956	12.92	18
19	Laundry					19
20	Administrator	2,040	2,112	147,335	69.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,456	17,579	281,217	16.00	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	1,768	2,080	33,765	16.23	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	6,430	6,887	165,302	24.00	33
34	TOTAL (lines 1 - 33)	200,083	212,526	$ 4,096,500 *	$ 19.28	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 32,966	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	22,293	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	3,527	L12, C3	45
46	Other(specify) Rehab Mgmt	Monthly	24,000	L10a, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 94,786		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	417	18,768	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	417	$ 18,768		53

Courtyard Healthcare

Period Beginning **1/1/2017**
Period End **12/31/2017**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator		2,565	2,592	97,594	37.65
Transportation		817	1,079	12,601	11.68
Marketing		3,048	3,216	55,107	17.14
	TOTAL	6,430	6,887	165,302	

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Jacobson	Asst Administrator	0	$ 147,335
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 147,335

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 523,881
TOTAL (agree to Schedule V, line 17, col. 3)	$ 523,881
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 19,884
Richard Peelo & Associates, Inc	Accounting	2,100
CohnReznick LLP	Accounting	10,510
LTC	Consulting Fees	85,758
Singer Networks, LLC	Data Processing	17,259
MatrixCare	Data Processing	34,271
ADP	Data Processing	1,717
HDSI	Data Processing	4,095
Change Healthcare	Data Processing	813
E-Solutions	Data Processing	4,515
See Attached Schedule 21A		50,249
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 231,171

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 136,936
Unemployment Compensation Insurance	69,033
FICA Taxes	307,875
Employee Health Insurance	126,242
Employee Meals	1,632
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	7,718
Physical Exams	525
Pension Contributions	20,977
TOTAL (agree to Schedule V, line 22, col.8)	$ 670,938

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	12,655
Health Care Worker Background Check	
(Indicate # of checks performed 137)	1,759
Patient Background Checks 382	7,168
Dues & Subscriptions	6,618
Licenses & Permits	16,850
IL Council on LTC	635
Allocated from Management Co.	757
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,442

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,153
Allocated from Management Co.	177
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,330

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Courtyard Healthcare**
IDPH License ID Number: **0050807**
Fiscal Year End: **12/31/2017**

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
M & M Financial	Accounting/Tax	5,373
Terrill Consulting Services, Inc.	Billing Consultant	18,985
Personnel Planners	UC Consultant	3,162
Paycor	Payroll Processing	22,729
Total		**50,249**

Facility Name & ID Number Courtyard Healthcare # 0050807 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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. **635 IL Council on LTC**

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

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

(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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,233** 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. $ **303,316**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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. $ **1,632** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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