

Facility Name & ID Number Chester Rehab & Nrsng Center

0051532 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

N/A

	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	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3	37	Intermediate (ICF)	37	13,505	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	117	TOTALS	117	42,705	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	5,125	2,961	702	8,788	8
9	SNF/PED					9
10	ICF	2,370	1,370	325	4,065	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,495	4,331	1,027	12,853	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 30.10%

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

0 (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)

N/A

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 6/1/11

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

YES Date 6/1/11 NO

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

YES NO If YES, enter number of beds certified 31 and days of care provided 1,027

Medicare Intermediary Wisconsin Physician Services

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.

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
	A. General Services										
1	Dietary	130,523	4,785	4,990	140,298		140,298	(108)	140,190		1
2	Food Purchase		64,714		64,714		64,714		64,714		2
3	Housekeeping	66,274	8,391		74,665		74,665		74,665		3
4	Laundry	29,174	5,177		34,351		34,351		34,351		4
5	Heat and Other Utilities			90,355	90,355		90,355	2,208	92,563		5
6	Maintenance	26,080	8,796	27,833	62,709		62,709	17	62,726		6
7	Other (specify):*										7
8	TOTAL General Services	252,051	91,863	123,178	467,092		467,092	2,117	469,209		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	703,257	96,494	29,449	829,200		829,200	(4,318)	824,882		10
10a	Therapy			153,341	153,341		153,341		153,341		10a
11	Activities	22,215	1,922		24,137		24,137		24,137		11
12	Social Services	29,919		5,148	35,067		35,067		35,067		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Pharmacy Consultant			1,752	1,752		1,752		1,752		15
16	TOTAL Health Care and Programs	755,391	98,416	195,690	1,049,497		1,049,497	(4,318)	1,045,179		16
	C. General Administration										
17	Administrative	50,011			50,011		50,011		50,011		17
18	Directors Fees										18
19	Professional Services			215,290	215,290		215,290	(168,302)	46,988		19
20	Dues, Fees, Subscriptions & Promotions			1,295	1,295		1,295	76	1,371		20
21	Clerical & General Office Expenses		14,300	17,190	31,490		31,490	100,255	131,745		21
22	Employee Benefits & Payroll Taxes			196,973	196,973		196,973	27,686	224,659		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,186	2,186		2,186	6,923	9,109		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			147,431	147,431		147,431	70	147,501		26
27	Other (specify):*										27
28	TOTAL General Administration	50,011	14,300	580,365	644,676		644,676	(33,292)	611,384		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,057,453	204,579	899,233	2,161,265		2,161,265	(35,493)	2,125,772		29

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

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

Facility Name & ID Number

Chester Rehab & Nrsng Center

#0051532

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	
	D. Ownership											
30	Depreciation			5,754	5,754		5,754	2,349	8,103			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,997	30,997		30,997	(1,567)	29,430			32
33	Real Estate Taxes			3,300	3,300		3,300		3,300			33
34	Rent-Facility & Grounds			264,000	264,000		264,000	4,667	268,667			34
35	Rent-Equipment & Vehicles							119	119			35
36	Other (specify):*											36
37	TOTAL Ownership			304,051	304,051		304,051	5,568	309,619			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		22,706		22,706		22,706		22,706			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			135,527	135,527		135,527		135,527			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		22,706	135,527	158,233		158,233		158,233			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,057,453	227,285	1,338,811	2,623,549		2,623,549	(29,925)	2,593,624			45

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

Facility Name & ID Number Chester Rehab & Nrsng Center

0051532

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	1,402	30		9
10	Interest and Other Investment Income	(1,567)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(108)	1		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	12,845	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,866)	21		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 10,706		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	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)	(40,631)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (40,631)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (29,925)		37

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

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

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

Chester Rehab & Nrsg Center

ID# 0051532

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chester Rehab & Nrsrg Center# 0051532

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(108)	0	0	0	0	0	0	0	0	0	0	(108)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,208	0	0	0	0	0	0	0	0	0	2,208	5
6	Maintenance	0	17	0	0	0	0	0	0	0	0	0	17	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(108)	2,225	0	0	0	0	0	0	0	0	0	2,117	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(4,318)	0	0	0	0	0	0	0	0	0	(4,318)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(4,318)	0	0	0	0	0	0	0	0	0	(4,318)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(168,302)	0	0	0	0	0	0	0	0	0	(168,302)	19
20	Fees, Subscriptions & Promotions	0	76	0	0	0	0	0	0	0	0	0	76	20
21	Clerical & General Office Expenses	10,979	85,865	3,411	0	0	0	0	0	0	0	0	100,255	21
22	Employee Benefits & Payroll Taxes	0	27,686	0	0	0	0	0	0	0	0	0	27,686	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,923	0	0	0	0	0	0	0	0	0	6,923	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	70	0	0	0	0	0	0	0	0	0	70	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	10,979	(47,682)	3,411	0	(33,292)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	10,871	(49,775)	3,411	0	(35,493)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chester Rehab & Nrsg Center

0051532

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	1,402	947	0	0	0	0	0	0	0	0	0	2,349	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,567)	0	0	0	0	0	0	0	0	0	0	(1,567)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	4,667	0	0	0	0	0	0	0	0	0	4,667	34
35	Rent-Equipment & Vehicles	0	119	0	0	0	0	0	0	0	0	0	119	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(165)	5,733	0	5,568	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	10,706	(44,042)	3,411	0	0	0	0	0	0	0	0	(29,925)	45

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
Steven Blisko	60	Anna Rehab & Nursing	Anna	Senior Healthcare	Skokie	Management Co.
A&F General Partnership	35	Carbondale Rehab & Nursing	Carbondale			
Ted Lerman	5	Cobden Rehab & Nursing	Cobden			
		Herrin Rehab & Nursing	Herrin			
		Marion Rehab & Nursing	Marion			
		Ridgway Rehab & Nursing	Ridgway			
		Alton Rehab & Nursing	Alton			

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)	
1	V	10 Nursing Wages	\$ 29,449	Senior Healthcare Management		\$ 25,131	\$ (4,318)	1
2	V	21 Payroll	10,660	Senior Healthcare Management		95,121	84,461	2
3	V	5 Utilities		Senior Healthcare Management		2,208	2,208	3
4	V	19 Professional Services	198,000	Senior Healthcare Management		29,698	(168,302)	4
5	V	20 Licenses & Fees		Senior Healthcare Management		76	76	5
6	V	21 Office Expense		Senior Healthcare Management		1,404	1,404	6
7	V	22 Employee Benefits		Senior Healthcare Management		27,686	27,686	7
8	V	24 Travel/Seminar		Senior Healthcare Management		6,923	6,923	8
9	V	26 Insurance		Senior Healthcare Management		70	70	9
10	V	30 Depreciation Expense		Senior Healthcare Management		947	947	10
11	V	34 Rent Expense		Senior Healthcare Management		4,667	4,667	11
12	V	35 Equipment Lease		Senior Healthcare Management		119	119	12
13	V	6 Repairs and Maintenance		Senior Healthcare Management		17	17	13
14	Total		\$ 238,109			\$ 194,067	\$ * (44,042)	14

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

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	21 Office Expense	\$	Senior Healthcare Management		\$ 3,411	\$ 3,411	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$ 3,411	\$ *	3,411	39

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

Facility Name & ID Number

Chester Rehab & Nrsg Center

0051532

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			Columbia Rehab & Nursing Center	Columbia				1
2			Midwest Rehab & Respiratory Center	Belleville				2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Chester Rehab & Nrsg Center # 0051532 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									\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Chester Rehab & Nrsg Center

0051532

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2012 report.		\$	9,467		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	17,340		2
3. Under or (over) accrual (line 2 minus line 1).		\$	7,873		3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	(4,573)		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	3,300		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	_____	8	FOR BHF USE ONLY	
	2009	_____	9	13	FROM R. E. TAX STATEMENT FOR 2012 \$ _____ 13
	2010	36,226	10	14	PLUS APPEAL COST FROM LINE 5 \$ _____ 14
	2011	17,015	11	15	LESS REFUND FROM LINE 6 \$ _____ 15
	2012	17,340	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16

NOTES:

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Chester Rehab & Nrsg Center COUNTY Randolph
 FACILITY IDPH LICENSE NUMBER 0051532
 CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar
 TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

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>18-037-005-00</u>	<u>Nursing Facility</u>	\$ <u>115.20</u>	\$ <u>115.20</u>
2. <u>18-037-006-00</u>	<u>Nursing Facility</u>	\$ <u>176.36</u>	\$ <u>176.36</u>
3. <u>18-034-009-00</u>	<u>Nursing Facility</u>	\$ <u>94.80</u>	\$ <u>94.80</u>
4. <u>18-034-011-00</u>	<u>Nursing Facility</u>	\$ <u>16,693.84</u>	\$ <u>16,693.84</u>
5. <u>08-040-003-00</u>	<u>Nursing Facility</u>	\$ <u>260.06</u>	\$ <u>260.06</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>17,340.26</u></u>	\$ <u><u>17,340.26</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? YES X NO

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

C. **Tax Bills**

Attach a copy of the original 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.

Facility Name & ID Number Chester Rehab & Nrsg Center

0051532 Report Period Beginning:

01/01/13 Ending:

12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,246 B. General Construction Type: Exterior Brick Frame Wood, Concrete 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).

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: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number **Chester Rehab & Nrsg Center**

0051532

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		
	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	
	Improvement Type**										
9		New Shingle Roof	2013		71,720	1,532	39	1,532		1,532	9
10		New Sprinkler System	2013		150,000	2,564	39	2,564		2,564	10
11		Canopy	2013		4,500	67	39	67		67	11
12		Concrete Work for Parking Lot, Steps, and Rail	2013		4,355	37	39	37		37	12
13		Wiring Nurse Stations and Kiosks	2013		9,394	80	39	80		80	13
14		Plumbing / Pipe Replacement	2013		4,925	11	39	11		11	14
15		Facility Doors	2013		4,792	72	39	72		72	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

Facility Name & ID Number Chester Rehab & Nrsg Center

0051532

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								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 249,686	\$ 4,363		\$ 4,363	\$	\$ 4,363	70

**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	\$ 11,747	\$	\$ 2,349	\$ 2,349	5	\$ 11,747	71
72	Current Year Purchases	13,919	1,391	1,391		5	1,391	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 25,666	\$ 1,391	\$ 3,740	\$ 2,349		\$ 13,138	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)	\$ 275,352	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 5,754	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 8,103	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,349	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 17,501	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Chester Nursig Realty, 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:		119	06/01/2011	\$ 264,000	10		3
4	Additions							4
5								5
6								6
7	TOTAL		119		\$ 264,000			7

10. Effective dates of current rental agreement:

Beginning 06/01/2011

Ending 05/31/2021

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

Fiscal Year Ending Annual Rent

12. 12/31/14 \$ 264,000

13. 12/31/15 \$ 264,000

14. 12/31/16 \$ 264,000

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 _____.

N/A

N/A

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: \$ N/A Description: N/A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Chester Rehab & Nrsg Center # 0051532 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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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>2. CLASSROOM PORTION:</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>3. CLINICAL PORTION:</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	10a-3	hrs	\$			\$ 78,767	\$		\$ 78,767	1	
2	Licensed Speech and Language Development Therapist	10a-3	hrs				11,634			11,634	2	
3	Licensed Recreational Therapist		hrs								3	
4	Licensed Physical Therapist	10a-3	hrs				62,940			62,940	4	
5	Physician Care		visits								5	
6	Dental Care		visits								6	
7	Work Related Program		hrs								7	
8	Habilitation		hrs								8	
9	Pharmacy	39-2	# of prescripts					18,892		18,892	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10	
11	Academic Education		hrs								11	
12	Other (specify): <u>Radiology & Lab</u>	39-2						3,814		3,814	12	
13	Other (specify):										13	
14	TOTAL			\$			\$ 153,341	\$ 22,706		\$ 176,047	14	

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

Facility Name & ID Number Chester Rehab & Nrsg Center# 0051532Report 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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,736	\$ 2,736	1
2	Cash-Patient Deposits	(177)	(177)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	494,751	494,751	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 497,310	\$ 497,310	10
	B. Long-Term Assets			
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	249,686	249,686	15
16	Equipment, at Historical Cost	25,665	25,665	16
17	Accumulated Depreciation (book methods)	(17,501)	(17,501)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 257,850	\$ 257,850	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 755,160	\$ 755,160	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 346,799	\$ 346,799	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	73,409	73,409	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
	Other Current Liabilities(specify):			
36	<u>Working Capital Note</u>	1,875,000	1,875,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,295,208	\$ 2,295,208	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,295,208	\$ 2,295,208	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,540,048)	\$ (1,540,048)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 755,160	\$ 755,160	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (635,871)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (635,871)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(904,177)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (904,177)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,540,048)	24 *

* This must agree with page 17, line 47.

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,678,143	1
2	Discounts and Allowances for all Levels	(171,287)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,506,856	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	195,690	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 195,690	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	13,359	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	803	19
20	Radiology and X-Ray	1,096	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 15,258	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,567	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,567	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,719,372	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	467,092	31
32	Health Care	1,049,497	32
33	General Administration	644,676	33
B. Capital Expense			
34	Ownership	304,051	34
C. Ancillary Expense			
35	Special Cost Centers	22,706	35
36	Provider Participation Fee	135,527	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,623,549	40
41	Income before Income Taxes (line 30 minus line 40)**	(904,177)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (904,177)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 592,752	44
45	Private Pay - Net Inpatient Revenue	514,626	45
46	Medicare - Net Inpatient Revenue	352,839	46
47	Other-(specify) <u>Commercial Insurance</u>	46,639	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,506,856	49

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

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

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

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

Facility Name & ID Number Chester Rehab & Nrsg Center

0051532

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	1,585	1,730	\$ 55,441	\$ 32.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,193	2,313	57,820	25.00	3
4	Licensed Practical Nurses	11,418	12,317	225,841	18.34	4
5	CNAs & Orderlies	26,774	28,850	315,645	10.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,521	1,661	22,215	13.37	9
10	Activity Assistants					10
11	Social Service Workers	1,974	2,131	29,919	14.04	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,713	12,406	130,523	10.52	15
16	Dishwashers					16
17	Maintenance Workers	1,904	2,004	26,080	13.01	17
18	Housekeepers	4,909	5,593	66,274	11.85	18
19	Laundry	2,911	3,173	29,174	9.19	19
20	Administrator	1,607	1,707	50,010	29.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					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	309	430	6,098	14.18	31
32	Other Health C: <u>MDS</u>	1,734	1,903	42,413	22.29	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	70,552	76,218	\$ 1,057,453 *	\$ 13.87	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	143	\$ 4,990	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	35	1,752	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	147	5,148	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	325	\$ 11,890		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
Martin Giordana	Admin		\$ 21,539	Workers' Compensation Insurance	\$ 67,113	IDPH License Fee	\$		
Jan Tabor	Admin		28,472	Unemployment Compensation Insurance		Advertising: Employee Recruitment			
				FICA Taxes	127,969	Health Care Worker Background Check			
				Employee Health Insurance	15,237	(Indicate # of checks performed _____)			
				Employee Meals		Senior Healthcare - License	76		
				Illinois Municipal Retirement Fund (IMRF)*		CMS	532		
				Employee Expense	14,167	Meyer Magence	188		
				Education	173	Randolph County Health	200		
						Secretary of State	250		
						State Fire Marshall	125		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 50,011	TOTAL (agree to Schedule V, line 22, col.8)		\$ 224,659	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 1,371
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description				Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
							Auto Allowance / Mileage	2,186	
							Management Lodging and gasoline	6,923	
							Seminar Expense		
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL	\$ 9,109	

C. Professional Services			Amount
Vendor/Payee	Type		
Senior Healthcare	Professional	\$ 198,000	
Bradley Associates	Accounting	7,289	
Johnson Goldberg	Accounting	2,650	
Fendelman Floodman	Legal	205	
Meyer Magence	Legal	563	
Bank Attorney Fees	Legal	311	
MTS Consulting	Professional	3,554	
WB Architects	Professional	2,718	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 215,290

* Attach copy of IMRF notifications

**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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Chester Rehab & Nrsg Center# 0051532

Report Period Beginning:

01/01/13

Ending:

12/31/13**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,608 Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? X YES _____ NO _____
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 135,527
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (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? N/A 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. \$ None Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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. \$ 0
- (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? N/A
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.