FOR BHF USE

LL1

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: 0046201

Facility Name: Lemont Nursing & Rehab Center, Llc

Address: 12450 Walker Road (Number) Lemont (City) 60439 (Zip Code)

County: Cook

Telephone Number: (630) 243-0400 **Fax #** (630) 243-5063

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2003

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: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/17 to 12/31/17 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 12/20/17

	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	158	Skilled (SNF)	173	57,850	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	158	TOTALS	173	57,850	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	24,071	9,462	15,777	49,310	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,071	9,462	15,777	49,310	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.24%

D. How many bed reserve days during this year were paid by the Department?
None (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 02/01/03

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/03 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [Y] NO [ ] If YES, enter number of beds certified 158 and days of care provided 11,379

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	325,606	80,469	30,248	436,323		436,323	9,921	446,244			1
2	Food Purchase		339,370		339,370		339,370	(108)	339,262			2
3	Housekeeping	193,040	45,002		238,042		238,042	1,236	239,278			3
4	Laundry	78,348	36,174		114,522		114,522		114,522			4
5	Heat and Other Utilities			170,304	170,304		170,304	1,515	171,819			5
6	Maintenance	110,023		379,562	489,585		489,585	(8,046)	481,539			6
7	Other (specify):*							5,566	5,566			7
8	TOTAL General Services	707,017	501,015	580,114	1,788,146		1,788,146	10,084	1,798,230			8
	B. Health Care and Programs											
9	Medical Director			39,000	39,000		39,000		39,000			9
10	Nursing and Medical Records	2,805,936	278,541	1,322,127	4,406,604		4,406,604	40,456	4,447,060			10
10a	Therapy	235,657			235,657		235,657		235,657			10a
11	Activities	175,369	28,499		203,868		203,868		203,868			11
12	Social Services	218,190			218,190		218,190	35,067	253,257			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							11,062	11,062			15
16	TOTAL Health Care and Programs	3,435,152	307,040	1,361,127	5,103,319		5,103,319	86,585	5,189,904			16
	C. General Administration											
17	Administrative	146,265			146,265		146,265	104,947	251,212			17
18	Directors Fees											18
19	Professional Services			779,526	779,526	(43,327)	736,199	(636,536)	99,663			19
20	Dues, Fees, Subscriptions & Promotions			133,521	133,521		133,521	(50,979)	82,542			20
21	Clerical & General Office Expenses	173,285	40,252	389,521	603,058		603,058	(211,037)	392,021			21
22	Employee Benefits & Payroll Taxes			784,091	784,091		784,091	(9,512)	774,579			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,671	1,671		1,671	1,301	2,972			24
25	Other Admin. Staff Transportation			3,775	3,775		3,775	910	4,685			25
26	Insurance-Prop.Liab.Malpractice			245,435	245,435		245,435	2,291	247,726			26
27	Other (specify):*							37,718	37,718			27
28	TOTAL General Administration	319,550	40,252	2,337,540	2,697,342	(43,327)	2,654,015	(760,897)	1,893,118			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,461,719	848,307	4,278,781	9,588,807	(43,327)	9,545,480	(664,227)	8,881,253			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc #0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			123,873	123,873		123,873	370,368	494,241			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,462	1,462		1,462	272,600	274,062			32
33	Real Estate Taxes			398,766	398,766	43,327	442,093	4,612	446,705			33
34	Rent-Facility & Grounds			1,864,108	1,864,108		1,864,108	(1,860,000)	4,108			34
35	Rent-Equipment & Vehicles			8,351	8,351		8,351	1,005	9,356			35
36	Other (specify):*			1,106	1,106		1,106	(1,106)				36
37	TOTAL Ownership			2,397,666	2,397,666	43,327	2,440,993	(1,212,521)	1,228,472			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		278,499	1,765,100	2,043,599		2,043,599	(33,109)	2,010,490			39
40	Barber and Beauty Shops			156	156		156		156			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			310,369	310,369		310,369		310,369			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		278,499	2,075,625	2,354,124		2,354,124	(33,109)	2,321,015			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,461,719	1,126,806	8,752,072	14,340,597		14,340,597	(1,909,857)	12,430,740			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 Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	188,326	30		9
10	Interest and Other Investment Income	(153,568)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(639)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(333,752)	21		24
25	Fund Raising, Advertising and Promotional	(42,762)	20		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	(44,758)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (387,153)		$	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)	(1,522,704)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,522,704)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,909,857)		37

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

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

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

Lemont Nursing & Rehab Center, Llc

ID# 0046201

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (690)	10	1
2	Resident Clothing	(650)	10	2
3	Theft Loss	(1,790)	21	3
4	Collection Expense	(7,633)	21	4
5	Amortization	(1,106)	36	5
6	PAC Dues	(9,373)	20	6
7	Chamber of Commerce Dues	(695)	20	7
8	Capitalized R&M	(20,104)	6	8
9	Non-Allowable Legal	(937)	19	9
10	Building Company - Management Fees	(7,900)	19	10
11	Building Company - Filing Fees	(250)	20	11
12	Building Company - Legal Expense	(1,273)	19	12
13	Building Company - Amortization	(33,300)	36	13
14	Additional Professional Fee - Tax Appeal	43,327	19	14
15	Non-Allowable Professional Fee	(2,384)	19	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**	(44,758)		49

Lemont Nursing & Rehab Center, Llc

ID# 0046201

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc **#** 0046201 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			182		9,739							9,921	1
2	Food Purchase	(639)		531									(108)	2
3	Housekeeping			1,099		137							1,236	3
4	Laundry													4
5	Heat and Other Utilities			1,361		154							1,515	5
6	Maintenance	(20,104)		3,749	8,043	266							(8,046)	6
7	Other (specify):*				4,202	1,364							5,566	7
8	**TOTAL General Services**	(20,743)		6,922	12,245	11,660							10,084	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,340)				43,926		(2,130)					40,456	10
10a	Therapy													10a
11	Activities													11
12	Social Services					35,067							35,067	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					11,062							11,062	15
16	**TOTAL Health Care and Programs**	(1,340)				90,055		(2,130)					86,585	16
	C. General Administration													
17	Administrative			2,805	16,131	86,011							104,947	17
18	Directors Fees													18
19	Professional Services	30,833	9,173	(507,161)		(169,438)		57					(636,536)	19
20	Fees, Subscriptions & Promotions	(53,080)	250	815		1,036							(50,979)	20
21	Clerical & General Office Expenses	(343,175)		8,061	100,889	23,188							(211,037)	21
22	Employee Benefits & Payroll Taxes				(9,512)								(9,512)	22
23	Inservice Training & Education													23
24	Travel and Seminar			35		1,266							1,301	24
25	Other Admin. Staff Transportation			910									910	25
26	Insurance-Prop.Liab.Malpractice			1,641		650							2,291	26
27	Other (specify):*				22,667	15,051							37,718	27
28	**TOTAL General Administration**	(365,422)	9,423	(492,894)	130,175	(42,236)		57					(760,897)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(387,505)	9,423	(485,972)	142,420	59,479		(2,072)					(664,227)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc **#** 0046201 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	188,326	179,248	2,333		461							370,368	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(153,568)	411,388	14,612		168							272,600	32
33	Real Estate Taxes			4,100		512							4,612	33
34	Rent-Facility & Grounds		(1,860,000)										(1,860,000)	34
35	Rent-Equipment & Vehicles			1,005									1,005	35
36	Other (specify):*	(34,406)	33,300										(1,106)	36
37	**TOTAL Ownership**	352	(1,236,064)	22,050		1,141							(1,212,521)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(33,109)					(33,109)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**							(33,109)					(33,109)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(387,153)	(1,226,641)	(463,922)	142,420	60,620		(35,181)					(1,909,857)	45

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,860,000	Lemont Property, LLC	100.00%	$	$ (1,860,000)	1
2	V	33	Real Estate Tax	398,766	Lemont Property, LLC	100.00%	398,766		2
3	V	32	Interest	136,064	Lemont Property, LLC	100.00%	547,452	411,388	3
4	V	19	Management Fees		Lemont Property, LLC	100.00%	7,900	7,900	4
5	V	20	Filing Fees		Lemont Property, LLC	100.00%	250	250	5
6	V	19	Legal Expense		Lemont Property, LLC	100.00%	1,273	1,273	6
7	V	30	Depreciation		Lemont Property, LLC	100.00%	179,248	179,248	7
8	V	36	Amortization		Lemont Property, LLC	100.00%	33,300	33,300	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,394,830			$ 1,168,189	$ * (1,226,641)	14

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 182	$ 182	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	531	531	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,099	1,099	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,361	1,361	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,749	3,749	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,805	2,805	20
21	V	19	Professional Fees	510,768	Extended Care Consulting, LLC	100.00%	3,607	(507,161)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	815	815	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	8,061	8,061	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	35	35	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	910	910	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,641	1,641	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,333	2,333	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	14,612	14,612	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	4,100	4,100	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,005	1,005	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			$ 510,768			$ 46,846	$ * (463,922)	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	8,043	$ 8,043	15
16	V	06	Maintenance (Direct)	31,006	Extended Care Consulting, LLC	100.00%	31,006		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	746	746	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	3,456	3,456	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	16,131	16,131	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	100,889	100,889	22
23	V	21	Office and Clerical (Direct)	701	Extended Care Consulting, LLC	100.00%	701		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	22,611	22,611	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	56	56	25
26	V	22	Employee Benefits	9,512	Extended Care Consulting, LLC	100.00%		(9,512)	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			$ 41,219			$ 183,639	$ * 142,420	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 137	$ 137	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	154	154	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	266	266	17
18	V	19	Professional Fees	170,256	Extended Care Clinical, LLC	100.00%	818	(169,438)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	1,036	1,036	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,723	1,723	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,266	1,266	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	650	650	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	461	461	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	168	168	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	512	512	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	9,739	9,739	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,364	1,364	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	43,926	43,926	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	35,067	35,067	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	11,062	11,062	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	86,011	86,011	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	21,465	21,465	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	15,051	15,051	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 170,256			$ 230,876	$ * 60,620	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Various Equipment	10,760	Vent Lease LLC	100.00%	10,760	$	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			$ 10,760			$ 10,760	$ *	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	25,781	MAC Rx, LLC	100.00%	23,651	(2,130)	15
16	V	10A	Therapy		MAC Rx, LLC	100.00%			16
17	V	19	Professional Services	(693)	MAC Rx, LLC	100.00%	(636)	57	17
18	V	21	Clerical & General Office Expenses		MAC Rx, LLC	100.00%			18
19	V	22	Employee Benefits		MAC Rx, LLC	100.00%			19
20	V	39	Ancillary	400,829	MAC Rx, LLC	100.00%	367,721	(33,109)	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			$ 425,917			$ 390,736	$ * (35,181)	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 333,156	$ 333,156	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	333,156	CCS Employee Benefits Group	100.00%		(333,156)	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			$ 333,156			$ 333,156	$ *	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	ROTHNER HEALTH VENTURES G II, LLC	100.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	LEMONT PROPERTY, LLC	EVANSTON	BUILDING COMPANY	1
2			BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5			GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7			MAJOR HOSPITAL DYER	DYER, IN	MAC RX	DES PLAINES	PHARMACY	7
8			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	8
9			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				9
10			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				10
11			MAJOR HOSPITAL SEBOS	HOBART, IN				11
12			MCKINLEY HEALTH CARE CENTER	CANTON, OH				12
13			LITTLE VILLAGE NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO				13
14			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				14
15			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				15
16			RAINBOW BEACH QOC, L.L.C.	CHICAGO				16
17			SHEFFIELD MANOR	DYER, IN				17
18			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				18
19			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				19
20			SPRING CREEK NURSING & REHAB CENTER	JOLIET				20
21			SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			THE PARC AT JOLIET	JOLIET				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				25
26			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				26
27			WHEATON CARE CENTER	WHEATON				27
28								28
29								29
30								30

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Mark Steinberg	Relative	Administrative	0	See Attached	2.77	5.04%	Alloc Fee/Sal	$ 10,079	17-7	1
2	Adam Vales	Relative	Clerical	0	See Attached	1.48	3.70%	Alloc Salary	2,560	22-7	2
3											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	$ 12,639		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 Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	01	Dietary	Patient Days	1,476,506	37	$ 5,451	$	49,310	$ 182	1
2	02	Food	Patient Days	1,476,506	37	15,903		49,310	531	2
3	03	Housekeeping	Patient Days	1,476,506	37	32,901		49,310	1,099	3
4	05	Utilities	Patient Days	1,476,506	37	40,755		49,310	1,361	4
5	06	Maintenance	Patient Days	1,476,506	37	112,249		49,310	3,749	5
6	17	Administrative	Patient Days	1,476,506	37	84,000		49,310	2,805	6
7	19	Professional Fees	Patient Days	1,476,506	37	107,994		49,310	3,607	7
8	20	Dues and Subscriptions	Patient Days	1,476,506	37	24,409		49,310	815	8
9	21	Office and Clerical	Patient Days	1,476,506	37	241,371		49,310	8,061	9
10	24	Seminar and Travel	Patient Days	1,476,506	37	1,048		49,310	35	10
11	25	Other Staff Admin. Trans.	Patient Days	1,476,506	37	27,239		49,310	910	11
12	26	Insurance	Patient Days	1,476,506	37	49,139		49,310	1,641	12
13	30	Depreciation	Patient Days	1,476,506	37	69,861		49,310	2,333	13
14	32	Interest	Patient Days	1,476,506	37	437,528		49,310	14,612	14
15	33	Real Estate Taxes	Patient Days	1,476,506	37	122,769		49,310	4,100	15
16	35	Rent - Equipment & Auto	Patient Days	1,476,506	37	30,092		49,310	1,005	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,402,709	$		$ 46,846	25

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	06	Maintenance (Pooled)	Patient Days	1,476,506	37	240,841	240,841	49,310	8,043	1
2	06	Maintenance (Direct)	Direct		21	358,056	358,056		31,006	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,476,506	37	22,330		49,310	746	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		21	51,193			3,456	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,476,506	37	483,002	483,002	49,310	16,131	7
8	21	Office and Clerical (Pooled)	Patient Days	1,476,506	37	3,020,951	3,020,951	49,310	100,889	8
9	21	Office and Clerical (Direct)	Direct		28	498,631	498,631		701	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,476,506	37	677,040		49,310	22,611	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		28	74,203			56	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					$ 5,426,248	$ 4,601,481		$ 183,639	25

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: Extended Care Clinical, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	03	Housekeeping	Patient Days	781,509	20	$ 2,174	$	49,310	$ 137	1
2	05	Utilities	Patient Days	781,509	20	2,440		49,310	154	2
3	06	Maintenance	Patient Days	781,509	20	4,212		49,310	266	3
4	19	Professional Fees	Patient Days	781,509	20	12,959		49,310	818	4
5	20	Dues and Subscriptions	Patient Days	781,509	20	16,422		49,310	1,036	5
6	21	Office & Clerical	Patient Days	781,509	20	27,302		49,310	1,723	6
7	24	Travel and Seminar	Patient Days	781,509	20	20,068		49,310	1,266	7
8	26	Insurance	Patient Days	781,509	20	10,303		49,310	650	8
9	30	Depreciation	Patient Days	781,509	20	7,302		49,310	461	9
10	32	Interest	Patient Days	781,509	20	2,656		49,310	168	10
11	33	Real Estate Taxes	Patient Days	781,509	20	8,112		49,310	512	11
12	01	Dietary Salary	Patient Days	781,509	20	154,359	154,359	49,310	9,739	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	781,509	20	21,616		49,310	1,364	13
14	10	Nursing Salary	Patient Days	781,509	20	696,174	696,174	49,310	43,926	14
15	12	Social Service Salary	Patient Days	781,509	20	555,767	555,767	49,310	35,067	15
16	15	Emp. Ben. - Healthcare	Patient Days	781,509	20	175,320		49,310	11,062	16
17	17	Administration Salary	Patient Days	781,509	20	1,363,182	1,363,182	49,310	86,011	17
18	21	Office Salary	Patient Days	781,509	20	340,193	340,193	49,310	21,465	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	781,509	20	238,538		49,310	15,051	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,659,098	$ 3,109,674		$ 230,876	25

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: Vent Lease, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	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	Various Equipment	Direct Allocation						10,760	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					$	$		$ 10,760	25

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	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	Direct Allocation						23,651	1
2	10A	Therapy	Direct Allocation							2
3	19	Professional Services	Direct Allocation						(636)	3
4	21	Clerical & General Office Expense	Direct Allocation							4
5	22	Employee Benefits	Direct Allocation							5
6	39	Ancillary	Direct Allocation						367,721	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					$	$		$ 390,736	25

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	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	22	Employee Health Insurance	Direct Allocation			$	$		$ 333,156	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					$	$		$ 333,156	25

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	MB Financial		X	Mortgage			$	$ 18,935,000			$ 547,452	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Allocated from Extended Care Consulting										14,612	6
7	Allocated from Extended Care Clinical										168	7
8												8
9	TOTAL Facility Related						$	$ 18,935,000			$ 562,232	9
	B. Non-Facility Related*											
10	Interest Income		X								(153,568)	10
11	Interest Expense		X								1,462	11
12	Interst Income (Bldg Co)		X								(136,064)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (288,170)	14
15	TOTALS (line 9+line14)						$	$ 18,935,000			$ 274,062	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc **#** 0046201 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2016 report.	$	389,943	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.)	$	370,491	2
3. Under or (over) accrual (line 2 minus line 1).	$	(19,452)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	422,830	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.)	$	43,327	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.	$	446,705	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	342,061	8
	2013	352,783	9
	2014	374,929	10
	2015	371,374	11
	2016	365,879	12

2017 accrual is based on information in the attorney letter summary.

Allocated from Extended Care Consulting - $4,100

Allocated from Extended Care Clinical - $512

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 Lemont Nursing & Rehab Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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.	22-27-300-076-0000	Long Term Care Property	$ 357,343.52	$ 357,343.52
2.	22-27-300-076-0000	Long Term Care Property	$ 8,535.44	$ 8,535.44
3.	See Attached	Allocated from Care Center Bldg	$ 181,041.32	$ 4,100.04
4.	See Attached	Allocated from Care Center Bldg	$ 181,041.32	$ 511.84
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 727,961.60	$ 370,490.84

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2016 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lemont Nursing & Rehab Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,662 B. General Construction Type: Exterior Brick Frame Masonry & Steel Number of Stories 1

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		2003	$ 823,094	1
2	Allocated from Care Center Building			20,889	2
3	TOTALS			$ 843,983	3

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	158		2003	1995	$ 5,391,423	$ 179,248	35	$ 154,041	$ (25,207)	$ 3,911,535	4
5	15		2017	2017	6,640,000		35	189,714	189,714	189,714	5
6			2017	2017	1,041,901		35	29,769	29,769	29,769	6
7											7
8											8
	Improvement Type**										
9	Various			2003	48,664		20	2,045	2,045	37,110	9
10	Various			2004	35,166		20	1,266	1,266	26,724	10
11	Various			2005	7,375		20	369	369	4,763	11
12	Various			2007	30,675		20	1,809	1,809	19,374	12
13	Various			2008	46,456		20	2,323	2,323	22,150	13
14	Various			2010	120,716		20	6,301	6,301	44,922	14
15	Various			2011	280,159		20	13,516	13,516	95,433	15
16	Various			2012	169,979		20	6,472	6,472	93,642	16
17	Various			2013	139,294		20	7,351	7,351	34,323	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 Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		102,160	1,525		1,525		68,465	68
69	Financial Statement Depreciation			123,873			(123,873)		69
70	TOTAL (lines 4 thru 69)		$ 14,053,967	$ 304,646		$ 416,501	$ 111,855	$ 4,577,924	70

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 14,053,967	$ 304,646		$ 416,501	$ 111,855	$ 4,577,924	1
2	Door Replacment	2014	3,600		20	180	180	645	2
3	Resident Room Repair - Asbestos Survey, Sawcutting, New Floor,	2014	21,500		20	1,075	1,075	3,673	3
4	Signage	2014	13,365		20	891	891	2,896	4
5	Dementia Shower Room - Ceiling Replacement, Plumbing Revisio	2014	79,000		20	3,950	3,950	15,142	5
6	Repair Hot Water Tank # 3	2014	3,134		20	157	157	614	6
7	Replace Annunciator On 2Nd Floor Nurses Station	2014	3,539		20	177	177	605	7
8	Repack Fire Pump & Replace Pressure Switch	2014	4,371		20	219	219	856	8
9	Dry System Compressor Repair	2014	3,940		20	197	197	706	9
10	Sprinkler System Repair	2014	3,080		20	154	154	552	10
11	New Compressor For Sprinkler System	2014	4,533		20	227	227	793	11
12	Preferred Mechanical - Hot Water Tank Replacement (80 Gallon)	2015	16,795		20	840	840	2,519	12
13	Hugo'S Construction-Work On Lower Soffit Section Where Sprin	2015	11,600		20	580	580	1,740	13
14	Generator-Automatic Transfer Switch (Ats) Faceplate, Ats Ztg Se	2015	4,127		20	206	206	585	14
15	Install Expansion Joint Material At All Cracked Seams In Drywal	2015	12,000		20	600	600	1,650	15
16	12X12 Vct Comm Tile - Hardware, Roppe 4X4 Fawn Cove Base -	2015	4,571		20	914	914	2,286	16
17	1X 2-Ton Mitsubishi, Ductless Mini-Split System, 1X Wall Mount	2015	7,800		20	390	390	943	17
18	Hvac - Replace Compressor, Liquid Line Drier, And Contactor	2015	3,393		20	170	170	396	18
19	Installed Duct Detectors. Replaced And Tested 8 Detectors.	2015	10,332		20	517	517	1,076	19
20	4 Crimson King Maple Trees	2016	3,187		20	159	159	305	20
21	Relocate Emergency Circuits	2016	7,150		20	358	358	715	21
22	1 6-Ton Rooftop Unit	2016	11,480		20	574	574	909	22
23	1 7.5-Ton Rooftop Unit	2016	12,995		20	650	650	1,029	23
24	Clean Out & Replace Concrete	2016	5,500		20	275	275	390	24
25	Air Curtain	2017	8,578		20	1,716	1,716	1,716	25
26	2 Sinks	2017	9,531		20	238	238	238	26
27	Call System For 1St Floor	2017	38,304		20	1,277	1,277	1,277	27
28	29 Blinds	2017	4,433		20	148	148	148	28
29	Fire Alarm And Sprinklers	2017	11,268		20	94	94	94	29
30	Phone System Wiring	2017	9,431		20	157	157	157	30
31	Signs - Resident Rooms And Throughout Facility	2017	5,648		20	282	282	282	31
32	Window Treatment - Cornices	2017	6,626		20	331	331	331	32
33	Sprinkler System - Replace Piping	2017	2,829		20	141	141	141	33
34	TOTAL (lines 1 thru 33)		$ 14,401,609	$ 304,646		$ 434,343	$ 129,697	$ 4,623,332	34

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 14,401,609	$ 304,646		$ 434,343	$ 129,697	$ 4,623,332	1
2	Resupply Power To Transfer Switch And Elevator	2017	5,000		20	250	250	250	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,406,609	$ 304,646		$ 434,593	$ 129,947	$ 4,623,582	34

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 14,406,609	$ 304,646		$ 434,593	$ 129,947	$ 4,623,582	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,406,609	$ 304,646		$ 434,593	$ 129,947	$ 4,623,582	34

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 14,406,609	$ 304,646		$ 434,593	$ 129,947	$ 4,623,582	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,406,609	$ 304,646		$ 434,593	$ 129,947	$ 4,623,582	34

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting- Care Center Bldg	2002	25,591	656	35	656		10,034	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	8,015	178	35	178		1,864	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	3,195	82	35	82		1,253	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting- Care Center Bldg	2002	21,140		20			21,140	9
10	Allocated from Extended Care Consulting- Care Center Bldg	2003	24,913		20			24,913	10
11	Allocated from Extended Care Consulting- Care Center Bldg	2005	1,238		20			1,238	11
12	Allocated from Extended Care Consulting- Care Center Bldg	2009	223	11	20	11		100	12
13	Allocated from Extended Care Consulting- Care Center Bldg	2014	2,144	107	20	107		429	13
14	Allocated from Extended Care Consulting- Care Center Bldg	2015	352	18	20	18		114	14
15	Allocated from Extended Care Consulting- Care Center Bldg	2016	1,391	70	20	70		139	15
16	Allocated from Extended Care Consulting- Care Center Bldg	2017	2,413	121	20	121		121	16
17									17
18	Allocated from Extended Care Consulting	2007	154	8	20	8		84	18
19	Allocated from Extended Care Consulting	2009	92	5	20	5		41	19
20	Allocated from Extended Care Consulting	2010	901	45	20	45		360	20
21	Allocated from Extended Care Consulting	2011	324	16	20	16		114	21
22	Allocated from Extended Care Consulting	2012	107	5	20	5		32	22
23	Allocated from Extended Care Consulting	2014	1,481	74	20	74		296	23
24	Allocated from Extended Care Consulting	2016	1,776	89	20	89		178	24
25									25
26	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,639		20			2,639	26
27	Allocated from Extended Care Clinical - Care Center Bldg	2003	3,110		20			3,110	27
28	Allocated from Extended Care Clinical - Care Center Bldg	2005	155		20			155	28
29	Allocated from Extended Care Clinical - Care Center Bldg	2009	28	1	20	1		13	29
30	Allocated from Extended Care Clinical - Care Center Bldg	2014	259	13	20	13		52	30
31	Allocated from Extended Care Clinical - Care Center Bldg	2015	44	2	20	2		14	31
32	Allocated from Extended Care Clinical - Care Center Bldg	2016	174	9	20	9		17	32
33	Allocated from Extended Care Clinical - Care Center Bldg	2017	301	15	20	15		15	33
34	TOTAL (lines 1 thru 33)		$ 102,160	$ 1,525		$ 1,525	$	$ 68,465	34

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 102,160	$ 1,525		$ 1,525	$	$ 68,465	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
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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)		$ 102,160	$ 1,525		$ 1,525	$	$ 68,465	34

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 330,372	$ 761	$ 59,076	$ 58,315	10	$ 227,040	71
72	Current Year Purchases	3,815		64	64	10	64	72
73	Fully Depreciated Assets	554,950				10	554,950	73
74								74
75	TOTALS	$ 889,138	$ 761	$ 59,140	$ 58,379		$ 782,054	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Extended Care Consulting		$ 6,027	$ 170	$ 170	$	5	$ 5,857	76
77		Allocated from Extended Care Clinical		3,242	339	339		5	3,242	77
78										78
79										79
80	TOTALS			$ 9,269	$ 509	$ 509	$		$ 9,099	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)	$ 16,148,999	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 305,916	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 494,242	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 188,326	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,414,734	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 Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Offsite Storage				4,107			5
6								6
7	TOTAL				$ 4,107 **			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: $ 9,357 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 721,615	$		$ 721,615	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			119,426			119,426	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			809,389			809,389	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				162,532		162,532	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					114,670	115,967		230,637	13
14	TOTAL			$		$ 1,765,100	$ 278,499		$ 2,043,599	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 Lemont Nursing & Rehab Center, Llc **#** 0046201 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 1,561,073	$ 1,961,884	1
2	Cash-Patient Deposits	23,658	23,658	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,537,724	1,537,724	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,333	67,333	6
7	Other Prepaid Expenses	1,493	1,493	7
8	Accounts Receivable (owners or related parties)	4,394,179	17,517,517	8
9	Other(specify): See Attached Schedule	10,183,431	10,318,353	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 17,768,891	$ 31,427,962	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		823,094	13
14	Buildings, at Historical Cost		5,590,504	14
15	Leasehold Improvements, at Historical Cost	1,035,851	8,717,752	15
16	Equipment, at Historical Cost	555,818	555,818	16
17	Accumulated Depreciation (book methods)	(1,080,192)	(4,895,511)	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	1,567	150,256	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 513,044	$ 10,941,913	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 18,281,935	$ 42,369,875	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 623,704	$ 623,704	26
27	Officer's Accounts Payable		5,117,778	27
28	Accounts Payable-Patient Deposits	18,471	18,471	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	190,803	190,803	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,199	9,199	31
32	Accrued Real Estate Taxes(Sch.IX-B)	422,830	422,830	32
33	Accrued Interest Payable		74,175	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	71,857	71,857	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,336,864	$ 6,528,817	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		18,935,000	39
40	Mortgage Payable			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)**	$	$ 18,935,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,336,864	$ 25,463,817	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 16,945,071	$ 16,906,058	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 18,281,935	$ 42,369,875	48

***(See instructions.)**

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc **#** 0046201 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 15,968,585	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 15,968,585	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,228,486	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	(252,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 976,486	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)**	$ 16,945,071	24 *

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 15,154,259	1
2	Discounts and Allowances for all Levels	(7,106,088)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,048,171	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,742,758	6
7	Oxygen	8,404	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,751,162	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	1,376	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	394,251	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	99,252	19
20	Radiology and X-Ray	24,090	20
21	Other Medical Services	92,091	21
22	Laundry	4,432	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 615,492	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	153,568	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 153,568	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	690	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 690	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,569,083	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,788,146	31
32	Health Care	5,103,319	32
33	General Administration	2,697,342	33
	B. Capital Expense		
34	Ownership	2,397,666	34
	C. Ancillary Expense		
35	Special Cost Centers	2,043,755	35
36	Provider Participation Fee	310,369	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,340,597	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,228,486	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,228,486	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,198,341	44
45	Private Pay - Net Inpatient Revenue	2,895,548	45
46	Medicare - Net Inpatient Revenue	739,739	46
47	Other-(specify) Hospice	291,380	47
48	Other-(specify) Insurance	(76,837)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,048,171	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.**

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,969	2,254	$ 111,470	$ 49.45	1
2	Assistant Director of Nursing	1,784	2,271	87,083	38.35	2
3	Registered Nurses	18,773	21,021	704,216	33.50	3
4	Licensed Practical Nurses	28,038	30,871	954,756	30.93	4
5	CNAs & Orderlies	58,886	63,162	862,777	13.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,203	12,194	235,657	19.33	8
9	Activity Director	1,837	2,118	50,594	23.89	9
10	Activity Assistants	11,715	12,804	124,775	9.75	10
11	Social Service Workers	8,987	9,839	218,190	22.18	11
12	Dietician					12
13	Food Service Supervisor	1,749	1,864	43,635	23.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,329	10,449	160,734	15.38	15
16	Dishwashers	10,921	12,110	121,237	10.01	16
17	Maintenance Workers	4,636	5,111	110,023	21.53	17
18	Housekeepers	17,985	19,505	193,040	9.90	18
19	Laundry	6,293	6,956	78,348	11.26	19
20	Administrator	1,777	2,017	109,463	54.27	20
21	Assistant Administrator	1,342	1,507	36,802	24.42	21
22	Other Administrative					22
23	Office Manager	1,977	2,172	33,300	15.33	23
24	Clerical	6,184	6,944	139,985	20.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,660	2,932	48,911	16.68	31
32	Other Health Care(specify)					32
33	Other(specify)	2,171	2,341	36,723	15.69	33
34	TOTAL (lines 1 - 33)	210,216	230,442	$ 4,461,719 *	$ 19.36	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	613	$ 30,248	01-03	35
36	Medical Director	Monthly	39,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,961	10-03	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				45
46	Other(specify)	64			46
47		46			47
48		27			48
49	TOTAL (lines 35 - 48)	750	$ 77,209		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,497	$ 223,827	10-03	50
51	Licensed Practical Nurses	4,285	197,746	10-03	51
52	Certified Nurse Assistants/Aides	33,055	892,593	10-03	52
53	TOTAL (lines 50 - 52)	40,837	$ 1,314,166		53

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jomarie Silver	Administrator		$ 51,043
Niki Mehta	Administrator		58,420
Elimelech Mayer	Asst Administrator		14,993
Jennifer Davey	Asst Administrator		21,809
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 146,265

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
Paycor	Payroll Processing	$ 24,054
Matrixcare	Billing Software	18,379
Coburn Enterprises	Data Processing	251
Ability Network	Medicare Billing	6,917
National Datacare Corp.	Resident Fund Processing	1,000
Marcum LLP	Accounting Services	25,300
Personnel Planners	Unemployment Services	1,665
Extended Care Consulting	Home Office Allocation	510,768
Extended Care Clinical	Home Office Allocation	170,256
See Attached	Legal	5,770
See Supplemental Schedule		15,165
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 779,525

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 119,829
Unemployment Compensation Insurance	91,904
FICA Taxes	329,891
Employee Health Insurance	213,989
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	12,022
Holiday Expense	6,871
Employee Physicals	73
TOTAL (agree to Schedule V, line 22, col.8)	$ 774,579

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	40,231
Health Care Worker Background Check	
(Indicate # of checks performed 391)	
Patient Background Checks	4,840
Dues & Subscriptions	25,223
Licenses & Fees	8,407
Allocated from Extended Care Consulting	815
See Supplemental Schedule	1,036
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 82,542

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,671
Allocated from Extended Care Consulting	35
Allocated from Extended Care Clinical	1,266
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,972

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/17 Ending: 12/31/17

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $18,747**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **89,074** 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. $ **310,369**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 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? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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