FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

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

I. IDPH License ID Number: 0054361

Facility Name: SELECT POST ACUTE CARE LLC

Address: 700 N MAIN STREET (Number) EUREKA (City) 61530 (Zip Code)

County: WOODFORD

Telephone Number: (309) 467-2387 **Fax #** (309) 467-9011

HFS ID Number:

Date of Initial License for Current Owners: 08/09/2016

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2017 to 12/31/2017 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) DANIEL AARON
(Title) CFO

Paid Preparer

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

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

Facility Name & ID Number SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	92	Skilled (SNF)	92	33,580	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	12	Sheltered Care (SC)	12	4,380	5
6		ICF/DD 16 or Less			6
7	104	TOTALS	104	37,960	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			976	976	8
9	SNF/PED					9
10	ICF	10,827	8,507	102	19,436	10
11	ICF/DD					11
12	SC			2,696	2,696	12
13	DD 16 OR LESS					13
14	TOTALS	10,827	8,507	3,774	23,108	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.87%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 08/09/2016

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 08/09/2016 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 92 and days of care provided 976

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number SELECT POST ACUTE CARE LLC # 0054361 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary			505,554	505,554		505,554		505,554			1
2	Food Purchase											2
3	Housekeeping			161,183	161,183		161,183		161,183			3
4	Laundry			107,183	107,183		107,183		107,183			4
5	Heat and Other Utilities			128,348	128,348		128,348		128,348			5
6	Maintenance	75,249	1,924	36,598	113,771		113,771	18,973	132,744			6
7	Other (specify):*			15,985	15,985		15,985		15,985			7
8	**TOTAL General Services**	75,249	1,924	954,851	1,032,024		1,032,024	18,973	1,050,997			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,431,669	100,793	68,580	1,601,042		1,601,042		1,601,042			10
10a	Therapy											10a
11	Activities	88,204	6,806	736	95,746		95,746		95,746			11
12	Social Services			864	864		864		864			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,519,873	107,599	82,180	1,709,652		1,709,652		1,709,652			16
	C. General Administration											
17	Administrative	117,939			117,939		117,939	17,850	135,789			17
18	Directors Fees											18
19	Professional Services			99,674	99,674		99,674	8,400	108,074			19
20	Dues, Fees, Subscriptions & Promotions			17,731	17,731		17,731	(12,395)	5,336			20
21	Clerical & General Office Expenses	138,661	10,606	26,565	175,832		175,832	(1,430)	174,402			21
22	Employee Benefits & Payroll Taxes			244,363	244,363		244,363		244,363			22
23	Inservice Training & Education			190	190		190		190			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			5,275	5,275		5,275		5,275			25
26	Insurance-Prop.Liab.Malpractice			23,211	23,211		23,211	58,776	81,987			26
27	Other (specify):*							2,066	2,066			27
28	**TOTAL General Administration**	256,600	10,606	417,009	684,215		684,215	73,267	757,482			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,851,722	120,129	1,454,040	3,425,891		3,425,891	92,240	3,518,131			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#: SELECT POST ACUTE CARE LLC **#0054361** **Report Period Beginning: 01/01/2017** **Ending: 12/31/2017**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	0	
	REPAIRS & MAINTENANCE		0	
	CONTRACTED DIETARY SERVICE		505,554	505,554
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKEEPING SERVICE		161,183	
				161,183
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
	CONTRACTED LAUNDRY SERVICE		107,183	107,183
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		32,854	
	ELECTRICITY		61,927	
	WATER		25,317	
	CABLE TV - LOBBY		8,250	
				128,348
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,381	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		28,675	
	ELEVATOR MAINTENANCE & REPAIR		4,942	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		600	
	FIRE SERVICE		0	
				36,598
7	**OTHER**			
	SCAVENGER		14,882	
	SECURITY SERVICE		1,103	
				15,985
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000	12,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	59,352	
	LABORATORY & XRAY EXPENSE		231	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,373	
	PHARMACY CONSULTANT	XVIII B 39-2	6,624	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
				68,580
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	736	
				736
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	864	
				864
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number SELECT POST ACUTE CARE LLC **#0054361** **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	
				0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	70,728	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	28,946	
				99,674
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	12,395	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	1,543	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	1,072	
	LICENSES & PERMITS	XIX F	2,721	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	0	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				17,731
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		4,250	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,430	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		20,885	
	MESSENGER SERVICE		0	
				26,565

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	141,006	
	UNEMPLOYMENT COMPENSATION	XIX D	35,579	
	WORKERS COMPENSATION INSURANC	XIX D	50,050	
	HOSPITALIZATION INSURANCE	XIX D	12,832	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,256	
	EMPLOYEE PHYSICAL EXAMS	XIX D	2,640	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				244,363
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		190	
				190
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,275	
				5,275
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		23,211	
				23,211
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **1,454,040**

SELECT POST ACUTE CARE LLC
SCHEDULES
12/31/2017

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

TOTAL FOOD PURCHASE	0
LESS SALES TAX	0
NET FOOD	0
TOTAL PATIENT CENSUS	23,108
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	69,324
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	33,580
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	69,324
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	69,324
NET FOOD	0
DIVIDE TOTAL MEALS/YEAR	69,324
COST PER MEAL	0.00
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

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

Facility Name & ID Number SELECT POST ACUTE CARE LLC #0054361 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			11,213	11,213		11,213	49,439	60,652			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,703	17,703		17,703	191,294	208,997			32
33	Real Estate Taxes							48,644	48,644			33
34	Rent-Facility & Grounds			514,305	514,305		514,305	(514,305)				34
35	Rent-Equipment & Vehicles			13,972	13,972		13,972		13,972			35
36	Other (specify):*											36
37	**TOTAL Ownership**			557,193	557,193		557,193	(224,928)	332,265			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		65,001	294,911	359,912		359,912		359,912			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,167	164,167		164,167		164,167			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		65,001	459,078	524,079		524,079		524,079			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,851,722	185,130	2,470,311	4,507,163		4,507,163	(132,688)	4,374,475			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 SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(183,154)	30		9
10	Interest and Other Investment Income	(3)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(1,430)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(12,395)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PG 5A				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (196,982)		$	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)	64,294		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 64,294		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (132,688)		37

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

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

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

SELECT POST ACUTE CARE LLC

ID# 0054361

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SELECT POST ACUTE CARE LLC # 0054361 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Operating Expenses	PAGES	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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	18,973	0	0	0	0	0	0	0	0	0	18,973	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	18,973	0	0	0	0	0	0	0	0	0	18,973	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	17,850	0	0	0	0	0	0	0	0	0	17,850	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,400	0	0	0	0	0	0	0	0	0	8,400	19
20	Fees, Subscriptions & Promotions	(12,395)	0	0	0	0	0	0	0	0	0	0	(12,395)	20
21	Clerical & General Office Expenses	(1,430)	0	0	0	0	0	0	0	0	0	0	(1,430)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	58,776	0	0	0	0	0	0	0	0	0	58,776	26
27	Other (specify):*	0	2,066	0	0	0	0	0	0	0	0	0	2,066	27
28	**TOTAL General Administration**	(13,825)	87,092	0	0	0	0	0	0	0	0	0	73,267	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(13,825)	106,065	0	0	0	0	0	0	0	0	0	92,240	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SELECT POST ACUTE CARE LLC # 0054361 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Capital Expense / D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(183,154)	232,593	0	0	0	0	0	0	0	0	0	49,439	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3)	191,297	0	0	0	0	0	0	0	0	0	191,294	32
33	Real Estate Taxes	0	48,644	0	0	0	0	0	0	0	0	0	48,644	33
34	Rent-Facility & Grounds	0	(514,305)	0	0	0	0	0	0	0	0	0	(514,305)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(183,157)	(41,771)	0	0	0	0	0	0	0	0	0	(224,928)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(196,982)	64,294	0	0	0	0	0	0	0	0	0	(132,688)	45

Facility Name & ID Number SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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	$ 514,305	SELECT POST ACUTE CARE REALTY LLC	100.00%	$	$ (514,305)	1
2	V				SELECT POST ACUTE CARE REALTY LLC				2
3	V	30	DEPRECIATION		SELECT POST ACUTE CARE REALTY LLC		232,593	232,593	3
4	V	26	INSURANCE		SELECT POST ACUTE CARE REALTY LLC		58,776	58,776	4
5	V	32	INTEREST		SELECT POST ACUTE CARE REALTY LLC		191,297	191,297	5
6	V	6	GROUNDS MAINTENANCE		SELECT POST ACUTE CARE REALTY LLC		625	625	6
7	V	6	REPAIR & MAINTENANCE		SELECT POST ACUTE CARE REALTY LLC		18,348	18,348	7
8	V	33	REAL ESTATE TAX		SELECT POST ACUTE CARE REALTY LLC		48,644	48,644	8
9	V	19	ACCOUNTING FEES		SELECT POST ACUTE CARE REALTY LLC		8,400	8,400	9
10	V								10
11	V	17	SALARY		SELECT HEALTHCARE CONSULTANTS		17,850	17,850	11
12	V	27	BNEFITS		SELECT HEALTHCARE CONSULTANTS		2,066	2,066	12
13	V								13
14	Total			$ 514,305			$ 578,599	$ * 64,294	14

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

Facility Name & ID Number SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BERGER FAMILY TRUST	4.95			SELECT POST ACUTE CARE REALTY LLC		BUILDING	1
2	STERN FAMILY INVESTMENT	4.95			SELECT HEALTHCARE CONSULTANTS IN		MANAGEMENT	2
3	ISRAEL FAMILY INVESTMENT TRUST	2.475						3
4	ISRAEL INVESTMENT TRUST	2.475						4
5	SUSAN STERN	4.95						5
6	DIANIA KUFTA	1.50						6
7	DENNIS NEHMER	1.50						7
8	BRITTANY AVERY	2.00						8
9	HOWARD ALTER	3.00						9
10	ESTHER MARYLES	2.475						10
11	CHANA MAUER	2.475						11
12	DANIEL AARON	16.813						12
13	ROBERT AARON	16.813						13
14	ADAM AARON	16.813						14
15	MICHAEL AARON	16.812						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 SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DANIEL AARON	MEMBER						17	$ 8,925	17-7	1
2	ROBERT AARON	MEMBER						17	8,925	17-7	2
3											3
4	DANIEL AARON	MEMBER	SCHEDULE ATTACHED						0		4
5	ROBERT AARON		SCHEDULE ATTACHED						0		5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 17,850		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 SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	LANCASTER POLLARD		X	MORTGAGE	9/1/2016	9/1/16	$ 4,287,028	$ 4,184,924	2043	4.5300	$ 191,297	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL	INTEREST			292,840			17,703	6
7												7
8												8
9	TOTAL Facility Related				$42,614.00		$ 4,287,028	$ 4,477,764			$ 209,000	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,287,028	$ 4,477,764			$ 209,000	15

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

* 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 SELECT POST ACUTE CARE LLC # 0054361 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	35,259	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.)	$	41,403	2
3. Under or (over) accrual (line 2 minus line 1).	$	6,144	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	42,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	48,644	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012		8
2013		9
2014		10
2015		11
2016	41,403	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~101% OF THE PRIOR YEAR REAL ESTATE TAX BILL - THE PAYMENT ON LINE 2 APPLIES TO THE 2016 TAX BILL.

FOR BHF USE ONLY

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

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SELECT POST ACUTE CARE LLC COUNTY WOODFORD

FACILITY IDPH LICENSE NUMBER 0054361

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-12-201-030	NURSING HOME	$ 36,467.14	$ 36,467.14
2.	13-12-201-026	NURSING HOME	$ 4,936.28	$ 4,936.28
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 41,403.42	$ 41,403.42

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		2016	$ 37,179	1
2					2
3	TOTALS			$ 37,179	3

Facility Name & ID Number SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	104		2016		$ 3,001,595	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	IMPROVEMENTS - LANDLORD										9
10	SELECT CARE SIGN			2017	32,210		15	2,147	2,147	2,147	10
11	HALL 6 MEDICARE ROOMS 600-612 - NEW FLOORING, DRYWALL, WALLPAPER, DOORS, PAINT, LIGHT FIXTURES, BATHROOMS TILE, FIXTURES, CUBI										11
12				2017	227,193		39	5,825	5,825	5,825	12
13	THERAPY ROOM - FLOORING, WALLCOVERING, LIGHTING, CABINETS, WALL PROTECTION										13
14				2017	154,298		39	3,956	3,956	3,956	14
15	SKYLIGHT			2017	1,913		39	49	49	49	15
16	ELECTRICAL WORK			2017	1,800		39	46	46	46	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						243,806			(243,806)		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 SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,419,009	$ 243,806		$ 12,024	$ (231,782)	$ 12,023	70

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

Facility Name & ID Number SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 282,598	$	$ 28,260	$ 28,260	10 YRS	$ 28,260	71
72	Current Year Purchases	203,676		20,368	20,368	10YRS	20,368	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 486,274	$	$ 48,627	$ 48,627		$ 48,628	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,942,462	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 243,806	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 60,652	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (183,154)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 60,651	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 SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/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: $ 6,815 Description: COPIER
(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	NURSING, ACTIVITIES	2016 FORD TRANSIT	$ 705.00	$ 7,157	17
18	MAINTENANCE	T350			18
19					19
20					20
21	TOTAL		$ 705.00	$ 7,157	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 SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

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

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

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

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 113,267	$		$ 113,267	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			84,934			84,934	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			96,710			96,710	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				53,965		53,965	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-2					11,036		11,036	13
14	TOTAL			$		$ 294,911	$ 65,001		$ 359,912	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 SELECT POST ACUTE CARE LLC **#** 0054361 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 20,327	$ 56,802	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	827,861	827,861	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,267	48,524	6
7	Other Prepaid Expenses	4,288	4,288	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): ESCROWS/RESERVES		210,887	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 891,743	$ 1,148,362	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		52,051	13
14	Buildings, at Historical Cost		3,594,945	14
15	Leasehold Improvements, at Historical Cost		671,877	15
16	Equipment, at Historical Cost	33,329	523,454	16
17	Accumulated Depreciation (book methods)	(15,842)	(329,360)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 17,487	$ 4,512,967	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 909,230	$ 5,661,329	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 447,804	$ 509,186	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	292,840	292,840	29
30	Accrued Salaries Payable	69,195	69,195	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,724	5,724	31
32	Accrued Real Estate Taxes(Sch.IX-B)		42,500	32
33	Accrued Interest Payable		15,798	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 815,563	$ 935,243	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,184,924	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE OTHER	177,880	177,880	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 177,880	$ 4,362,804	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 993,443	$ 5,298,047	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (84,213)	$ 363,282	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 909,230	$ 5,661,329	48

***(See instructions.)**

Facility Name & ID Number SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3	**OPENING EQUITY**	146,151	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 146,151	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(230,364)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **OUT OF PERIOD EXPENSES**		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (230,364)	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)**	$ (84,213)	24 *

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

Facility Name & ID Number SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,016,739	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,016,739	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	232,462	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 232,462	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	27,595	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 27,595	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,276,799	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,032,024	31
32	Health Care	1,709,652	32
33	General Administration	684,215	33
	B. Capital Expense		
34	Ownership	557,193	34
	C. Ancillary Expense		
35	Special Cost Centers	359,912	35
36	Provider Participation Fee	164,167	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,507,163	40
41	**Income before Income Taxes (line 30 minus line 40)****	(230,364)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (230,364)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,432,127	44
45	Private Pay - Net Inpatient Revenue	2,098,053	45
46	Medicare - Net Inpatient Revenue	461,510	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	25,049	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,016,739	49

****TAX RETURN PREPARED ON CASH BASIS**

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO** If not, please attach a reconciliation.**

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

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

Facility Name & ID Number SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,240	3,588	$ 134,152	$ 37.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,360	11,336	346,019	30.52	3
4	Licensed Practical Nurses	6,148	6,639	165,944	25.00	4
5	CNAs & Orderlies	51,991	55,195	748,998	13.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,949	2,116	28,387	13.42	9
10	Activity Assistants	4,185	4,277	59,817	13.99	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,978	4,497	75,249	16.73	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,984	2,080	80,547	38.72	20
21	Assistant Administrator	1,968	2,131	37,392	17.55	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,560	7,198	138,661	19.26	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	2,010	2,133	36,556	17.14	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	94,373	101,190	$ 1,851,722 *	$ 18.30	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 0	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	2,373	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,624	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	736	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 21,733		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 37,117	10-3	50
51	Licensed Practical Nurses		10,905	10-3	51
52	Certified Nurse Assistants/Aides		11,330	10-3	52
53	TOTAL (lines 50 - 52)		$ 59,352		53

Facility Name & ID Number SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JORDAN POST	ADMINISTRATOR	0	$ 80,547
ERIN NEUKOMM	ASST ADMIN	0	37,392
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 117,939

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
KBKB	ACCOUNTING	$ 18,000
FRED FRANKEL	LEGAL	1,946
PAYCOR	DATA PROCESSING	13,333
CASAMBA	DATA PROCESSING	4,060
POINT CLICKCARE TECH	DATA PROCESSING	35,300
ABILITY NETWORK	DATA PROCESSING	882
CHANGE HEALTHCARE	DATA PROCESSING	1,339
MEDIACOM	DATA PROCESSING	2,701
SINGER NETWORKS	DATA PROCESSING	13,113
LPC HEALTHCARE	RECRUITING	9,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 99,674

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,050
Unemployment Compensation Insurance	35,579
FICA Taxes	141,006
Employee Health Insurance	12,832
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,256
EMPLOYEE PHYSICAL EXAMS	2,640
TOTAL (agree to Schedule V, line 22, col.8)	$ 244,363

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	1,543
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	0
MARKETING/ADV/PROMO	12,395
LICENSES/DUES/SUBSCRIPTIONS	1,803
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(12,395)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,336

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

SELECT POST ACUTE CARE LLC
Legal Fee Schedule

Facility Name & ID Number SELECT POST ACUTE CARE LLC # 0054361 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XX. GENERAL INFORMATION:

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

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

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,651** Line **10-2**

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

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

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **164,167**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(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