

Facility Name & ID Number Cedar Pointe Rehab & Nursing

0050955 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	148	Skilled (SNF)	148	54,020	1
2		Skilled Pediatric (SNF/PED)			2
3	337	Intermediate (ICF)	337	123,005	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	18,243	178	3,809	22,230	8
9	SNF/PED					9
10	ICF	75,312		791	76,103	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	93,555	178	4,600	98,333	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.55%

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 3,809

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number

Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	528,343	69,057	18,551	615,951		615,951	615,951			1
2	Food Purchase		474,157		474,157		474,157	3,171	477,328		2
3	Housekeeping	328,028	49,175		377,203		377,203	2,288	379,491		3
4	Laundry	105,308	25,716		131,024		131,024		131,024		4
5	Heat and Other Utilities			240,647	240,647		240,647	2,216	242,863		5
6	Maintenance	283,975	31	92,497	376,503		376,503	(42,276)	334,227		6
7	Other (specify):*										7
8	TOTAL General Services	1,245,654	618,136	351,695	2,215,485		2,215,485	(34,601)	2,180,884		8
	B. Health Care and Programs										
9	Medical Director			21,500	21,500		21,500		21,500		9
10	Nursing and Medical Records	3,314,115	106,289	18,349	3,438,753		3,438,753	(52,206)	3,386,547		10
10a	Therapy	100,729	2,796		103,525		103,525		103,525		10a
11	Activities	187,163	12,900	2,360	202,423		202,423		202,423		11
12	Social Services	314,782		6,407	321,189		321,189		321,189		12
13	CNA Training										13
14	Program Transportation			2,012	2,012		2,012		2,012		14
15	Other (specify):*							14,864	14,864		15
16	TOTAL Health Care and Programs	3,916,789	121,985	50,628	4,089,402		4,089,402	(37,342)	4,052,060		16
	C. General Administration										
17	Administrative	157,322			157,322		157,322	81,308	238,630		17
18	Directors Fees										18
19	Professional Services			292,865	292,865	(44,857)	248,008	(21,179)	226,829		19
20	Dues, Fees, Subscriptions & Promotions			64,512	64,512		64,512	(29,273)	35,239		20
21	Clerical & General Office Expenses	94,617		161,132	255,749		255,749	86,098	341,847		21
22	Employee Benefits & Payroll Taxes			1,013,870	1,013,870		1,013,870		1,013,870		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,725	1,725		1,725	998	2,723		24
25	Other Admin. Staff Transportation			1,179	1,179		1,179	9,327	10,506		25
26	Insurance-Prop.Liab.Malpractice			411,587	411,587		411,587	(19,376)	392,211		26
27	Other (specify):*							33,609	33,609		27
28	TOTAL General Administration	251,939		1,946,870	2,198,809	(44,857)	2,153,952	141,512	2,295,464		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,414,382	740,121	2,349,193	8,503,696	(44,857)	8,458,839	69,569	8,528,408		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 Cedar Pointe Rehab & Nursing

#0050955

Report Period Beginning:

01/01/14

Ending:

12/31/14

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			79,237	79,237		79,237	28,873	108,110			30
31	Amortization of Pre-Op. & Org.			1,844	1,844		1,844		1,844			31
32	Interest			33,106	33,106		33,106	5,735	38,841			32
33	Real Estate Taxes			1,342,595	1,342,595	44,857	1,387,452	13,383	1,400,835			33
34	Rent-Facility & Grounds			1,919,405	1,919,405		1,919,405	(0)	1,919,405			34
35	Rent-Equipment & Vehicles			10,185	10,185		10,185		10,185			35
36	Other (specify):*											36
37	TOTAL Ownership			3,386,372	3,386,372	44,857	3,431,229	47,991	3,479,220			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		98,012	402,320	500,332		500,332		500,332			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			844,258	844,258		844,258		844,258			42
43	Other (specify):*			41,314	41,314		41,314	(41,314)				43
44	TOTAL Special Cost Centers		98,012	1,287,892	1,385,904		1,385,904	(41,314)	1,344,590			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,414,382	838,133	7,023,457	13,275,972		13,275,972	76,246	13,352,218			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 Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning: 01/01/14

Ending: 12/31/14

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	21,045	30		9
10	Interest and Other Investment Income	(12)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(9)	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	(20,802)	21		18
19	Entertainment				19
20	Contributions	(1,649)	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	(2,123)	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	(208,161)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (211,711)		\$	30

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)	287,957		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 287,957		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 76,246		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Cedar Pointe Rehab & Nursing

ID# 0050955

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Medicare Sequestration	\$ (43,059)	21	1
2	Rental Income- Antenna	(36,908)	06	2
3	Miscellaneous Income	(5,673)	21	3
4	Website Fees	(8,409)	20	4
5	Other Marketing Expenses	(14,928)	43	5
6	Bank Charges	(4,608)	21	6
7	Additional R&M	2,400	06	7
8	Capitalized R&M	(11,326)	06	8
9	Non-Allowable Legal	(25,021)	19	9
10	PAC Dues	(17,527)	20	10
11	Settlements	(19,786)	26	11
12	Collections	(23,316)	21	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	(208,161)	49

Cedar Pointe Rehab & Nursing

ID# 0050955

Report Period Beginning: 01/01/14

Ending: 12/31/14

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	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	(9)		2,957		223							3,171	2
3	Housekeeping			2,288									2,288	3
4	Laundry													4
5	Heat and Other Utilities			2,216									2,216	5
6	Maintenance	(45,834)		3,536		22							(42,276)	6
7	Other (specify):*													7
8	TOTAL General Services	(45,843)		10,997		245							(34,601)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records					(52,206)							(52,206)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					14,864							14,864	15
16	TOTAL Health Care and Programs					(37,342)							(37,342)	16
	C. General Administration													
17	Administrative			76,737		4,571							81,308	17
18	Directors Fees													18
19	Professional Services	(25,021)		595	342	2,905							(21,179)	19
20	Fees, Subscriptions & Promotions	(29,708)		353		82							(29,273)	20
21	Clerical & General Office Expenses	(97,458)		159,905		23,651							86,098	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			316		682							998	24
25	Other Admin. Staff Transportation					9,327							9,327	25
26	Insurance-Prop.Liab.Malpractice	(19,786)		410									(19,376)	26
27	Other (specify):*			33,609									33,609	27
28	TOTAL General Administration	(171,973)		271,925	342	41,218							141,512	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(217,816)		282,922	342	4,121							69,569	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Cedar Pointe Rehab & Nursing # 0050955 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	21,045			7,828								28,873	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(12)		27	5,720								5,735	32
33	Real Estate Taxes				13,383								13,383	33
34	Rent-Facility & Grounds			20,943	(20,943)								(0)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	21,033		20,970	5,988								47,991	37
	Ancillary Expense													
	E. Special Cost Centers													
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):*	(14,928)				(26,386)							(41,314)	43
44	TOTAL Special Cost Centers	(14,928)				(26,386)							(41,314)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(211,711)		303,892	6,330	(22,265)							76,246	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
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	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		
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.

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%	\$ 2,957	\$ 2,957	15
16	V	3	HOUSEKEEPING		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	2,288	2,288	16
17	V	5	UTILITIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	2,216	2,216	17
18	V	6	REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	3,536	3,536	18
19	V	17	S WEBSTER SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	38,313	38,313	19
20	V	17	Y LEVOVITZ-SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	38,424	38,424	20
21	V	19	PROFESSIONAL FEES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	595	595	21
22	V	20	DUES FEES SUBSCRIPTIONS		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	353	353	22
23	V	21	CLERICAL AND GENERAL		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	14,478	14,478	23
24	V	21	CLERICAL & GENERAL SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	145,427	145,427	24
25	V	24	SEMINARS & EDUCATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	316	316	25
26	V	26	INSURANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	410	410	26
27	V	27	EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	33,609	33,609	27
28	V	32	INTEREST		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	27	27	28
29	V	34	RENT		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	20,943	20,943	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		\$				\$ 303,892	\$ * 303,892	39

* 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	19 PROFESSIONAL FEES		PREMIER HC REAL ESTATE, LLC	100.00%	342	\$	342	15
16	V	30 DEPRECIATION		PREMIER HC REAL ESTATE, LLC	100.00%	7,828		7,828	16
17	V	32 INTEREST EXPENSE		PREMIER HC REAL ESTATE, LLC	100.00%	5,720		5,720	17
18	V	33 REAL ESTATE TAXES		PREMIER HC REAL ESTATE, LLC	100.00%	13,383		13,383	18
19	V								19
20	V	34 RENT	20,943	PREMIER HC REAL ESTATE LLC	100.00%			(20,943)	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		\$ 20,943			\$ 27,273	\$ *	6,330	39

* 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	2 DIETARY	\$	iCare Consulting Services LLC	100.00%	\$ 223	\$	223	15
16	V	6 REPAIRS AND MAINTENANCE		iCare Consulting Services LLC	100.00%	22		22	16
17	V	10 NURSING SALARIES	186,558	iCare Consulting Services LLC	100.00%	134,352		(52,206)	17
18	V	15 EMPLOYEE BEN. HC PROGRAMS		iCare Consulting Services LLC	100.00%	14,864		14,864	18
19	V	17 ADMIN SALARY NON-RELATED		iCare Consulting Services LLC	100.00%	4,571		4,571	19
20	V	19 PROFESSIONAL FEES		iCare Consulting Services LLC	100.00%	2,905		2,905	20
21	V	20 DUES FEES SUBSCRIPTIONS		iCare Consulting Services LLC	100.00%	82		82	21
22	V	21 CLERICAL AND GENERAL		iCare Consulting Services LLC	100.00%	6,454		6,454	22
23	V	21 CLERICAL & GENERAL SALARIES		iCare Consulting Services LLC	100.00%	17,197		17,197	23
24	V	24 SEMINARS & EDUCATION		iCare Consulting Services LLC	100.00%	682		682	24
25	V	25 AUTO EXPENSE		iCare Consulting Services LLC	100.00%	9,327		9,327	25
26	V	27 EMPLOYEE BEN. GEN ADMIN.		iCare Consulting Services LLC	100.00%	2,411			26
27	V								27
28	V	21 ENVIRONMENTAL CONSULTANT	25,506	iCare Consulting Services LLC	100.00%				28
29	V	43 MARKETING CONSULTANT	26,386	iCare Consulting Services LLC	100.00%			(26,386)	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		\$ 238,450			\$ 193,090	\$ *	(22,265)	39

* 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: 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	Total		\$			\$	\$ *	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

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	Total		\$			\$	\$ *	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

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	Total		\$			\$	\$ *	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning:

01/01/14

Ending:

12/31/14

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%	RIVER VIEW REHAB CENTER	ELGIN				4
5	JEFFREY J. WEBSTER	12.371%	FOREST CITY REHAB & NURSING CENTER	ROCKFORD				5
6	SHIMON WEBSTER	32.474%	ROCK RIVER HEALTH CARE	ROCKFORD				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

Facility Name & ID Number

Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number Cedar Pointe Rehab & Nursing # 0050955 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	11.32	28.30%	Alloc Salary	\$ 38,313	17-7	1
2	Yeruchom Levovitz	Owner	Administrative	30.31%	See Attached	11.32	28.30%	Alloc Salary	38,424	17-7	2
3	Moshe Levovitz	Relative	Administrative	0.00%	See Attached	32.83	82.08%	Sal/Al Salary	73,528	17-1; 17-7	3
4	Yakov Kohen	Relative	Clerical	0.00%	See Attached	11.32	28.30%	Alloc Salary	24,766	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	\$ 175,031		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 Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Facility Name & ID Number Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning:

01/01/14

Ending: 12/31/14

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. 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	7	\$ 10,450		98,333	\$ 2,957	1
2	3	HOUSEKEEPING	PATIENT DAYS	7	8,084		98,333	2,288	2
3	5	UTILITIES	PATIENT DAYS	7	7,831		98,333	2,216	3
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	7	12,495		98,333	3,536	4
5	15	EMPLOYEE BEN. HC PROGRA	PATIENT DAYS	7			98,333		5
6	17	S WEBSTER SALARY	PATIENT DAYS	7	135,377	135,377	98,333	38,313	6
7	17	Y LEVOVITZ-SALARY	PATIENT DAYS	7	135,768	135,768	98,333	38,424	7
8	19	PROFESSIONAL FEES	PATIENT DAYS	7	2,104		98,333	595	8
9	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	7	1,246		98,333	353	9
10	21	CLERICAL AND GENERAL	PATIENT DAYS	7	51,157		98,333	14,478	10
11	21	CLERICAL & GENERAL SALA	PATIENT DAYS	7	513,852	513,852	98,333	145,427	11
12	24	SEMINARS & EDUCATION	PATIENT DAYS	7	1,118		98,333	316	12
13	25	AUTO EXPENSE	PATIENT DAYS	7			98,333		13
14	26	INSURANCE	PATIENT DAYS	7	1,450		98,333	410	14
15	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	7	118,755		98,333	33,609	15
16	32	INTEREST	PATIENT DAYS	7	96		98,333	27	16
17	34	RENT	PATIENT DAYS	7	74,000		98,333	20,943	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,073,783	\$ 784,997		\$ 303,892	25

Facility Name & ID Number Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 HC REAL ESTATE, 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	19	PROFESSIONAL FEES	PATIENT DAYS	347,452	7	1,210	98,333	342	1
2	30	DEPRECIATION	PATIENT DAYS	347,452	7	27,658	98,333	7,828	2
3	32	INTEREST EXPENSE	PATIENT DAYS	347,452	7	20,211	98,333	5,720	3
4	33	REAL ESTATE TAXES	PATIENT DAYS	347,452	7	47,288	98,333	13,383	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					\$ 96,367	\$	\$ 27,273	25

Facility Name & ID Number Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning:

01/01/14

Ending: 12/31/14

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	5	\$ 676		98,333	\$ 223	1
2	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	5	68		98,333	22	2
3	10	NURSING SALARIES	PATIENT DAYS	5	407,152	407,152	98,333	134,352	3
4	15	EMPLOYEE BEN. HC PROGRA	PATIENT DAYS	5	45,046		98,333	14,864	4
5	17	ADMIN SALARY NON-RELAT	PATIENT DAYS	5	13,853		98,333	4,571	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	5	8,806		98,333	2,905	6
7	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	5	250		98,333	82	7
8	21	CLERICAL AND GENERAL	PATIENT DAYS	5	19,558	19,558	98,333	6,454	8
9	21	CLERICAL & GENERAL SALA	PATIENT DAYS	5	52,114		98,333	17,197	9
10	24	SEMINARS & EDUCATION	PATIENT DAYS	5	2,068		98,333	682	10
11	25	AUTO EXPENSE	PATIENT DAYS	5	28,266		98,333	9,327	11
12	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	5	7,298		98,333	2,411	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				\$ 585,155	\$ 426,710		\$ 193,090	25

Facility Name & ID Number Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Facility Name & ID Number Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Facility Name & ID Number Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Facility Name & ID Number Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Facility Name & ID Number Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Facility Name & ID Number Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

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			
	A. Directly Facility Related															
	Long-Term															
1							\$	\$			\$	1				
2												2				
3												3				
4												4				
5												5				
	Working Capital															
6	MB Financial		X	Line of Credit				1,155,000			33,106	6				
7	Allocated from Premier		X								27	7				
8												8				
9	TOTAL Facility Related						\$	\$ 1,155,000			\$ 33,133	9				
	B. Non-Facility Related*															
10	Interest Income		X								(12)	10				
11	Allocated From Premier RE		X								5,720	11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ 5,708	14				
15	TOTALS (line 9+line14)						\$	\$ 1,155,000			\$ 38,841	15				

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.)

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

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			
	A. Directly Facility Related															
	Long-Term															
1							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8							\$	\$			\$					
9																
10																
11																
12																
13																
14	TOTAL Working Capital															
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

* 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.)

2013 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 2013 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 2013.

(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>159,823.05</u>	\$ <u>159,823.05</u>
2. <u>16-29-202-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>159,823.05</u>	\$ <u>159,823.05</u>
3. <u>16-29-202-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>319,646.10</u>	\$ <u>319,646.10</u>
4. <u>16-29-202-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>182,131.89</u>	\$ <u>182,131.89</u>
5. <u>16-29-202-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>319,544.43</u>	\$ <u>319,544.43</u>
6. <u>10-23-324-047-0000</u>	<u>Home Office Allocation</u>	\$ <u>37,288.03</u>	\$ <u>10,552.95</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>1,178,256.55</u></u>	\$ <u><u>1,151,521.47</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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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:

01/01/14 Ending:

12/31/14

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: _____
 (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>Allocated From Premier</u>			\$ <u>5,377</u>	1
2					2
3	TOTALS			\$ <u>5,377</u>	3

Facility Name & ID Number Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	Various		2009	7,005		20	467	467	2,491	9
10	Various		2010	73,139		20	7,163	7,163	31,113	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

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		314,093	7,652		13,159	5,507	40,505	68
69			79,237			(79,237)		69
70		\$ 394,237	\$ 86,889		\$ 20,789	\$ (66,100)	\$ 74,109	70

**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:

01/01/14

Ending:

12/31/14

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	Totals from Page 12A, Carried Forward		\$ 394,237	\$ 86,889		\$ 20,789	\$ (66,100)	\$ 74,109	1
2	Tuckpointing	2011	45,500		20	2,275	2,275	7,204	2
3	Overhead Bed Lights	2011	2,950		20	590	590	2,213	3
4	Sprinkler System Improvement	2011	9,775		20	489	489	1,874	4
5	Hot Water Storage Tank	2011	2,596		20	519	519	1,644	5
6	Hands Free Phones In Elevator	2011	3,150		20	315	315	1,024	6
7	Cubicle Curtain	2011	3,158		20	158	158	618	7
8	Baking Deck, Ceramic, Probe Assembly, Thermostat, And Gasket	2011	2,511		20	126	126	460	8
9	Refrigeration Lines, Drain Lines, Insulation	2012	7,810		20	1,562	1,562	3,645	9
10	Sprinkler System	2012	3,067		20	79	79	200	10
11	Fire Alarm	2012	8,343		20	214	214	455	11
12	Tuckpointing/Roofing	2012	7,375		20	189	189	481	12
13	Schwartz Drywall, Tile, Shower Faucets	2012	35,008		20	1,750	1,750	5,105	13
14	Walk In Cooler, Valves, Thermostats	2012	6,298		20	1,260	1,260	2,939	14
15	Tile, Protection For Tile	2012	14,892		20	745	745	2,234	15
16	Corian Sinks, Wall Accessories - Bathrooms	2012	5,729		20	286	286	716	16
17	Enamel Partitions, Plastic Parts, Lock And Hardware Changes	2012	4,280		20	214	214	624	17
18	B&B Formica Corian Countertops - Bathrooms	2012	3,694		20	185	185	539	18
19	Replace Gaskets,Radiator & Clamps	2012	3,792		20	190	190	458	19
20	Plumbing	2012	4,210		20	211	211	491	20
21	Staircase & Handrails Repair	2012	6,650		20	333	333	998	21
22	Repair Backflow	2012	2,688		20	134	134	280	22
23	Econocare-Flooring ,Painting, Moldings Doors, Nurses Stations, B:	2012	203,020		20	10,151	10,151	27,069	23
24	Water And Hose Pump	2013	4,526		20	226	226	396	24
25	Outlets For Computer Kiosks	2013	2,700		20	540	540	945	25
26	Traveling Cables For Elevators	2013	7,750		20	388	388	678	26
27	Sprinkler Work	2013	6,559		20	328	328	574	27
28	Traveling Cables For Elevator	2013	7,750		20	388	388	646	28
29	Heat Detectors And Fire Alarm	2013	5,518		20	276	276	460	29
30	Chiller Replacement	2013	42,900		20	2,145	2,145	3,218	30
31	Coil Replacements- 2Nd Floor East & West, Kitchen, Main Floor	2014	2,526		20	126	126	126	31
32	Hot Water Storage Tanks	2014	8,800		20	440	440	440	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 869,761	\$ 86,889		\$ 47,618	\$ (39,271)	\$ 142,862	34

**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	Totals from Page 12B, Carried Forward		\$ 869,761	\$ 86,889		\$ 47,618	\$ (39,271)	\$ 142,862	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)		\$ 869,761	\$ 86,889		\$ 47,618	\$ (39,271)	\$ 142,862	34

**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	Totals from Page 12C, Carried Forward		\$ 869,761	\$ 86,889		\$ 47,618	\$ (39,271)	\$ 142,862	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)		\$ 869,761	\$ 86,889		\$ 47,618	\$ (39,271)	\$ 142,862	34

**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	Totals from Page 12D, Carried Forward		\$ 869,761	\$ 86,889		\$ 47,618	\$ (39,271)	\$ 142,862	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)		\$ 869,761	\$ 86,889		\$ 47,618	\$ (39,271)	\$ 142,862	34

**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 12E, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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)		\$	\$		\$	\$	\$	34

**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	Totals from Page 12F, Carried Forward								
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

**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 12G, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Premier HC Realty, LLC	2011	105,396	2,702	35	3,011	309	9,282	3
4	Allocated from Premier HC Realty, LLC	2012	13,419	344	35	383	39	1,150	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Premier HC Mgmt	2012	2,391		20	120	120	359	9
10	Allocated from Premier HC Realty, LLC	2011	187,453	4,467	20	9,373	4,906	28,899	10
11	Allocated from Premier HC Realty, LLC	2012	5,434	139	20	272	133	815	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)		\$ 314,093	\$ 7,652		\$ 13,159	\$ 5,507	\$ 40,505	34

**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:

01/01/14

Ending:

12/31/14

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		\$ 314,093	\$ 7,652		\$ 13,159	\$ 5,507	\$ 40,505	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		\$ 314,093	\$ 7,652		\$ 13,159	\$ 5,507	\$ 40,505	34

**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	\$ 348,170	\$ 175	\$ 60,491	\$ 60,316	10	\$ 215,841	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 348,170	\$ 175	\$ 60,491	\$ 60,316		\$ 215,841	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)	\$ 1,223,308	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 87,064	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 108,109	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 21,045	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 358,702	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning: 01/01/14

Ending: 12/31/14

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		\$ 1,919,405			3
4	Additions							4
5								5
6								6
7	TOTAL		485		\$ 1,919,405			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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 10,186 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Cedar Pointe Rehab & Nursing # 0050955 Report Period Beginning: 01/01/14 Ending: 12/31/14
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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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		3		4		5	6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)		
			Staff		Outside Practitioner (other than consultant)									
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$				\$	170,584			\$	170,584	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					\$	61,957				61,957	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	39 - 03	hrs						169,779				169,779	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 prescripts							91,522			91,522	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>									6,490			6,490	13
14	TOTAL			\$				\$	402,320	\$	98,012	\$	500,332	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 Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 64,201	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,968,464		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	254,637		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	49,791		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,337,093	\$	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	237,996		15
16	Equipment, at Historical Cost	542,795		16
17	Accumulated Depreciation (book methods)	(622,143)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	27,663		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(10,297)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	500,378		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 676,392	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,013,485	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 598,945	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,236		28
29	Short-Term Notes Payable	1,155,000		29
30	Accrued Salaries Payable	641,647		30
31	Accrued Taxes Payable (excluding real estate taxes)	858		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	See Attached Schedule	95,516		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,508,202	\$	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	See Attached Schedule	7,763		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 7,763	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,515,965	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 497,520	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,013,485	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 349,753	1
2	Restatements (describe):		2
3	Rounding Adjustment	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 349,751	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	147,769	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)	\$ 147,769	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)	\$ 497,520	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	\$ 13,602,479	1
2	Discounts and Allowances for all Levels	(386,564)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,215,915	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	12	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	207,814	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 207,814	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,423,741	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,215,485	31
32	Health Care	4,089,402	32
33	General Administration	2,198,809	33
B. Capital Expense			
34	Ownership	3,386,372	34
C. Ancillary Expense			
35	Special Cost Centers	541,646	35
36	Provider Participation Fee	844,258	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,275,972	40
41	Income before Income Taxes (line 30 minus line 40)**	147,769	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 147,769	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 11,399,535	44
45	Private Pay - Net Inpatient Revenue	60,104	45
46	Medicare - Net Inpatient Revenue	1,527,949	46
47	Other-(specify)	88,616	47
48	Other-(specify)	139,711	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 13,215,915	49

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

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

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

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

Facility Name & ID Number Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	1,721	1,874	\$ 81,665	\$ 43.58	1
2	Assistant Director of Nursing	4,502	5,103	160,910	31.53	2
3	Registered Nurses	11,591	12,648	393,266	31.09	3
4	Licensed Practical Nurses	41,221	43,486	1,052,698	24.21	4
5	CNAs & Orderlies	111,734	122,935	1,590,530	12.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,269	5,900	100,729	17.07	8
9	Activity Director	1,977	2,106	35,632	16.92	9
10	Activity Assistants	12,168	13,658	151,531	11.09	10
11	Social Service Workers	19,722	20,823	314,782	15.12	11
12	Dietician					12
13	Food Service Supervisor	2,131	2,188	46,333	21.18	13
14	Head Cook					14
15	Cook Helpers/Assistants	37,350	41,872	482,010	11.51	15
16	Dishwashers					16
17	Maintenance Workers	23,871	25,753	283,975	11.03	17
18	Housekeepers	27,521	30,403	328,028	10.79	18
19	Laundry	7,661	8,582	105,308	12.27	19
20	Administrator	2,080	2,080	76,763	36.91	20
21	Assistant Administrator	2,080	2,080	80,559	38.73	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,542	6,993	94,617	13.53	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	1,760	2,120	35,046	16.53	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	320,901	350,604	\$ 5,414,382 *	\$ 15.44	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	\$ 18,551	01-03	35
36	Medical Director	Monthly	21,500	09-03	36
37	Medical Records Consultant	Monthly	5,088	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,261	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	39	2,360	11-03	44
45	Social Service Consultant	106	6,407	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	146	\$ 67,167		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-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	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Cedar Pointe Rehab & Nursing

0050955

Report Period Beginning:

01/01/14

Ending:

12/31/14

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 \$29,754
- (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. \$ 21,437 Line 10-02
- (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. \$ 844,258
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 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% Ln14
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.