



Facility Name & ID Number Cedar Pointe Rehab & Nursing

# 0050955 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 02/15/2013

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	74	Skilled (SNF)	148	50,690	1
2		Skilled Pediatric (SNF/PED)			2
3	411	Intermediate (ICF)	337	126,335	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	485	TOTALS	485	177,025	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	19,206	11	4,209	23,426	8
9	SNF/PED					9
10	ICF	79,286		215	79,501	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	98,492	11	4,424	102,927	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.14%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold 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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 05/20/2010

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 05/20/2010 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 148 and days of care provided 4,209

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Cedar Pointe Rehab &amp; Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	524,315	69,409	18,542	612,266		612,266		612,266		1
2	Food Purchase		449,259		449,259		449,259	3,231	452,490		2
3	Housekeeping	323,518	48,958		372,476		372,476	3,136	375,612		3
4	Laundry	101,679	23,760		125,439		125,439		125,439		4
5	Heat and Other Utilities			231,710	231,710		231,710	3,228	234,938		5
6	Maintenance	293,495		112,771	406,266		406,266	(20,853)	385,413		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,243,007	591,386	363,023	2,197,416		2,197,416	(11,259)	2,186,157		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	3,442,821	96,534	12,689	3,552,044		3,552,044	72,010	3,624,054		10
10a	Therapy	98,673			98,673		98,673		98,673		10a
11	Activities	202,324	11,900	4,189	218,413		218,413		218,413		11
12	Social Services	327,007		6,933	333,940		333,940		333,940		12
13	CNA Training										13
14	Program Transportation			1,644	1,644		1,644		1,644		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,070,825	108,434	49,455	4,228,714		4,228,714	72,010	4,300,724		16
	<b>C. General Administration</b>										
17	Administrative	150,054		467,280	617,334		617,334	(304,598)	312,736		17
18	Directors Fees										18
19	Professional Services			147,373	147,373	(16,690)	130,683	(42,801)	87,882		19
20	Dues, Fees, Subscriptions & Promotions			57,763	57,763		57,763	(16,623)	41,140		20
21	Clerical & General Office Expenses	82,314		112,801	195,115		195,115	90,071	285,186		21
22	Employee Benefits & Payroll Taxes			1,029,480	1,029,480		1,029,480		1,029,480		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,522	3,522		3,522	2,106	5,628		24
25	Other Admin. Staff Transportation			855	855		855	8,615	9,470		25
26	Insurance-Prop.Liab.Malpractice			378,582	378,582		378,582		378,582		26
27	Other (specify):*							60,294	60,294		27
28	<b>TOTAL General Administration</b>	232,368		2,197,656	2,430,024	(16,690)	2,413,334	(202,935)	2,210,399		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,546,200	699,820	2,610,134	8,856,154	(16,690)	8,839,464	(142,183)	8,697,281		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Cedar Pointe Rehab & Nursing

#0050955

Report Period Beginning:

01/01/13

Ending:

12/31/13

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			30,668	30,668		30,668	84,079	114,747			30
31	Amortization of Pre-Op. & Org.			1,844	1,844		1,844		1,844			31
32	Interest			37,203	37,203		37,203	8,288	45,491			32
33	Real Estate Taxes			1,134,993	1,134,993	16,690	1,151,683	7,523	1,159,206			33
34	Rent-Facility & Grounds			2,379,785	2,379,785		2,379,785		2,379,785			34
35	Rent-Equipment & Vehicles			9,591	9,591		9,591		9,591			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			3,594,084	3,594,084	16,690	3,610,774	99,890	3,710,664			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		78,030	419,489	497,519		497,519		497,519			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			718,615	718,615		718,615		718,615			42
43	Other (specify):*			65,838	65,838		65,838	(65,838)				43
44	<b>TOTAL Special Cost Centers</b>		78,030	1,203,942	1,281,972		1,281,972	(65,838)	1,216,134			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,546,200	777,850	7,408,160	13,732,210		13,732,210	(108,131)	13,624,079			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cedar Pointe Rehab & Nursing

# 0050955

Report Period Beginning: 01/01/13

Ending: 12/31/13

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	72,673	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(0)	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	(42,526)	21		18
19	Entertainment				19
20	Contributions	(250)	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				24
25	Fund Raising, Advertising and Promotional	(1,408)	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	(201,178)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (172,689)</b>		<b>\$</b>	<b>30</b>

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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	64,558		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 64,558</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (108,131)</b>		<b>37</b>

\*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	2	3	4	
		Yes	No	Amount	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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Cedar Pointe Rehab & Nursing

ID# 0050955

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Rental Income- Antenna	\$ (37,969)	06	1
2	Misc. Income	(12,678)	21	2
3	Marketing Expense	(46,294)	43	3
4	Bank Charges	(5,877)	21	4
5	Medical Record Income	(460)	21	5
6	Additional R&M	4,830	06	6
7	Non-Allowable Travel	(136)	25	7
8	Non-Allowable Legal	(7,625)	19	8
9	COPE Dues	(15,561)	20	9
10	Sequestration	(20,927)	21	10
11	Marketing Consultant	(19,544)	43	11
12	PY Seminar	(105)	24	12
13	Jury Duty Income	(69)	21	13
14	Reimbursed Legal Fees	(38,763)	19	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	(201,178)	49

Cedar Pointe Rehab & Nursing

ID# 0050955

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Cedar Pointe Rehab &amp; Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending:

12/31/13

## 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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(0)		3,148		83							3,231	2
3	Housekeeping			3,136									3,136	3
4	Laundry													4
5	Heat and Other Utilities			3,228									3,228	5
6	Maintenance	(33,139)		12,125	161								(20,853)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(33,139)</b>		<b>21,637</b>	<b>161</b>	<b>83</b>							<b>(11,259)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records					72,010							72,010	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>					<b>72,010</b>							<b>72,010</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(145,783)		(158,815)							(304,598)	17
18	Directors Fees													18
19	Professional Services	(46,388)		2,071	978	538							(42,801)	19
20	Fees, Subscriptions & Promotions	(17,219)		256		340							(16,623)	20
21	Clerical & General Office Expenses	(82,537)		145,418		27,190							90,071	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(105)		554		1,657							2,106	24
25	Other Admin. Staff Transportation	(136)				8,751							8,615	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			40,899		19,395							60,294	27
28	<b>TOTAL General Administration</b>	<b>(146,385)</b>		<b>43,415</b>	<b>978</b>	<b>(100,944)</b>							<b>(202,935)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(179,524)</b>		<b>65,052</b>	<b>1,139</b>	<b>(28,851)</b>							<b>(142,183)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Cedar Pointe Rehab & Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	72,673		31	11,375								84,079	30
31	Amortization of Pre-Op. & Org.													31
32	Interest				8,288								8,288	32
33	Real Estate Taxes				7,523								7,523	33
34	Rent-Facility & Grounds			24,660	(24,660)									34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>72,673</b>		<b>24,691</b>	<b>2,526</b>								<b>99,890</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(65,838)											(65,838)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(65,838)</b>											<b>(65,838)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(172,689)</b>		<b>89,743</b>	<b>3,665</b>	<b>(28,851)</b>							<b>(108,131)</b>	<b>45</b>

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 Supplemental Schedule		See Supplemental Schedule		See Supplemental Schedule		

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)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2	DIETARY	Premier Healthcare & Financial Services, Inc.	100.00%	\$ 3,148	\$ 3,148
16	V	3	HOUSEKEEPING	Premier Healthcare & Financial Services, Inc.	100.00%	3,136	3,136
17	V	5	UTILITIES	Premier Healthcare & Financial Services, Inc.	100.00%	3,228	3,228
18	V	6	REPAIRS AND MAINTENANCE	Premier Healthcare & Financial Services, Inc.	100.00%	12,125	12,125
19	V	17	S WEBSTER SALARY	Premier Healthcare & Financial Services, Inc.	100.00%	53,358	53,358
20	V	17	Y LEVOVITZ-SALARY	Premier Healthcare & Financial Services, Inc.	100.00%	53,153	53,153
21	V	19	PROFESSIONAL FEES	Premier Healthcare & Financial Services, Inc.	100.00%	2,071	2,071
22	V	20	DUES FEES SUBSCRIPTIONS	Premier Healthcare & Financial Services, Inc.	100.00%	256	256
23	V	21	CLERICAL AND GENERAL	Premier Healthcare & Financial Services, Inc.	100.00%	12,054	12,054
24	V	21	CLERICAL & GENERAL SALARIES	Premier Healthcare & Financial Services, Inc.	100.00%	133,365	133,365
25	V	24	SEMINARS & EDUCATION	Premier Healthcare & Financial Services, Inc.	100.00%	554	554
26	V	27	EMPLOYEE BEN. GEN ADMIN.	Premier Healthcare & Financial Services, Inc.	100.00%	40,899	40,899
27	V	30	DEPRECIATION	Premier Healthcare & Financial Services, Inc.	100.00%	31	31
28	V	34	RENT	Premier Healthcare & Financial Services, Inc.	100.00%	24,660	24,660
29	V						
30	V						
31	V	17	MANAGEMENT FEES	Premier Healthcare & Financial Services, Inc.	100.00%		(252,294)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 252,294			\$ 342,037	\$ * 89,743

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 REPAIRS & MAINTENANCE	\$	Premier Healthcare Realty, LLC	100.00%	\$ 161	\$	161	15
16	V	19 PROFESSIONAL FEES		Premier Healthcare Realty, LLC		978		978	16
17	V	30 DEPRECIATION		Premier Healthcare Realty, LLC		11,375		11,375	17
18	V	32 INTEREST EXPENSE		Premier Healthcare Realty, LLC		8,288		8,288	18
19	V	33 REAL ESTATE TAXES		Premier Healthcare Realty, LLC		7,523		7,523	19
20	V	34 RENT	24,660					(24,660)	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		\$ 24,660			\$ 28,325	\$ *	3,665	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 DIETARY	\$	iCare Consulting Services LLC	100.00%	\$ 83	\$	83	15
16	V	10 NURSING SALARIES		iCare Consulting Services LLC	100.00%	72,010		72,010	16
17	V	17 ADMIN SALARY NON-RELATED		iCare Consulting Services LLC	100.00%	56,171		56,171	17
18	V	19 PROFESSIONAL FEES		iCare Consulting Services LLC	100.00%	538		538	18
19	V	20 DUES FEES SUBSCRIPTIONS		iCare Consulting Services LLC	100.00%	340		340	19
20	V	21 CLERICAL AND GENERAL		iCare Consulting Services LLC	100.00%	6,948		6,948	20
21	V	21 CLERICAL & GENERAL SALARIES		iCare Consulting Services LLC	100.00%	20,242		20,242	21
22	V	24 SEMINARS & EDUCATION		iCare Consulting Services LLC	100.00%	1,657		1,657	22
23	V	25 AUTO EXPENSE		iCare Consulting Services LLC	100.00%	8,751		8,751	23
24	V	27 EMPLOYEE BEN. GEN ADMIN.		iCare Consulting Services LLC	100.00%	19,395		19,395	24
25	V								25
26	V								26
27	V								27
28	V	17 MANAGEMENT FEES	214,986	iCare Consulting Services LLC	100.00%			(214,986)	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		\$ 214,986			\$ 186,135	\$ *	(28,851)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	CHAIM O. LEVOVITZ	2.165%	CENTER HOME HISPANIC ELDERLY,LLC	CHICAGO	PREMIER HEALTHCARE & FIN	SKOKIE, IL	MANAGEMENT CO.	1
2	ELI WEBSTER	2.062%	PINE CREST HEALTH CARE, LLC	HAZEL CREST	PREMIER HEALTHCARE REAL	SKOKIE, IL	BUILDING CO.	2
3	EZ & A LLC	4.124%	PARK VIEW RWHAB CENTER, LLC	CHICAGO	ICARE CONSULTING SERVICES	SKOKIE, IL	CONSULTING	3
4	HOWARD L. WENGROW	16.495%						4
5	JEFFREY J. WEBSTER	12.371%						5
6	SHIMON WEBSTER	32.474%						6
7	YERUCHOM LEVOVITZ	30.309%						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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Cedar Pointe Rehab & Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cedar Pointe Rehab & Nursing # 0050955 Report Period Beginning: 01/01/13 Ending: 12/31/13

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Shimon Webster	Owner	Administrative	32.47%	See Attached	15.78	39.45%	Alloc Salary	\$ 53,358	17-7	1
2	Yeruchom Levovitz	Owner	Administrative	30.31%	See Attached	15.78	39.45%	Alloc Salary	53,153	17-7	2
3	Moshe Levovitz	Relative	Administrative	0.00%	None	40	100%	Salary	78,627	17-1	3
4	Yakov Kohen	Relative	Clerical	0.00%	See Attached	15.78	39.45%	Alloc Salary	32,133	21-7	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	\$ 217,271		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cedar Pointe Rehab & Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cedar Pointe Rehab & Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

Name of Related Organization PREMIER HEALTHCARE & FINANCIAL SER  
 Street Address 8153 N. LAWNDALE  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 773) 945-1000  
 Fax Number ( 773) 751-2027

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	DIETARY	PATIENT DAYS	260,876	4	\$ 7,978	\$ 102,927	\$ 3,148	1
2	3	HOUSEKEEPING	PATIENT DAYS	260,876	4	7,949	102,927	3,136	2
3	5	UTILITIES	PATIENT DAYS	260,876	4	8,182	102,927	3,228	3
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	260,876	4	30,733	102,927	12,125	4
5	17	S WEBSTER SALARY	PATIENT DAYS	260,876	4	135,240	135,240	53,358	5
6	17	Y LEVOVITZ-SALARY	PATIENT DAYS	260,876	4	134,720	134,720	53,153	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	260,876	4	5,250	102,927	2,071	7
8	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	260,876	4	650	102,927	256	8
9	21	CLERICAL AND GENERAL	PATIENT DAYS	260,876	4	30,551	102,927	12,054	9
10	21	CLERICAL & GENERAL SALA	PATIENT DAYS	260,876	4	338,022	338,022	133,365	10
11	24	SEMINARS & EDUCATION	PATIENT DAYS	260,876	4	1,405	102,927	554	11
12	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	260,876	4	103,662	102,927	40,899	12
13	30	DEPRECIATION	PATIENT DAYS	260,876	4	79	102,927	31	13
14	34	RENT	PATIENT DAYS	260,876	4	62,503	102,927	24,660	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 866,924	\$ 607,982	\$ 342,037		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cedar Pointe Rehab & Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

Name of Related Organization Premier Healthcare Realty, LLC  
 Street Address 8153 N. LAWNSDALE  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number (773) 945-1000  
 Fax Number (773) 751-2027

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	REPAIRS & MAINTENANCE	PATIENT DAYS	260,876	4	\$ 408	\$ 102,927	\$ 161	1
2	20	PROFESSIONAL FEES	PATIENT DAYS	260,876	4	2,480	102,927	978	2
3	30	DEPRECIATION	PATIENT DAYS	260,876	4	28,831	102,927	11,375	3
4	32	INTEREST EXPENSE	PATIENT DAYS	260,876	4	21,006	102,927	8,288	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	260,876	4	19,067	102,927	7,523	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					\$ 71,792	\$	\$ 28,325	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cedar Pointe Rehab & Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

Name of Related Organization iCare Consulting Services LLC  
 Street Address 8153 N. LAWDALE  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 773) 945-1000  
 Fax Number ( 773) 751-2027

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	DIETARY	PATIENT DAYS	260,876	4	\$ 211	\$ 102,927	\$ 83	1	
2	10	NURSING SALARIES	PATIENT DAYS	260,876	4	182,513	182,513	102,927	72,010	2
3	17	ADMIN SALARY NON-RELAT	PATIENT DAYS	260,876	4	142,370	142,370	102,927	56,171	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	260,876	4	1,363	102,927	538	4	
5	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	260,876	4	863	102,927	340	5	
6	21	CLERICAL AND GENERAL	PATIENT DAYS	260,876	4	17,606	102,927	6,948	6	
7	21	CLERICAL & GENERAL SALA	PATIENT DAYS	260,876	4	51,306	51,306	102,927	20,242	7
8	24	SEMINARS & EDUCATION	PATIENT DAYS	260,876	4	4,199	102,927	1,657	8	
9	25	AUTO EXPENSE	PATIENT DAYS	260,876	4	22,181	102,927	8,751	9	
10	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	260,876	4	49,157	102,927	19,395	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				\$ 471,769	\$ 376,189		\$ 186,135	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cedar Pointe Rehab & Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cedar Pointe Rehab & Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cedar Pointe Rehab & Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cedar Pointe Rehab & Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cedar Pointe Rehab & Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cedar Pointe Rehab & Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

SEE ACCOUNTANTS' COMPILATION REPORT

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6	MB Financial		X	Line of Credit				1,055,000		37,203										
7	Premier Healthcare & Financial Servi		X							8,288										
8																				
9	<b>TOTAL Facility Related</b>							\$ 1,055,000		\$ 45,491										
<b>B. Non-Facility Related*</b>																				
10																				
11																				
12																				
13																				
14	<b>TOTAL Non-Facility Related</b>							\$		\$										
15	<b>TOTALS (line 9+line14)</b>							\$ 1,055,000		\$ 45,491										

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

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

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

Facility Name & ID Number

Cedar Pointe Rehab & Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending:

12/31/13

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	<b>A. Directly Facility Related</b>															
	<b>Long-Term</b>															
1							\$	\$			\$					
2																
3																
4																
5																
6																
7	<b>TOTAL Long-Term</b>															
	<b>Working Capital</b>															
8							\$	\$			\$					
9																
10																
11																
12																
13																
14	<b>TOTAL Working Capital</b>															
	<b>B. Non-Facility Related*</b>															
15							\$	\$			\$					
16																
17																
18																
19																
20	<b>TOTAL Non-Facility Related</b>															

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)



## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cedar Pointe Rehab & Nursing COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050955

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>16-29-202-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>161,708.21</u>	\$ <u>161,708.21</u>
2. <u>16-29-202-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>161,708.21</u>	\$ <u>161,708.21</u>
3. <u>16-29-202-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>323,416.71</u>	\$ <u>323,416.71</u>
4. <u>16-29-202-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>184,310.80</u>	\$ <u>184,310.80</u>
5. <u>16-29-202-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>323,319.85</u>	\$ <u>323,319.85</u>
6. <u>10-23-324-003-0000</u>	<u>Home Office Allocation</u>	\$ <u>2,427.62</u>	\$ <u>957.70</u>
7. <u>10-23-324-042-0000</u>	<u>Home Office Allocation</u>	\$ <u>20,996.47</u>	\$ <u>8,283.11</u>
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>1,177,887.87</u></u>	\$ <u><u>1,163,704.58</u></u>

**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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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.**



4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ _____	\$ _____

**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 & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Cedar Pointe Rehab & Nursing

# 0050955 Report Period Beginning:

01/01/13 Ending:

12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 124,020 B. General Construction Type: Exterior Masonry Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (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  NO  
 If so, please complete the following:

1. Total Amount Incurred: 27,663 2. Number of Years Over Which it is Being Amortized: 15  
 3. Current Period Amortization: 1,844 4. Dates Incurred: 2009

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Premier Healthcare &amp; Financial Services, Inc.</u>			\$ <u>7,496</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>7,496</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		2009		7,005		20	467	467	2,024	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cedar Pointe Rehab & Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			437,873	10,698	18,344	7,646	38,125	68
69				30,668		(30,668)		69
70			\$ 444,878	\$ 41,366	\$ 18,811	\$ (22,555)	\$ 40,149	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Cedar Pointe Rehab &amp; Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 444,878	\$ 41,366		\$ 18,811	\$ (22,555)	\$ 40,149	1
2	Furnishing And Installation Of Exhaust Fan	2010	2,625		20	175	175	591	2
3	Electrical Work For Lighting In Bedrooms	2010	6,142		20	410	410	1,383	3
4	Security System Installation	2010	19,280		20	1,286	1,286	4,018	4
5	Compressor And Chiller Coil	2010	23,745		20	1,584	1,584	4,948	5
6	Ptac Units	2010	17,607		20	3,521	3,521	12,325	6
7	Air Conditioning Repairs	2010	3,740		20	187	187	686	7
8	Tuckpointing	2011	45,500		20	2,275	2,275	4,929	8
9	Overhead Bed Lights	2011	2,950		20	590	590	1,623	9
10	Sprinkler System Improvement	2011	9,775		20	489	489	1,385	10
11	Hot Water Storage Tank	2011	2,596		20	519	519	1,125	11
12	Hands Free Phones In Elevator	2011	3,150		20	315	315	709	12
13	Cubicle Curtain	2011	3,158		20	158	158	461	13
14	Baking Deck, Ceramic, Probe Assembly, Thermostat, And Gasket	2011	2,511		20	126	126	335	14
15	Refrigeration Lines, Drain Lines, Insulation	2012	7,810		20	1,562	1,562	2,083	15
16	Sprinkler System	2012	3,067		20	79	79	121	16
17	Fire Alarm	2012	8,343		20	214	214	241	17
18	Tuckpointing/Roofing	2012	7,375		20	189	189	292	18
19	Schwartz Drywall, Tile, Shower Faucets	2012	35,008		20	1,750	1,750	3,355	19
20	Walk In Cooler, Valves, Thermostats	2012	6,298		20	1,260	1,260	1,680	20
21	Tile, Protection For Tile	2012	14,892		20	745	745	1,489	21
22	Corian Sinks, Wall Accessories - Bathrooms	2012	5,729		20	286	286	430	22
23	Enamel Partitions, Plastic Parts, Lock And Hardware Changes	2012	4,280		20	214	214	410	23
24	B&B Formica Corian Countertops - Bathrooms	2012	3,694		20	185	185	354	24
25	Replace Gaskets,Radiator & Clamps	2012	3,792		20	190	190	269	25
26	Plumbing	2012	4,210		20	211	211	281	26
27	Staircase & Handrails Repair	2012	6,650		20	333	333	665	27
28	Repair Backflow	2012	2,688		20	134	134	146	28
29	Econocare-Flooring ,Painting, Moldings Doors, Nurses Stations, B	2012	203,020		20	10,151	10,151	16,918	29
30	Water And Hose Pump	2013	4,526		20	170	170	170	30
31	Outlets For Computer Kiosks	2013	2,700		20	405	405	405	31
32	Traveling Cables For Elevators	2013	7,750		20	291	291	291	32
33	Sprinkler Work	2013	6,559		20	246	246	246	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 926,048	\$ 41,366		\$ 49,058	\$ 7,692	\$ 104,508	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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		\$ 926,048	\$ 41,366		\$ 49,058	\$ 7,692	\$ 104,508	1
2	Traveling Cables For Elevator	2013	7,750		20	258	258	258	2
3	Heat Detectors And Fire Alarm	2013	5,518		20	184	184	184	3
4	Chiller Replacement	2013	42,900		20	1,073	1,073	1,073	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 982,216	\$ 41,366		\$ 50,573	\$ 9,207	\$ 106,022	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 982,216	\$ 41,366		\$ 50,573	\$ 9,207	\$ 106,022	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 982,216	\$ 41,366		\$ 50,573	\$ 9,207	\$ 106,022	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward	\$ 982,216	\$ 41,366		\$ 50,573	\$ 9,207	\$ 106,022		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 982,216	\$ 41,366		\$ 50,573	\$ 9,207	\$ 106,022		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**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	<b>Building Company Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements</b>								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	Allocated from Premier HC Realty, LLC	2011	146,931	3,767	35	4,198	431	8,742	3
4	Allocated from Premier HC Realty, LLC	2012	18,707	479	35	534	55	1,069	4
5									5
6									6
7									7
8	<b>Leasehold Information</b>								8
9	Premier Healthcare & Financial Services, Inc.	2012	3,334	31	20	167	136	334	9
10	Allocated from Premier HC Realty, LLC	2011	261,326	6,227	20	13,066	6,839	27,222	10
11	Allocated from Premier HC Realty, LLC	2012	7,575	194	20	379	185	758	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Cedar Pointe Rehab & Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending:

12/31/13

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1		\$	\$		\$	\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (12H &amp; 12I lines 1 thru 33)</b>		\$ 437,873	\$ 10,698		\$ 18,344	\$ 7,646	\$ 38,125	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 343,715	\$ 240	\$ 57,711	\$ 57,471	10	\$ 155,344	71
72	Current Year Purchases	35,871	467	6,462	5,995	10	6,462	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 379,586	\$ 707	\$ 64,173	\$ 63,466		\$ 161,806	75

D. Vehicle Costs. (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,369,298	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 42,073	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 114,746	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 72,673	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 267,829	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Westshire Healthcare Properties LLC

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:		485		\$ 2,379,785			3
4	Additions							4
5								5
6								6
7	TOTAL		485		\$ 2,379,785			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
 by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ 9,592 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cedar Pointe Rehab & Nursing # 0050955 Report Period Beginning: 01/01/13 Ending: 12/31/13  
**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.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39 - 03	hrs			419,489			419,489	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					73,367	73,367	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify): <u>See Supplemental</u>							4,663	4,663	13	
14	<b>TOTAL</b>			\$		\$ 419,489	\$	78,030	\$ 497,519	14	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cedar Pointe Rehab & Nursing# 0050955Report Period Beginning: 01/01/13

Ending:

12/31/13

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 44,281	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,851,489		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	261,270		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	13,707		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,170,747	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	237,997		15
16	Equipment, at Historical Cost	540,395		16
17	Accumulated Depreciation (book methods)	(542,906)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	27,663		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(8,453)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	500,375		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 755,071	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,925,818	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 717,807	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,280		28
29	Short-Term Notes Payable	1,055,000		29
30	Accrued Salaries Payable	624,719		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	144,496		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,568,302	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>	7,763		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 7,763	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,576,065	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 349,753	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,925,818	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 640,136	1
2	Restatements (describe):		2
3	Rounding Adj	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 640,134	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(47,881)	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	(242,500)	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)	\$ (290,381)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 349,753	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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.**

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 14,043,710	1
2	Discounts and Allowances for all Levels	(449,320)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 13,594,390</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	89,939	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 89,939</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 13,684,329</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,197,416	31
32	Health Care	4,228,714	32
33	General Administration	2,430,024	33
<b>B. Capital Expense</b>			
34	Ownership	3,594,084	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	563,357	35
36	Provider Participation Fee	718,615	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 13,732,210</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(47,881)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (47,881)</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 11,784,717	44
45	Private Pay - Net Inpatient Revenue	4,348	45
46	Medicare - Net Inpatient Revenue	1,655,578	46
47	Other-(specify) <u>Hospice</u>	37,229	47
48	Other-(specify) <u>Insurance</u>	112,518	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 13,594,390</b>	49

\* This must agree with page 4, line 45, column 4.  
 \*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.  
 \*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Cedar Pointe Rehab & Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,081	\$ 91,499	\$ 43.97	1
2	Assistant Director of Nursing	5,321	5,860	178,598	30.48	2
3	Registered Nurses	12,224	14,148	450,851	31.87	3
4	Licensed Practical Nurses	43,227	47,175	1,134,522	24.05	4
5	CNAs & Orderlies	110,777	121,594	1,540,661	12.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,165	5,813	98,673	16.97	8
9	Activity Director	2,604	2,825	52,947	18.74	9
10	Activity Assistants	12,169	13,358	149,377	11.18	10
11	Social Service Workers	23,185	24,331	327,007	13.44	11
12	Dietician					12
13	Food Service Supervisor	2,051	2,198	44,760	20.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	37,121	41,148	479,555	11.65	15
16	Dishwashers					16
17	Maintenance Workers	22,948	24,359	293,495	12.05	17
18	Housekeepers	27,257	30,603	323,518	10.57	18
19	Laundry	7,363	8,008	101,679	12.70	19
20	Administrator	2,105	2,142	78,627	36.71	20
21	Assistant Administrator	1,983	2,019	71,427	35.38	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,908	6,350	82,314	12.96	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	2,501	2,751	46,690	16.97	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	325,989	356,763	\$ 5,546,200 *	\$ 15.55	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 18,542	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant	Monthly	3,456	10-03	37
38	Nurse Consultant	94	5,850	10-03	38
39	Pharmacist Consultant	Monthly	3,383	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	70	4,189	11-03	44
45	Social Service Consultant	115	6,933	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	279	\$ 66,353		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Moshe Levovitz	Administrator	0	\$ 78,627	Workers' Compensation Insurance	\$ 196,997	IDPH License Fee	\$ 1,990	
Olivia Carrey	Asst. Admin.	0	63,035	Unemployment Compensation Insurance	193,167	Advertising: Employee Recruitment	14,169	
Eli Waldman	Asst. Admin.	0	8,392	FICA Taxes	405,488	Health Care Worker Background Check	3,042	
				Employee Health Insurance	207,500	(Indicate # of checks performed 304 )		
				Employee Meals		Patient Background Checks	101 1,014	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	15,114	
				Pension Expense	16,695	Licenses and Permits	5,215	
				Other Employee Benefits	4,908	Allocated from iCare Consulting	340	
				Holiday Expense	4,725	Allocated from Premier	256	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 150,054					
<b>B. Administrative - Other</b>								
Description			Amount					
Premier Healthcare & Financial Services, Inc- Mgmt Fees			\$ 252,294				Less: Public Relations Expense ( )	
iCare Consulting Services LLC- Mgmt Fees			214,986				Non-allowable advertising ( )	
							Yellow page advertising ( )	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 467,280	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,029,480	
(Attach a copy of any management service agreement)							TOTAL (agree to Sch. V, line 20, col. 8) \$ 41,140	
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Skidelsky	R/E Tax Appeals		\$ 16,690				Out-of-State Travel	\$
FR&R	Accounting		15,959					
MTS Consulting	Tax Consulting		4,244					
Reliable Health System	Computer Services		19,105				In-State Travel	
Emdeon Business Service	Computer Services		2,012					
E- Health Data	Computer Services		4,275					
Tik Tek It Solutions	Computer Services		125					
Point Click Care	Billing Software		22,257				Seminar Expense	3,417
Various	Legal		62,704				Allocated from Premier	554
							Allocated from iCare	1,657
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 147,371				\$ 5,628	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Cedar Pointe Rehab &amp; Nursing

# 0050955

Report Period Beginning:

01/01/13

Ending:

12/31/13

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Council on LTC \$29,925
- (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. \$ 21,853 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. \$ 718,615  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

## SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation 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? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.