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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0052589

Facility Name: Elmhurst Extended Care Center

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

County: DuPage

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Andrew Cutler Telephone Number: (847) 374-0400
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2018 to 12/31/2018 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name)

(Title)

Paid Preparer

(Signed) (Date)

(Print Name and Title) Andrew B. Cutler, Managing Director, Healthcare

(Firm Name & Address) FGMK, LLC, 2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015

(Telephone) (847) 374-0400 Fax # (847) 374-0420

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

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	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	505	3,380	3,018	6,903	8
9	SNF/PED					9
10	ICF	1,879	13,011	2,754	17,644	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,384	16,391	5,772	24,547	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.27%

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 12/31/2013

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 108 and days of care provided 2,528

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	285,187	27,031		312,218		312,218	6,412	318,630			1
2	Food Purchase		208,809		208,809		208,809		208,809			2
3	Housekeeping	142,311	14,756		157,067		157,067		157,067			3
4	Laundry	38,025	16,078		54,103		54,103		54,103			4
5	Heat and Other Utilities			110,580	110,580		110,580		110,580			5
6	Maintenance	70,182		70,506	140,688		140,688		140,688			6
7	Other (specify):*											7
8	TOTAL General Services	535,705	266,674	181,086	983,465		983,465	6,412	989,877			8
	B. Health Care and Programs											
9	Medical Director			49,800	49,800		49,800		49,800			9
10	Nursing and Medical Records	2,209,052	153,479	57,872	2,420,403		2,420,403		2,420,403			10
10a	Therapy		6,611	500	7,111		7,111		7,111			10a
11	Activities	128,245	113	2,068	130,426		130,426		130,426			11
12	Social Services	78,686			78,686		78,686		78,686			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,415,983	160,203	110,240	2,686,426		2,686,426		2,686,426			16
	C. General Administration											
17	Administrative	101,748			101,748		101,748		101,748			17
18	Directors Fees											18
19	Professional Services			45,359	45,359		45,359	(8,454)	36,905			19
20	Dues, Fees, Subscriptions & Promotions			50,329	50,329		50,329	(38,375)	11,954			20
21	Clerical & General Office Expenses	313,646	6,518	215,224	535,388		535,388	(179,972)	355,416			21
22	Employee Benefits & Payroll Taxes			464,445	464,445		464,445		464,445			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,533	17,533		17,533	(1,165)	16,368			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			87,748	87,748		87,748		87,748			26
27	Other (specify):*											27
28	TOTAL General Administration	415,394	6,518	880,638	1,302,550		1,302,550	(227,966)	1,074,584			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,367,082	433,395	1,171,964	4,972,441		4,972,441	(221,554)	4,750,887			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Elmhurst Extended Care Center #0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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			46,766	46,766		46,766	590,051	636,817			30
31	Amortization of Pre-Op. & Org.							7,119	7,119			31
32	Interest			48,190	48,190		48,190	363,533	411,723			32
33	Real Estate Taxes			54,000	54,000		54,000	4,818	58,818			33
34	Rent-Facility & Grounds			549,468	549,468		549,468	(546,000)	3,468			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			698,424	698,424		698,424	419,521	1,117,945			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	252,932	180,624	93,549	527,105		527,105		527,105			39
40	Barber and Beauty Shops			6,488	6,488		6,488	(6,488)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			191,329	191,329		191,329		191,329			42
43	Other (specify):*	67,876		6,801	74,677		74,677		74,677			43
44	**TOTAL Special Cost Centers**	320,808	180,624	298,167	799,599		799,599	(6,488)	793,111			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,687,890	614,019	2,168,555	6,470,464		6,470,464	191,479	6,661,943			45

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

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	227,480	30		9
10	Interest and Other Investment Income	(3,734)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,617)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(175,617)	21		24
25	Fund Raising, Advertising and Promotional	(33,338)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,362)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 8,812		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 8,812		37

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

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

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

Elmhurst Extended Care Center

ID# 0052589

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Expense	$ 6,412	1	1
2	Barber & Beauty	(6,488)	40	2
3	Bank Charges	(310)	21	3
4	Misc. Income/rebate Offset	(428)	21	4
5	Non-Allowable Legal	(8,454)	19	5
6	Non-Allowable out of State Travel	(815)	24	6
7	Offset Non-Allowable Lobbying Exp. - IHCA	(2,675)	20	7
8	Non-Allowable Out of State Seminar Exp.	(350)	24	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**	(13,108)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	6,412	0	0	0	0	0	0	0	0	0	0	6,412	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	6,412	0	0	0	0	0	0	0	0	0	0	6,412	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,454)	0	0	0	0	0	0	0	0	0	0	(8,454)	19
20	Fees, Subscriptions & Promotions	(38,375)	0	0	0	0	0	0	0	0	0	0	(38,375)	20
21	Clerical & General Office Expenses	(179,972)	0	0	0	0	0	0	0	0	0	0	(179,972)	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	(1,165)	0	0	0	0	0	0	0	0	0	0	(1,165)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(227,966)	0	0	0	0	0	0	0	0	0	0	(227,966)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(221,554)	0	0	0	0	0	0	0	0	0	0	(221,554)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 **Report Period Beginning:** 1/1/2018 **Ending:** 12/31/2018

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	227,480	362,571	0	0	0	0	0	0	0	0	0	590,051	30
31	Amortization of Pre-Op. & Org.	0	7,119	0	0	0	0	0	0	0	0	0	7,119	31
32	Interest	(3,734)	367,267	0	0	0	0	0	0	0	0	0	363,533	32
33	Real Estate Taxes	0	4,818	0	0	0	0	0	0	0	0	0	4,818	33
34	Rent-Facility & Grounds	0	(546,000)	0	0	0	0	0	0	0	0	0	(546,000)	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**	223,746	195,775	0	0	0	0	0	0	0	0	0	419,521	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	(6,488)	0	0	0	0	0	0	0	0	0	0	(6,488)	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**	(6,488)	0	0	0	0	0	0	0	0	0	0	(6,488)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(4,296)	195,775	0	0	0	0	0	0	0	0	0	191,479	45

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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
Love Dave	15%			LKNY, LLC		Bldg. Ptrshp.
Madhusudan Dave	60%					
Dipti Dave	25%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 546,000			$	$ (546,000)	1
2	V	30	Depreciation Expense				362,571	362,571	2
3	V	31	Amortization Expense				7,119	7,119	3
4	V	32	Mortgage Interest	48,190			386,579	338,389	4
5	V	33	Real Estate Taxes	54,000			58,818	4,818	5
6	V	32	Interest Expense - LOC				28,878	28,878	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 648,190			$ 843,965	$ * 195,775	14

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

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Love Dave	Owner	Administrative	15.00	None	60	100.00	Salary	$ 101,748	17-1	1
2	Madhusudan Dave	Owner	Administrative	60.00	None	40	100.00	Salary	93,628	21-1	2
3	Dipti Dave	Owner	Bookkeeping	25.00	None	40	100.00	Salary	69,256	21-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 264,632		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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 Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	Byline Bank		X	Mortgage			$ 5,000,000	$ 4,541,995			$ 338,389	1
2	Seller Finance		X	Seller Fianance			1,000,000	917,898			48,190	2
3												3
4												4
5												5
	Working Capital											
6	Byline Bank		X	Working Capital			500,000	263,675			18,378	6
7	Itasca Bank		X	Working Capital				181,755			10,500	7
8	Marlin Equip. Finance		X	Capital Lease				3,463				8
9	TOTAL Facility Related						$ 6,500,000	$ 5,908,786			$ 415,457	9
	B. Non-Facility Related*											
10	Interest Expense										(3,734)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,734)	14
15	TOTALS (line 9+line14)						$ 6,500,000	$ 5,908,786			$ 411,723	15

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

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

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

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	58,818	2
3. Under or (over) accrual (line 2 minus line 1).	$	58,818	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	58,818	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	51,033	8
	2014	51,316	9
	2015	48,281	10
	2016	48,844	11
	2017	58,818	12

No Real Estate Tax Accrual as Provider pays real estate tax as part of Rent
Rent Expense is fixed therefor no accrual is required.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmhurst Extended Care Center COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0052589

CONTACT PERSON REGARDING THIS REPORT Andrew Cutler

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

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-36-309-029	Long-Term Care Property	$ 50,764.52	$ 50,764.52
2.	03-36-309-020	Long-Term Care Property	$ 4,832.24	$ 4,832.24
3.	03-36-309-021	Long-Term Care Property	$ 3,221.50	$ 3,221.50
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 58,818.26	$ 58,818.26

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,019 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

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

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

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

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

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

None

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

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

3. Current Period Amortization: 7,119 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	Residential Care	41,851	2013	$ 92,016	1
2	Parking Lot			6,950	2
3	TOTALS	41,851		$ 98,966	3

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	108		2013		$ 2,860,030	$	27	$ 105,927	$ 105,927	$ 471,414	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2014	84,438		20	4,222	4,222	18,025	9
10	Generator Repair			2015	3,888		20	194	194	729	10
11	Fire Sprinkler Repair			2015	3,012		20	151	151	477	11
12	Valve Repair			2015	2,504		20	125	125	396	12
13	Call Light System			2015	21,138		27.5	769	769	2,818	13
14	Fire Panel / Dampers			2015	34,338		20	1,717	1,717	6,724	14
15	2nd Fl new floors dining room, nurses station, corridor,			2015	22,850		7	3,264	3,264	10,065	15
16	3Bedrooms, 4 closets										16
17	New VMS security (Video Management System)			2015	11,763		5	2,353	2,353	7,254	17
18	Room Renovations 1 East, Patient Rooms, Painting, Flooring			2016	20,450		20	1,023	1,023	2,045	18
19	Room renovations 2 East Flooring, painting			2017	23,095		5	4,619	4,619	6,159	19
20	Water Shut Off Valve Replacement			2017	2,900		20	145	145	205	20
21	Elevator Clutch Replacment Front/Rear Doors			2017	3,692		20	185	185	231	21
22	Elevator Pump Motor Replacement			2017	3,136		20	157	157	183	22
23	2 East Renovations - Patient rooms, Painting, Flooring, Lighting			2018	22,536		20	563	563	563	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	Current Book Depreciation					409,337					36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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)		$ 3,119,770	$ 409,337		$ 125,413	$ 125,413	$ 527,288	70

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

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,632,725	$	$ 510,203	$ 510,203	5-7	$ 2,511,684	71
72	Current Year Purchases	6,550		1,201	1,201	5	1,201	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,639,275	$	$ 511,404	$ 511,404		$ 2,512,885	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,858,011	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 409,337	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 636,817	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 227,480	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,040,173	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Office Storage Rental				3,468			5
6								6
7	TOTAL				$ 3,468 **			7

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: *

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: $ 0 Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-1; 39-3	hrs	$ 65,256		$ 48,308	$		$ 113,564	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,337			3,337	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1; 39-3	hrs	187,676		23,011			210,687	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				180,624		180,624	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs			18,893			18,893	11
12	Other (specify): Lab and X-Ray	39-3								12
13	Other (specify):									13
14	TOTAL			$ 252,932		$ 93,549	$ 180,624		$ 527,105	14

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

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (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	$ 451,760	$ 770,086	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (159,455))	854,775	2,301,429	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,307	13,307	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,000	3,000	8
9	Other(specify):	(7)	(7)	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,322,835	$ 3,087,815	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		493,227	13
14	Buildings, at Historical Cost		2,486,821	14
15	Leasehold Improvements, at Historical Cost	204,444	577,653	15
16	Equipment, at Historical Cost	141,148	2,639,273	16
17	Accumulated Depreciation (book methods)	(127,796)	(3,139,379)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		42,879	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(79,961)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached		179,465	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 217,796	$ 3,199,978	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,540,631	$ 6,287,793	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 102,015	$ 102,015	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	373,533	373,533	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,742	20,742	31
32	Accrued Real Estate Taxes(Sch.IX-B)		50,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	583,094	583,094	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,079,384	$ 1,129,384	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	921,361	2,284,689	39
40	Mortgage Payable		4,541,995	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)**	$ 921,361	$ 6,826,684	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,000,745	$ 7,956,068	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (460,114)	$ (1,668,275)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,540,631	$ 6,287,793	48

*(See instructions.)

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	A. Current Assets	Operating	After Consolidation
9	Due from Employees	(7)	(7)
		(7)	(7)

	B. Long-Term Assets	Amount	
23	Loan Fees	-	179,465
		-	179,465

	Other Current Liabilities	Amount	
36	Due to LKNY	533,756	533,756
	Overpayment BCBS	49,338	49,338
		583,094	583,094

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (571,617)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (571,617)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	111,503	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 111,503	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)**	$ (460,114)	24 *

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

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,696,677	1
2	Discounts and Allowances for all Levels	(2,201,667)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,495,010	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	703,956	6
7	Oxygen	17,330	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 721,286	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	8,764	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	159,825	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,063	19
20	Radiology and X-Ray	4,221	20
21	Other Medical Services	158,420	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 343,293	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,734	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,734	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Misc. Income/Vending Income/3rd Party Settlements**	18,644	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 18,644	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,581,967	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	983,465	31
32	Health Care	2,686,426	32
33	General Administration	1,302,550	33
	B. Capital Expense		
34	Ownership	698,424	34
	C. Ancillary Expense		
35	Special Cost Centers	608,270	35
36	Provider Participation Fee	191,329	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,470,464	40
41	**Income before Income Taxes (line 30 minus line 40)****	111,503	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 111,503	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 499,784	44
45	Private Pay - Net Inpatient Revenue	4,139,338	45
46	Medicare - Net Inpatient Revenue	562,644	46
47	Other-(specify) **Hospice**	63,206	47
48	Other-(specify) **Insurance**	230,038	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,495,010	49

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

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

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

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

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	1,864	2,080	$ 180,650	$ 86.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,120	19,139	569,410	29.75	3
4	Licensed Practical Nurses	13,949	15,206	432,947	28.47	4
5	CNAs & Orderlies	62,557	67,235	1,011,283	15.04	5
6	CNA Trainees					6
7	Licensed Therapist	4,836	5,327	252,932	47.48	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,896	2,080	61,123	29.39	9
10	Activity Assistants	4,858	5,153	67,122	13.03	10
11	Social Service Workers	1,848	2,080	78,686	37.83	11
12	Dietician	1,930	2,066	53,120	25.71	12
13	Food Service Supervisor					13
14	Head Cook	2,158	2,384	45,522	19.09	14
15	Cook Helpers/Assistants	8,145	9,029	119,118	13.19	15
16	Dishwashers	6,262	6,522	67,427	10.34	16
17	Maintenance Workers	2,146	2,426	70,182	28.93	17
18	Housekeepers	1,089	12,207	142,311	11.66	18
19	Laundry	2,008	2,241	38,025	16.97	19
20	Administrator	1,904	2,080	101,748	48.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,029	10,404	313,646	30.15	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	704	808	14,762	18.27	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	2,170	2,252	67,876	30.14	33
34	TOTAL (lines 1 - 33)	148,473	170,719	$ 3,687,890 *	$ 21.60	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	49,800	9-3	36
37	Medical Records Consultant	24	1,440	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,312	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	10	500	10A-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	888	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	50	$ 57,940		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 345	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	17	1,028	10-3	52
53	TOTAL (lines 50 - 52)	25	$ 1,373		53

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Love Dave	Administrator	15%	$ 101,748
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 101,748

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
Keith Goldberg	Legal	$ 8,454
Polsinelli	Legal	1,027
Mpro	Legal	1,094
Talx	Unemployement Consultant	755
FGMK, LLC	Accounting/Consulting	23,078
Aldrich Technical Services	Data Processing	4,674
Keep It Safe	Data Processing	3,326
Cantata Health	Computer Programming	2,951
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 45,359

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,682
Unemployment Compensation Insurance	14,926
FICA Taxes	274,773
Employee Health Insurance	120,506
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	1,530
401K Match	28
TOTAL (agree to Schedule V, line 22, col.8)	$ 464,445

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,173
Health Care Worker Background Check	
(Indicate # of checks performed)	264
Patient Background Checks	2,170
Dues & Subscriptions	8,522
Marketing/Advertising Public Relations	32,838
Yellow Page Advertising	2,362
Less: Public Relations Expense	(32,838)
Non-allowable advertising	(3,175)
Yellow page advertising	(2,362)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,954

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	282
Seminar Expense	16,086
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,368

* Attach copy of IMRF notifications

**See instructions.

Elmhurst Extended Care Center
0052589
LEGAL SERVICES
FYE:1/1/2018-12/31/2018

DATE	G/L ACCT	PAYEE/VENDOR	AMOUNT	ADJ
1/4/2018	64-4485	MPRO	1,094	
1/23/2018	64-4485	Keith Goldberg	310	ADJ
2/19/2018	64-4485	Polsinelli	356	
2/28/2018	64-4485	Keith Goldberg	560	ADJ
3/15/2018	64-4485	Keith Goldberg	435	ADJ
3/31/2018	64-4485	Keith Goldberg	1,458	ADJ
4/27/2018	64-4485	Keith Goldberg	939	ADJ
5/23/2018	64-4485	Keith Goldberg	935	ADJ
6/21/2018	64-4485	Keith Goldberg	1,016	ADJ
7/30/2018	64-4485	Keith Goldberg	810	ADJ
9/17/2018	64-4485	Keith Goldberg	1,060	ADJ
11/23/2018	64-4485	Keith Goldberg	2,187	ADJ
11/20/2018	64-4485	Keith Goldberg	4,397	ADJ
11/30/2018	64-4485	Polsinelli	671	
12/24/2018	64-4485	Keith Goldberg	1,198	ADJ
		Legal Fees Billed To Residents (KG)	(6,850)	ADJ
		Total	10,575	
		Non-Allowable ADJ P.5	8,454	
		Adjusted Total	2,121	

Elmhurst Extended Care Center
0052589
SEMINAR EXPENSE
FYE:1/1/2018-12/31/2018

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE	
01/30/18	INHAA	Thinking Outside the Box	Love Dave	Administrator	Peoria, IL	100.00	
01/02/18	TNS Life Safety	In-Services	all	various	on-site	945.00	
01/27/18	Lyf Savers, Inc.	CPR	Nursing	Nursing	On-Site	2,250.00	
01/05/18	Skill path	How to communicate	Rachel Troy	Medical Records	OakBrook, IL	199.00	
02/22/19	AHCA NCAL	Independent Owner Leadership	Love Dave	Administrator	New Orleans, LA	350.00	ADJ
03/07/18	Noel Tapia	RAC-CT Class	Noel Tapia	MDS Coordinator	Webinar	180.00	
03/07/18	Nadona LTC	Infection Control master prog.	Melissa Stefanowicz	DON	On-Line	510.00	
04/04/08	CE Solutions	On line education classes	Nursing	Nursing	On-Line	1,880.63	
04/30/18	Cont. Ed. Inst. Of IL	Alzheimers Conference	Cindy Gawryla	Activites Director	Naperville, IL	85.00	
05/06/18	Food Safety Training	food safety	Jessica Parran	Dietitian	On-line	19.95	
05/22/18	Jill Simko	Semester Tuition - Adm.	Jayne Maher	Accountant	On-Line	925.00	
06/19/18	Melissa Stefanowicz	Tuition	Melissa Stefanowicz	DON	On-Line	5,000.00	
07/04/18	TNS Life Safety	In-Services	all	various	on-site	945.00	
07/07/18	Alzheimer's Association	Dementia Training DVD	nursing	various	on-site	131.80	
08/09/18	Triton College	CNA Program	Alberto Guadarrama	Kitchen - CNA	Triton	1,307.00	
08/23/18	Healthcare Information Network	MDS3.0/RAI Manual	Noel Tapia	MDS Coordinator	Schaumburg, IL	209.00	
09/18/18	Cynthia Chow	Conference - Vendor Expo	Jessica Parran	Dietitian	Chicago, IL	130.00	
10/09/18	Healthcare Information Network	PPS FY 2019 Final Rule	Love Dave/ Jayne Mahe	Administrator	Schaumburg, IL	418.00	
11/19/18	IL Healthcare Association	PDPM	Various	various	Webinar	55.00	
12/18/18	Jill Simko	Tuition - Administrator	Jayne Maher	Accountant	On-Line	795.00	
					Adjustments	(350.00)	
					Adjusted Total	16,085.38	

Elmhurst Extended Care Center
0052589
AUTO & TRAVEL
FYE:1/1/2018-12/31/2018

DATE	EMPLOYEE NAME	JOB DESCRIPTION	DESTINATION	PURPOSE OF TRIP	FOOD	AIRFARE	HOTEL	TOTAL	
03/01/18	Love Dave	Administrator	Peoria	Seminar	55.63		226.24	281.87	
03/14/18	Love Dave	Administrator	New Orleans	Conference	9.95	335.96	469.45	815.36	ADJ

Total	1097.23
Non-Allowable Adj P. 5	-815.36
Adjusted Total	281.87

Facility Name & ID Number Elmhurst Extended Care Center # 0052589 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $6,772**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **24,524** 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 fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **191,329**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
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? **Ln 14**
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: **N/A**

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