		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0046201

Facility Name: Lemont Nursing & Rehab Center, Llc

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/18 to 12/31/18 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)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title) Steven N. Lavenda, CPA, Partner
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	173	Skilled (SNF)	173	63,145	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	173	TOTALS	173	63,145	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	27,121	8,544	17,677	53,342	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,121	8,544	17,677	53,342	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.48%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 02/01/03

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 173 and days of care provided 11,973

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: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	336,824	91,709	31,595	460,128		460,128	13,026	473,154			1
2	Food Purchase		357,355		357,355		357,355	(152)	357,203			2
3	Housekeeping	192,364	45,538		237,902		237,902	1,243	239,145			3
4	Laundry	99,768	38,688		138,456		138,456		138,456			4
5	Heat and Other Utilities			186,614	186,614		186,614	1,839	188,453			5
6	Maintenance	114,707		429,662	544,369		544,369	(96,126)	448,243			6
7	Other (specify):*							4,035	4,035			7
8	**TOTAL General Services**	743,663	533,290	647,871	1,924,824		1,924,824	(76,135)	1,848,689			8
	B. Health Care and Programs											
9	Medical Director			39,000	39,000		39,000		39,000			9
10	Nursing and Medical Records	3,144,154	261,572	1,074,260	4,479,986		4,479,986	49,770	4,529,756			10
10a	Therapy	235,063			235,063		235,063		235,063			10a
11	Activities	184,883	31,077		215,960		215,960		215,960			11
12	Social Services	235,793			235,793		235,793	36,467	272,260			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							12,410	12,410			15
16	**TOTAL Health Care and Programs**	3,799,893	292,649	1,113,260	5,205,802		5,205,802	98,647	5,304,449			16
	C. General Administration											
17	Administrative	162,010			162,010		162,010	122,657	284,667			17
18	Directors Fees											18
19	Professional Services			841,181	841,181	(339)	840,842	(674,560)	166,282			19
20	Dues, Fees, Subscriptions & Promotions			147,203	147,203		147,203	(51,974)	95,229			20
21	Clerical & General Office Expenses	181,257	45,732	892,395	1,119,384		1,119,384	(671,595)	447,789			21
22	Employee Benefits & Payroll Taxes			721,825	721,825		721,825	(3,888)	717,937			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,322	2,322		2,322	1,314	3,636			24
25	Other Admin. Staff Transportation			5,137	5,137		5,137	1,017	6,154			25
26	Insurance-Prop.Liab.Malpractice			445,099	445,099		445,099	2,068	447,167			26
27	Other (specify):*							46,434	46,434			27
28	**TOTAL General Administration**	343,267	45,732	3,055,162	3,444,161	(339)	3,443,822	(1,228,527)	2,215,295			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,886,823	871,671	4,816,293	10,574,787	(339)	10,574,448	(1,206,015)	9,368,433			29

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc #0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			121,824	121,824		121,824	370,557	492,381			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			730	730		730	452,543	453,273			32
33	Real Estate Taxes			399,961	399,961	339	400,300	5,497	405,797			33
34	Rent-Facility & Grounds			2,279,058	2,279,058		2,279,058	(2,275,000)	4,058			34
35	Rent-Equipment & Vehicles			11,192	11,192		11,192	506	11,698			35
36	Other (specify):*			1,106	1,106		1,106	(1,106)				36
37	**TOTAL Ownership**			2,813,871	2,813,871	339	2,814,210	(1,447,003)	1,367,207			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		674,350	1,788,409	2,462,759		2,462,759	(44,672)	2,418,087			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			318,932	318,932		318,932		318,932			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		674,350	2,107,341	2,781,691		2,781,691	(44,672)	2,737,019			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,886,823	1,546,021	9,737,505	16,170,349		16,170,349	(2,697,690)	13,472,659			45

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(401,893)	30		9
10	Interest and Other Investment Income	(257,425)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(564)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(834,029)	21		24
25	Fund Raising, Advertising and Promotional	(43,857)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(180,641)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,718,909)		$	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)	(978,781)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (978,781)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,697,690)		37

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

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

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

Lemont Nursing & Rehab Center, Llc

ID# 0046201

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized R&M	$ (62,033)	06	1
2	Other Income	(258)	10	2
3	Residents Clothing	(69)	10	3
4	Theft Loss	(1,788)	21	4
5	Collection Expense	(75)	21	5
6	Amortization	(1,106)	36	6
7	Resident Dental Insurance	(78)	10	7
8	PAC Dues	(10,784)	20	8
9	Capitalized R & M	(47,882)	06	9
10	Building Company - Management Fees	(7,900)	19	10
11	Building Company - Filing Fees	(75)	20	11
12	Building Company - Legal Expense	(4,524)	19	12
13	Building Company - Amortization	(33,300)	36	13
14	Building Company - Professional Fees	(10,450)	19	14
15	Non-Allowable Legal	(319)	19	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(180,641)		49

Lemont Nursing & Rehab Center, Llc

ID# 0046201

Report Period Beginning: 01/01/18

Ending: 12/31/18

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			203		12,823							13,026	1
2	Food Purchase	(564)		412									(152)	2
3	Housekeeping			1,101		142							1,243	3
4	Laundry													4
5	Heat and Other Utilities			1,646		193							1,839	5
6	Maintenance	(109,915)		4,408	9,311	70							(96,126)	6
7	Other (specify):*				2,235	1,800							4,035	7
8	**TOTAL General Services**	(110,479)		7,770	11,546	15,028							(76,135)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(405)				51,924	(1,749)						49,770	10
10a	Therapy													10a
11	Activities													11
12	Social Services					36,467							36,467	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					12,410							12,410	15
16	**TOTAL Health Care and Programs**	(405)				100,801	(1,749)						98,647	16
	C. General Administration													
17	Administrative			1,579	18,133	102,945							122,657	17
18	Directors Fees													18
19	Professional Services	(23,193)	22,874	(505,008)		(169,233)							(674,560)	19
20	Fees, Subscriptions & Promotions	(55,216)	75	2,024		1,143							(51,974)	20
21	Clerical & General Office Expenses	(835,892)		10,389	118,744	35,164							(671,595)	21
22	Employee Benefits & Payroll Taxes				(3,888)								(3,888)	22
23	Inservice Training & Education													23
24	Travel and Seminar			384		930							1,314	24
25	Other Admin. Staff Transportation			1,017									1,017	25
26	Insurance-Prop.Liab.Malpractice			1,849		219							2,068	26
27	Other (specify):*				27,372	19,062							46,434	27
28	**TOTAL General Administration**	(914,301)	22,949	(487,766)	160,361	(9,770)							(1,228,527)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,025,185)	22,949	(479,996)	171,907	106,059	(1,749)						(1,206,015)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	(401,893)	769,611	2,689		150							370,557	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(257,425)	686,738	23,059		171							452,543	32
33	Real Estate Taxes			4,868		629							5,497	33
34	Rent-Facility & Grounds		(2,275,000)										(2,275,000)	34
35	Rent-Equipment & Vehicles			506									506	35
36	Other (specify):*	(34,406)	33,300										(1,106)	36
37	**TOTAL Ownership**	(693,724)	(785,351)	31,122		950							(1,447,003)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(44,672)						(44,672)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(44,672)						(44,672)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,718,909)	(762,402)	(448,874)	171,907	107,009	(46,421)						(2,697,690)	45

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 2,275,000	Lemont Property, LLC		$	$ (2,275,000)	1
2	V	33	Real Estate Tax	399,961	Lemont Property, LLC		399,961		2
3	V	32	Interest	136,424	Lemont Property, LLC		823,162	686,738	3
4	V	19	Management Fees		Lemont Property, LLC		7,900	7,900	4
5	V	20	Filing Fees		Lemont Property, LLC		75	75	5
6	V	19	Legal Expense		Lemont Property, LLC		4,524	4,524	6
7	V	30	Depreciation		Lemont Property, LLC		769,611	769,611	7
8	V	36	Amortization		Lemont Property, LLC		33,300	33,300	8
9	V	19	Professional Fees		Lemont Property, LLC		10,450	10,450	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,811,385			$ 2,048,983	$ * (762,402)	14

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting, LLC		$ 203	$ 203	15
16	V	02	Food		Extended Care Consulting, LLC		412	412	16
17	V	03	Housekeeping		Extended Care Consulting, LLC		1,101	1,101	17
18	V	05	Utilities		Extended Care Consulting, LLC		1,646	1,646	18
19	V	06	Maintenance		Extended Care Consulting, LLC		4,408	4,408	19
20	V	17	Administrative		Extended Care Consulting, LLC		1,579	1,579	20
21	V	19	Professional Fees	510,768	Extended Care Consulting, LLC		5,760	(505,008)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC		2,024	2,024	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC		10,389	10,389	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC		384	384	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC		1,017	1,017	25
26	V	26	Insurance		Extended Care Consulting, LLC		1,849	1,849	26
27	V	30	Depreciation		Extended Care Consulting, LLC		2,689	2,689	27
28	V	32	Interest		Extended Care Consulting, LLC		23,059	23,059	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC		4,868	4,868	29
30	V	35	Rent - Equipment		Extended Care Consulting, LLC		506	506	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 510,768			$ 61,894	$ * (448,874)	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC		9,311	$ 9,311	15
16	V	06	Maintenance (Direct)	12,960	Extended Care Consulting, LLC		12,960		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC		808	808	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC		1,427	1,427	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC		18,133	18,133	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC		118,744	118,744	22
23	V	21	Office and Clerical (Direct)		Extended Care Consulting, LLC				23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC		27,372	27,372	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC				25
26	V	22	Employee Benefits	3,888	Extended Care Consulting, LLC			(3,888)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 16,848			$ 188,755	$ * 171,907	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 142	$ 142	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	193	193	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	70	70	17
18	V	19	Professional Fees	170,256	Extended Care Clinical, LLC	100.00%	1,023	(169,233)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	1,143	1,143	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,340	2,340	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	930	930	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	219	219	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	150	150	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	171	171	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	629	629	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	12,823	12,823	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,800	1,800	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	51,924	51,924	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	36,467	36,467	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	12,410	12,410	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	102,945	102,945	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	32,824	32,824	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	19,062	19,062	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 170,256			$ 277,265	$ * 107,009	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	20,292	MAC Rx, LLC		18,543	(1,749)	15
16	V	39	Ancillary	518,322	MAC Rx, LLC		473,650	(44,672)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 538,614			$ 492,193	$ * (46,421)	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group		$ 347,123	$ 347,123	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	347,123	CCS Employee Benefits Group			(347,123)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 347,123			$ 347,123	$ *	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Steinberg	Relative	Administrative	0	See Attached	1.03	1.88%	Alloc Fee/Sal	$ 8,614	17-7	1
2	Adam Vales	Relative	Clerical	0	See Attached	1.65	4.12%	Alloc Salary	3,122	22-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 11,736		13

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,389,746	40	$ 5,386	$	52,250	$ 203	1
2	02	Food	Patient Days	1,389,746	40	10,961		52,250	412	2
3	03	Housekeeping	Patient Days	1,389,746	40	29,295		52,250	1,101	3
4	05	Utilities	Patient Days	1,389,746	40	43,781		52,250	1,646	4
5	06	Maintenance	Patient Days	1,389,746	40	117,234		52,250	4,408	5
6	17	Administrative	Patient Days	1,389,746	40	42,000		52,250	1,579	6
7	19	Professional Fees	Patient Days	1,389,746	40	153,207		52,250	5,760	7
8	20	Dues and Subscriptions	Patient Days	1,389,746	40	53,847		52,250	2,024	8
9	21	Office and Clerical	Patient Days	1,389,746	40	276,330		52,250	10,389	9
10	24	Seminar and Travel	Patient Days	1,389,746	40	10,217		52,250	384	10
11	25	Other Staff Admin. Trans.	Patient Days	1,389,746	40	27,054		52,250	1,017	11
12	26	Insurance	Patient Days	1,389,746	40	49,193		52,250	1,849	12
13	30	Depreciation	Patient Days	1,389,746	40	71,516		52,250	2,689	13
14	32	Interest	Patient Days	1,389,746	40	613,328		52,250	23,059	14
15	33	Real Estate Taxes	Patient Days	1,389,746	40	129,471		52,250	4,868	15
16	35	Rent - Equipment	Patient Days	1,389,746	40	13,470		52,250	506	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,646,291	$		$ 61,894	25

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	1,389,746	40	247,664	247,664	52,250	9,311	1
2	06	Maintenance (Direct)	Direct		25	357,298	357,298		12,960	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,389,746	40	21,482		52,250	808	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		25	47,140			1,427	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,389,746	40	482,303	482,303	52,250	18,133	7
8	21	Office and Clerical (Pooled)	Patient Days	1,389,746	40	3,158,355	3,158,355	52,250	118,744	8
9	21	Office and Clerical (Direct)	Direct		28	484,472	484,472			9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,389,746	40	728,044		52,250	27,372	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		28	72,742				11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,599,498	$ 4,730,091		$ 188,755	25

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	710,509	22	$ 1,936	$	52,250	$ 142	1
2	05	Utilities	Patient Days	710,509	22	2,630		52,250	193	2
3	06	Maintenance	Patient Days	710,509	22	952		52,250	70	3
4	19	Professional Fees	Patient Days	710,509	22	13,906		52,250	1,023	4
5	20	Dues and Subscriptions	Patient Days	710,509	22	15,540		52,250	1,143	5
6	21	Office & Clerical	Patient Days	710,509	22	31,816		52,250	2,340	6
7	24	Travel and Seminar	Patient Days	710,509	22	12,645		52,250	930	7
8	26	Insurance	Patient Days	710,509	22	2,983		52,250	219	8
9	30	Depreciation	Patient Days	710,509	22	2,046		52,250	150	9
10	32	Interest	Patient Days	710,509	22	2,330		52,250	171	10
11	33	Real Estate Taxes	Patient Days	710,509	22	8,555		52,250	629	11
12	01	Dietary Salary	Patient Days	710,509	22	174,364	174,364	52,250	12,823	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	710,509	22	24,481		52,250	1,800	13
14	10	Nursing Salary	Patient Days	710,509	22	706,073	706,073	52,250	51,924	14
15	12	Social Service Salary	Patient Days	710,509	22	495,889	495,889	52,250	36,467	15
16	15	Emp. Ben. - Healthcare	Patient Days	710,509	22	168,758		52,250	12,410	16
17	17	Administration Salary	Patient Days	710,509	22	1,399,873	1,399,873	52,250	102,945	17
18	21	Office Salary	Patient Days	710,509	22	446,345	446,345	52,250	32,824	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	710,509	22	259,213		52,250	19,062	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,770,337	$ 3,222,544		$ 277,265	25

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation						18,543	1
2	39	Ancillary	Direct Allocation						473,650	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					$	$		$ 492,193	25

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 347,123	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					$	$		$ 347,123	25

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	MB Financial		X	Mortgage			$	$ 17,940,000			$ 823,162	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 17,940,000			$ 823,162	9
	B. Non-Facility Related*											
10	Interest Income		X								(257,425)	10
11	Interest Expense		X								730	11
12	Interest Income (Bldg Co)		X								(136,424)	12
13	See Supplemental Schedule										23,230	13
14	TOTAL Non-Facility Related						$	$			$ (369,889)	14
15	TOTALS (line 9+line14)						$	$ 17,940,000			$ 453,273	15

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

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

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.**	$	422,830	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.)	$	406,859	2
3. Under or (over) accrual (line 2 minus line 1).	$	(15,971)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	421,430	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.)**	$	339	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** $ 831 **For** 13-15 **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.	$	405,798	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	352,783	8
	2014	374,929	9
	2015	371,374	10
	2016	365,879	11
	2017	401,362	12

2018 accrual = 401,362 X 1.05 = 421,430

Allocated from Extended Care Consulting 4,868

Allocated from Extended Care Clinical $629

	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 Lemont Nursing & Rehab Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 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.	22-27-300-076-0000	Long Term Care Property	$ 311,175.70	$ 311,175.70
2.	22-27-300-077-0000	Long Term Care Property	$ 90,186.03	$ 90,186.03
3.	See Attached	Allocated from Care Center Bldg	$ 190,923.89	$ 4,867.68
4.	See Attached	Allocated from Care Center Bldg	$ 190,923.89	$ 629.12
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 783,209.51	$ 406,858.53

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 real estate tax bill.

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lemont Nursing & Rehab Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 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.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2003	$ 823,094	1
2	Allocated from Care Center Building			23,608	2
3	TOTALS			$ 846,702	3

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	158		2003	1995	$ 5,391,423	$ 769,611	35	$ 154,041	$ (615,570)	$ 4,065,576	4
5	15		2017	2017	6,640,000		35	189,714	189,714	379,428	5
6			2017	2017	1,041,901		35	29,769	29,769	59,538	6
7											7
8											8
	Improvement Type**										
9	Various			2003	48,664		20	2,045	2,045	39,155	9
10	Various			2004	35,166		20	1,266	1,266	27,990	10
11	Various			2005	7,375		20	369	369	5,132	11
12	Various			2007	30,675		20	1,809	1,809	21,183	12
13	Various			2008	46,456		20	2,323	2,323	24,473	13
14	Various			2010	120,716		20	6,301	6,301	51,223	14
15	Various			2011	280,159		20	13,516	13,516	108,950	15
16	Various			2012	169,979		20	5,237	5,237	98,879	16
17	Various			2013	139,294		20	7,051	7,051	41,374	17
18	Various			2014	140,062		20	7,226	7,226	33,707	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		116,808	1,791		1,791		79,182	68
69	Financial Statement Depreciation			121,824			(121,824)		69
70	TOTAL (lines 4 thru 69)		$ 14,208,678	$ 893,226		$ 422,457	$ (470,769)	$ 5,035,789	70

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 14,208,678	$ 893,226		$ 422,457	$ (470,769)	$ 5,035,789	1
2	Preferred Mechanical - Hot Water Tank Replacement (80 Gallon)	2015	16,795		20	840	840	3,359	2
3	Hugo'S Construction-Work On Lower Soffit Section Where Sprin	2015	11,600		20	580	580	2,320	3
4	Generator-Automatic Transfer Switch (Ats) Faceplate, Ats Ztg Se	2015	4,127		20	206	206	791	4
5	Install Expansion Joint Material At All Cracked Seams In Drywal	2015	12,000		20	600	600	2,250	5
6	12X12 Vct Comm Tile - Hardware, Roppe 4X4 Fawn Cove Base -	2015	4,571		20	914	914	3,200	6
7	1X 2-Ton Mitsubishi, Ductless Mini-Split System, 1X Wall Mount	2015	7,800		20	390	390	1,333	7
8	Hvac - Replace Compressor, Liquid Line Drier, And Contactor	2015	3,393		20	170	170	566	8
9	Installed Duct Detectors. Replaced And Tested 8 Detectors.	2015	10,332		20	517	517	1,593	9
10	4 Crimson King Maple Trees	2016	3,187		20	159	159	465	10
11	Relocate Emergency Circuits	2016	7,150		20	358	358	1,073	11
12	1 6-Ton Rooftop Unit	2016	11,480		20	574	574	1,483	12
13	1 7.5-Ton Rooftop Unit	2016	12,995		20	650	650	1,679	13
14	Clean Out & Replace Concrete	2016	5,500		20	275	275	665	14
15	Air Curtain	2017	8,578		20	429	429	858	15
16	2 Sinks	2017	9,531		20	477	477	715	16
17	Call System For 1St Floor	2017	38,304		20	1,915	1,915	2,234	17
18	29 Blinds	2017	4,433		20	222	222	259	18
19	Fire Alarm And Sprinklers	2017	11,268		20	563	563	657	19
20	Phone System Wiring	2017	9,431		20	472	472	511	20
21	Signs - Resident Rooms & Throughout Faciilty	2017	5,648		20	282	282	353	21
22	Window Treatments - Cornices	2017	6,626		20	331	331	414	22
23	Sprinkler System - Replace Piping	2017	2,829		20	141	141	283	23
24	Resupply Power To Transfer Switch & Elevator	2017	5,000		20	250	250	375	24
25	Dining Rm Wall Repair - Install Drywall, Prime, Paint	2018	22,250		20	1,020	1,020	1,020	25
26	Elevator Door Protection System	2018	4,609		20	96	96	96	26
27	Two Water Heaters	2018	17,849		20	707	707	707	27
28	Window Film Installation, Apply Ceramic 50 To Dining Room Wi	2018	7,525		20	135	135	135	28
29	Repair Metal Edge With Modified Strips In 4 Areas Of The Flat R	2018	2,500		20	125	125	125	29
30	Generator Repair- Replace Coolant, Battery, Jacket Water, Block	2018	3,612		20	181	181	181	30
31	Repaired Fire Alarm System	2018	2,518		20	126	126	126	31
32	Repaired Sprinkler System	2018	3,179		20	159	159	159	32
33	Replacement Of 3 Pipes In Ist Floor Dry System	2018	2,513		20	126	126	126	33
34	TOTAL (lines 1 thru 33)		$ 14,487,811	$ 893,226		$ 436,445	$ (456,781)	$ 5,065,895	34

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 14,487,811	$ 893,226		$ 436,445	$ (456,781)	$ 5,065,895	1
2	Repaired Fire Sprinkler Pipes	2018	4,129		20	206	206	206	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,491,939	$ 893,226		$ 436,651	$ (456,574)	$ 5,066,102	34

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 14,491,939	$ 893,226		$ 436,651	$ (456,574)	$ 5,066,102	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,491,939	$ 893,226		$ 436,651	$ (456,574)	$ 5,066,102	34

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 14,491,939	$ 893,226		$ 436,651	$ (456,574)	$ 5,066,102	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
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,491,939	$ 893,226		$ 436,651	$ (456,574)	$ 5,066,102	34

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from Extended Care Consulting-Care Center Bldg	2002	28,810	739	35	739		12,035	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	9,023	200	35	200		2,298	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	3,723	95	35	95		1,555	5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting-Care Center Bldg	2002	23,799		20			23,799	8
9	Allocated from Extended Care Consulting-Care Center Bldg	2003	28,046		20			28,046	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,393		20			1,393	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2009	251	13	20	13		126	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2014	2,413	121	20	121		603	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2015	396	20	20	20		171	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,566	78	20	78		235	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2017	2,716	136	20	136		272	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2018	1,245	62	20	62		62	16
17	Allocated from Extended Care Clinical - Care Center Bldg	2002	3,076		20			3,076	17
18	Allocated from Extended Care Clinical - Care Center Bldg	2003	3,625		20			3,625	18
19	Allocated from Extended Care Clinical - Care Center Bldg	2005	180		20			180	19
20	Allocated from Extended Care Clinical - Care Center Bldg	2009	33	2	20	2		16	20
21	Allocated from Extended Care Clinical - Care Center Bldg	2014	302	15	20	15		76	21
22	Allocated from Extended Care Clinical - Care Center Bldg	2015	51	3	20	3		22	22
23	Allocated from Extended Care Clinical - Care Center Bldg	2016	202	10	20	10		30	23
24	Allocated from Extended Care Clinical - Care Center Bldg	2017	351	18	20	18		35	24
25	Allocated from Extended Care Clinical - Care Center Bldg	2018	161	8	20	8		8	25
26	Allocated from Extended Care Consulting	2007	173	9	20	9		104	26
27	Allocated from Extended Care Consulting	2009	103	5	20	5		52	27
28	Allocated from Extended Care Consulting	2010	1,014	51	20	51		456	28
29	Allocated from Extended Care Consulting	2011	365	18	20	18		146	29
30	Allocated from Extended Care Consulting	2012	120	6	20	6		42	30
31	Allocated from Extended Care Consulting	2014	1,667	83	20	83		417	31
32	Allocated from Extended Care Consulting	2016	1,999	100	20	100		300	32
33									33
34	TOTAL (lines 1 thru 33)		$ 116,808	$ 1,791		$ 1,791	$	$ 79,182	34

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 116,808	$ 1,791		$ 1,791	$	$ 79,182	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 116,808	$ 1,791		$ 1,791	$	$ 79,182	34

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 299,561	$ 857	$ 49,213	$ 48,356	10	$ 241,288	71
72	Current Year Purchases	83,939		6,326	6,326	10	6,326	72
73	Fully Depreciated Assets	404,394				10	404,394	73
74								74
75	TOTALS	$ 787,894	$ 857	$ 55,539	$ 54,682		$ 652,008	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		Alloc. Extended Care Clinical	2012	$ 3,778	$	$	$	5	$ 3,778	76
77		Alloc. Extended Care Consulting	2014	957	192	192	(0)	5	957	77
78										78
79										79
80	TOTALS			$ 4,735	$ 192	$ 192	$ (0)		$ 4,735	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 16,131,271	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 894,275	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 492,382	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (401,893)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,722,845	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Offsite Storage				4,058			5
6								6
7	TOTAL				$ 4,058 **			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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 11,699 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 752,340	$		$ 752,340	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			107,079			107,079	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			851,210			851,210	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				525,873		525,873	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					77,780	148,477		226,257	13
14	TOTAL			$		$ 1,788,409	$ 674,350		$ 2,462,759	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 Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 (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	$ 48,572	$ 258,710	1
2	Cash-Patient Deposits	22,943	22,943	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,683,119	1,683,119	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	81,905	81,905	6
7	Other Prepaid Expenses	6,706	6,706	7
8	Accounts Receivable (owners or related parties)	4,420,000	17,543,338	8
9	Other(specify): See Attached Schedule	13,067,776	13,671,421	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 19,331,021	$ 33,268,142	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		823,094	13
14	Buildings, at Historical Cost		5,590,504	14
15	Leasehold Improvements, at Historical Cost	1,069,290	7,598,555	15
16	Equipment, at Historical Cost	567,086	1,702,862	16
17	Accumulated Depreciation (book methods)	(1,202,016)	(5,793,043)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	461	161,525	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 434,821	$ 10,083,497	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 19,765,842	$ 43,351,639	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,744,694	$ 1,744,695	26
27	Officer's Accounts Payable		5,117,778	27
28	Accounts Payable-Patient Deposits	21,388	21,388	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	226,145	226,145	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,353	9,353	31
32	Accrued Real Estate Taxes(Sch.IX-B)	421,430	421,430	32
33	Accrued Interest Payable		58,665	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	760	50,076	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,423,770	$ 7,649,530	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		17,940,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 17,940,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,423,770	$ 25,589,530	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 17,342,072	$ 17,762,109	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 19,765,842	$ 43,351,639	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 16,945,071	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 16,945,071	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	649,001	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(252,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 397,001	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)**	$ 17,342,072	24 *

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

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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	$ 16,345,958	1
2	Discounts and Allowances for all Levels	(7,903,202)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,442,756	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,270,114	6
7	Oxygen	2,818	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 7,272,932	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,297	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	504,367	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	147,570	19
20	Radiology and X-Ray	48,123	20
21	Other Medical Services	139,815	21
22	Laundry	4,729	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 845,901	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	257,425	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 257,425	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	336	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 336	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,819,350	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,924,824	31
32	Health Care	5,205,802	32
33	General Administration	3,444,161	33
	B. Capital Expense		
34	Ownership	2,813,871	34
	C. Ancillary Expense		
35	Special Cost Centers	2,462,759	35
36	Provider Participation Fee	318,932	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,170,349	40
41	**Income before Income Taxes (line 30 minus line 40)****	649,001	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 649,001	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,897,725	44
45	Private Pay - Net Inpatient Revenue	2,578,418	45
46	Medicare - Net Inpatient Revenue	574,900	46
47	Other-(specify) Hospice/ Insurance	391,713	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,442,756	49

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

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

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

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

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,029	2,452	$ 124,038	$ 50.59	1
2	Assistant Director of Nursing	1,613	1,846	67,691	36.67	2
3	Registered Nurses	23,484	26,035	857,848	32.95	3
4	Licensed Practical Nurses	33,310	36,129	1,139,498	31.54	4
5	CNAs & Orderlies	61,120	65,733	899,111	13.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,756	11,697	235,063	20.10	8
9	Activity Director	2,787	3,165	66,139	20.90	9
10	Activity Assistants	10,984	11,798	118,744	10.06	10
11	Social Service Workers	9,782	10,698	235,793	22.04	11
12	Dietician					12
13	Food Service Supervisor	1,660	1,824	43,950	24.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,439	22,444	292,874	13.05	15
16	Dishwashers					16
17	Maintenance Workers	4,540	5,046	114,707	22.73	17
18	Housekeepers	16,423	18,077	192,364	10.64	18
19	Laundry	8,005	8,693	99,768	11.48	19
20	Administrator	2,000	2,189	110,359	50.42	20
21	Assistant Administrator	1,410	1,614	51,651	32.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,066	9,124	181,257	19.87	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	2,947	3,252	54,942	16.89	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	46	68	1,026	15.09	33
34	TOTAL (lines 1 - 33)	221,401	241,884	$ 4,886,823 *	$ 20.20	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	645	$ 31,595	01-03	35
36	Medical Director	Monthly	39,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,027	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Dental Consultant	Monthly	234	10-03	47
48					48
49	TOTAL (lines 35 - 48)	645	$ 81,856		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,336	$ 224,069	10-03	50
51	Licensed Practical Nurses	2,443	109,087	10-03	51
52	Certified Nurse Assistants/Aides	28,952	729,843	10-03	52
53	TOTAL (lines 50 - 52)	34,731	$ 1,062,999		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ma-Maivette Gleeson	Administrator		$ 1,763
Niki Mehta	Administrator		106,889
Jamie Krieps	Asst Administrator		51,026
Jennifer Davey	Asst Administrator		2,332
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 162,010

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
See Attached	Legal	$ 3,427
Paycor	Payroll Processing	25,513
Matrixcare	Billing Software	18,784
Ability Network	Medicare Billing	8,785
National Datacare Corp.	Resident Fund Processing	896
Marcum LLP	Accounting Services	35,654
Personnel Planners	Unemployment Services	2,070
Extended Care Consulting	Home Office Allocation	510,768
Extended Care Clinical	Home Office Allocation	170,256
Pinnacle Quality Insight	Satisfaction Surveys	2,716
Benefit Services Group Inc.	Benefit Administration	813
See Supplemental Schedule		61,498
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 841,180

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 71,778
Unemployment Compensation Insurance	60,883
FICA Taxes	359,200
Employee Health Insurance	200,282
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	20,955
Holiday Expense	4,752
Employee Physicals	87
TOTAL (agree to Schedule V, line 22, col.8)	$ 717,937

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	56,676
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 661	6,611
Dues & Subscription	20,812
Licenses & Fees	5,973
Allocated from Extended Care Consulting	2,024
Allocated from Extended Care Clinical	1,143
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 95,229

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,322
Allocated from Extended Care Consulting	384
Allocated from Extended Care Clinical	930
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,636

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $21,567**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **79,059** Line **10**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **318,932**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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