

Facility Name & ID Number Chateau Nrsg & Rehab Center

0046177 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	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	34,842	7,339	8,551	50,732	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,842	7,339	8,551	50,732	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.66%

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 02/01/2003

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

YES Date 02/01/2003 NO

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

YES NO If YES, enter number of beds certified 150 and days of care provided 7,975

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 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	319,780	73,841	21,705	415,326		415,326	5,230	420,556		1
2	Food Purchase		314,319		314,319		314,319	(1,128)	313,191		2
3	Housekeeping	194,931	45,627		240,558		240,558	654	241,212		3
4	Laundry	146,350	41,190		187,540		187,540	(10,500)	177,040		4
5	Heat and Other Utilities			281,216	281,216		281,216	1,432	282,648		5
6	Maintenance	118,262		369,331	487,593		487,593	(52,858)	434,735		6
7	Other (specify):*							7,870	7,870		7
8	TOTAL General Services	779,323	474,977	672,252	1,926,552		1,926,552	(49,300)	1,877,252		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	3,412,717	268,172	45,104	3,725,993		3,725,993	43,922	3,769,915		10
10a	Therapy	235,940			235,940		235,940		235,940		10a
11	Activities	211,549	65,273		276,822		276,822		276,822		11
12	Social Services	205,788	656		206,444		206,444	21,143	227,587		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							7,742	7,742		15
16	TOTAL Health Care and Programs	4,065,994	334,101	63,104	4,463,199		4,463,199	72,807	4,536,006		16
	C. General Administration										
17	Administrative	129,190			129,190		129,190	95,671	224,861		17
18	Directors Fees										18
19	Professional Services			630,732	630,732		630,732	(523,042)	107,690		19
20	Dues, Fees, Subscriptions & Promotions			65,476	65,476		65,476	(20,930)	44,546		20
21	Clerical & General Office Expenses	138,648	35,251	497,592	671,491		671,491	(236,471)	435,020		21
22	Employee Benefits & Payroll Taxes			756,949	756,949		756,949	(24,366)	732,583		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,818	1,818		1,818	1,698	3,516		24
25	Other Admin. Staff Transportation			9,815	9,815		9,815	1,391	11,206		25
26	Insurance-Prop.Liab.Malpractice			233,728	233,728		233,728	2,059	235,787		26
27	Other (specify):*							44,230	44,230		27
28	TOTAL General Administration	267,838	35,251	2,196,110	2,499,199		2,499,199	(659,760)	1,839,439		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,113,155	844,329	2,931,466	8,888,950		8,888,950	(636,253)	8,252,697		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 Chateau Nrsg & Rehab Center

#0046177

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			95,593	95,593		95,593	68,825	164,418			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							296,192	296,192			32
33	Real Estate Taxes			57,453	57,453		57,453	3,191	60,644			33
34	Rent-Facility & Grounds			684,000	684,000		684,000	(684,000)				34
35	Rent-Equipment & Vehicles			12,115	12,115		12,115	818	12,933			35
36	Other (specify):*											36
37	TOTAL Ownership			849,161	849,161		849,161	(314,974)	534,187			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		627,750	1,017,283	1,645,033		1,645,033	(77,924)	1,567,109			39
40	Barber and Beauty Shops			16	16		16		16			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			277,981	277,981		277,981		277,981			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		627,750	1,295,280	1,923,030		1,923,030	(77,924)	1,845,106			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,113,155	1,472,079	5,075,907	11,661,141		11,661,141	(1,029,151)	10,631,990			45

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

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	(1,415)	02		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	(19,866)	30		9
10	Interest and Other Investment Income	(72,029)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(449)	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	(9,295)	21		18
19	Entertainment				19
20	Contributions	(149)	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	(371,896)	21		24
25	Fund Raising, Advertising and Promotional	(17,900)	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	(116,874)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (609,873)		\$	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)	(419,278)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (419,278)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,029,151)		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

Chateau Nrsrg & Rehab Center

ID# 0046177

Report Period Beginning: 01/01/14

Ending: 12/31/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Rental Income	\$ (1,500)	06	1
2	Additional R&M	4,504	06	2
3	Patient Clothing	(108)	10	3
4	Theft Loss	(916)	21	4
5	Collection Expense	(6,711)	21	5
6	Laundry Income	(10,500)	04	6
7	Prior Year Professional Fees	(1,307)	19	7
8	Prior Year Computer Maintenance	(51)	21	8
9	Capitalized R&M	(5,000)	06	9
10	Non-Allowable Legal	(11,018)	19	10
11	PAC Dues	(4,960)	20	11
12	Building Company - Misc. Admin. Expense	(47)	21	12
13	Building Company - Professional Fees	(2,038)	19	13
14	Building Company - Filing Fee	(250)	20	14
15	Building Company - Amortization	(12,172)	36	15
16	Capitalized R&M	(64,800)	06	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	(116,874)		49

Chateau Nrsng & Rehab Center

ID# 0046177

Report Period Beginning: 01/01/14

Ending: 12/31/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chateau Nrsg & Rehab Center# 0046177

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			164		5,066							5,230	1
2	Food Purchase	(1,864)		736									(1,128)	2
3	Housekeeping			550		104							654	3
4	Laundry	(10,500)											(10,500)	4
5	Heat and Other Utilities			1,241		191							1,432	5
6	Maintenance	(66,796)		5,124	8,657	157							(52,858)	6
7	Other (specify):*				7,292	578							7,870	7
8	TOTAL General Services	(79,160)		7,815	15,949	6,096							(49,300)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(108)				46,674					(2,644)		43,922	10
10a	Therapy													10a
11	Activities													11
12	Social Services					21,143							21,143	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,742							7,742	15
16	TOTAL Health Care and Programs	(108)				75,559					(2,644)		72,807	16
	C. General Administration													
17	Administrative			3,405	18,410	73,856							95,671	17
18	Directors Fees													18
19	Professional Services	(14,363)	2,038	(381,370)		(129,347)							(523,042)	19
20	Fees, Subscriptions & Promotions	(23,259)	250	1,809		270							(20,930)	20
21	Clerical & General Office Expenses	(388,916)	47	12,387	109,887	30,124							(236,471)	21
22	Employee Benefits & Payroll Taxes				(24,366)								(24,366)	22
23	Inservice Training & Education													23
24	Travel and Seminar			283		1,415							1,698	24
25	Other Admin. Staff Transportation			1,391									1,391	25
26	Insurance-Prop.Liab.Malpractice			1,495		564							2,059	26
27	Other (specify):*				32,538	11,692							44,230	27
28	TOTAL General Administration	(426,538)	2,335	(360,600)	136,469	(11,426)							(659,760)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(505,806)	2,335	(352,785)	152,418	70,229					(2,644)		(636,253)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chateau Nrsg & Rehab Center

0046177

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 TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(19,866)	82,755	4,606		1,330							68,825	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(72,029)	329,462	1,054		37,705							296,192	32
33	Real Estate Taxes			2,685		506							3,191	33
34	Rent-Facility & Grounds		(684,000)										(684,000)	34
35	Rent-Equipment & Vehicles			818									818	35
36	Other (specify):*	(12,172)	12,172											36
37	TOTAL Ownership	(104,067)	(259,611)	9,163		39,541							(314,974)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(1,721)	(68,991)			(7,211)		(77,924)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(1,721)	(68,991)			(7,211)		(77,924)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(609,873)	(257,276)	(343,622)	152,418	109,770	(1,721)	(68,991)			(9,855)		(1,029,151)	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 Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	34 Rent	\$ 684,000	Chateau Willowbrook Property, LLC	100.00%	\$	\$ (684,000)	1
2	V	33 Rental - RE Taxes	57,453	Chateau Willowbrook Property, LLC	100.00%		(57,453)	2
3	V	21 Misc Admin Expense		Chateau Willowbrook Property, LLC	100.00%			3
4	V	21 Bank Service Charge		Chateau Willowbrook Property, LLC	100.00%	47	47	4
5	V	20 Filing Fee		Chateau Willowbrook Property, LLC	100.00%	250	250	5
6	V	30 Depreciation		Chateau Willowbrook Property, LLC	100.00%	82,755	82,755	6
7	V	36 Amortization		Chateau Willowbrook Property, LLC	100.00%	12,172	12,172	7
8	V	33 Real Estate Tax Expense		Chateau Willowbrook Property, LLC	100.00%	57,453	57,453	8
9	V	32 Interest		Chateau Willowbrook Property, LLC	100.00%	329,462	329,462	9
10	V	19 Bookkeeping Fee		Chateau Willowbrook Property, LLC	100.00%	1,875	1,875	10
11	V	19 Legal Fees		Chateau Willowbrook Property, LLC	100.00%	163	163	11
12	V							12
13	V							13
14	Total		\$ 741,453			\$ 484,177	\$ * (257,276)	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	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 164	\$	164	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	736		736	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	550		550	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,241		1,241	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	5,124		5,124	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	3,405		3,405	20
21	V	19 Professional Fees	391,080	Extended Care Consulting, LLC	100.00%	9,710		(381,370)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,809		1,809	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	12,387		12,387	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	283		283	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,391		1,391	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	1,495		1,495	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	4,606		4,606	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	1,054		1,054	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,685		2,685	29
30	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	818		818	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		\$ 391,080			\$ 47,458	\$ *	(343,622)	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	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	8,829	\$	8,829	15
16	V	06 Maintenance (Direct)	39,183	Extended Care Consulting, LLC	100.00%	39,011		(172)	16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	838		838	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	6,454		6,454	18
19	V								19
20	V								20
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	18,410		18,410	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	108,023		108,023	22
23	V	21 Office and Clerical (Direct)	43,084	Extended Care Consulting, LLC	100.00%	44,948		1,864	23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	23,287		23,287	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	9,251		9,251	25
26	V	22 Employee Benefits	24,366	Extended Care Consulting, LLC	100.00%			(24,366)	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		\$ 106,633			\$ 259,051	\$ *	152,418	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	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 104	\$	104	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	191		191	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	157		157	17
18	V	19 Professional Fees	130,356	Extended Care Clinical, LLC	100.00%	1,009		(129,347)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	270		270	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	1,558		1,558	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,415		1,415	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	564		564	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	1,330		1,330	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	37,705		37,705	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	506		506	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	5,066		5,066	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	578		578	27
28	V	10 Nursing Salary		Extended Care Clinical, LLC	100.00%	46,674		46,674	28
29	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%	21,143		21,143	29
30	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	7,742		7,742	30
31	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	73,856		73,856	31
32	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	28,566		28,566	32
33	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	11,692		11,692	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 130,356			\$ 240,126	\$ *	109,770	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	39 Various Equipment	19,340	Vent Lease LLC	100.00%	17,619	\$ (1,721)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 19,340			\$ 17,619	\$ * (1,721)

* 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	39 Therapy	\$ 968,217	Tri Care Rehab	100.00%	\$ 899,226	\$ (68,991)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 968,217			\$ 899,226	\$ * (68,991)

* 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	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 294,517	\$ 294,517	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	294,517	CCS Employee Benefits Group	100.00%		(294,517)	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		\$ 294,517			\$ 294,517	\$ *	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	1 Dietary Supplies, Supplements	\$ 4,676	Care Centers Health Systems, Inc.	100.00%	\$ 4,676	\$	15
16	V	39 Ancillary Expense	2,437	Care Centers Health Systems, Inc.	100.00%	2,437		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		\$ 7,114			\$ 7,114	\$ *	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	10 Nursing Supplies / Nursing Equip. Rental	9,391	Reliable Medical of the Midwest, LLC	100.00%	6,747	\$ (2,644)
16	V	39 Ancillary Expense	25,608	Reliable Medical of the Midwest, LLC	100.00%	18,397	(7,211)
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 34,999			\$ 25,144	\$ * (9,855)

* 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

Chateau Nrsg & Rehab Center

0046177

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	ROTHNER HEALTH VENTURES G II, LLC	100.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC BEECHER		CHATEAU WILLOWBROOK PR	WILLOWBROOK	BUILDING CO.	1
2			BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKEEP	2
3			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4			GRASMERE PLACE, LLC	CHICAGO	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPLEM	4
5			LAKWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	ROTHNER VENTS LLC	EVANSTON	VENTALATOR RENTAL	6
7			MAJOR HOSPITAL DYER	DYER, IN	TRICARE REHAB	HILLSIDE	THERAPY	7
8			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLY	8
9			MAJOR HOSPITAL LINCOLNSHIRE	MERRVILLE, IN	CARE CENTER BUILDING LLC	EVANSTON	BLDG COMPANY	9
10			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				10
11			MAJOR HOSPITAL SEBOS	HOBART, IN				11
12			MCKINLEY HEALTH CARE CENTER	CANTON, OH				12
13			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				13
14			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				14
15			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				15
16			RAINBOW BEACH QOC, L.L.C.	CHICAGO				16
17			SHEFFIELD MANOR	DYER, IN				17
18			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				18
19			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMWOOD				19
20			ST. JAMES WELLNESS REHAB VILLAS	CRETE				20
21			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				21
22			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				22
23			WHEATON CARE CENTER	WHEATON				23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Chateau Nrsg & Rehab Center

0046177

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 Chateau Nrsg & Rehab Center # 0046177 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	N/A								\$	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 Chateau Nrsg & Rehab Center

0046177

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	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 Chateau Nrsg & Rehab Center

0046177

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

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

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

1	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	01	Dietary	Patient Days	31	\$ 4,057	\$	50,732	\$ 164	1
2	02	Food	Patient Days	31	18,150		50,732	736	2
3	03	Housekeeping	Patient Days	31	13,578		50,732	550	3
4	05	Utilities	Patient Days	31	30,626		50,732	1,241	4
5	06	Maintenance	Patient Days	31	126,400		50,732	5,124	5
6	17	Administrative	Patient Days	31	84,000		50,732	3,405	6
7	19	Professional Fees	Patient Days	31	239,560		50,732	9,710	7
8	20	Dues and Subscriptions	Patient Days	31	44,626		50,732	1,809	8
9	21	Office and Clerical	Patient Days	31	305,586		50,732	12,387	9
10	24	Seminar and Travel	Patient Days	31	6,989		50,732	283	10
11	25	Other Staff Admin. Trans.	Patient Days	31	34,307		50,732	1,391	11
12	26	Insurance	Patient Days	31	36,877		50,732	1,495	12
13	30	Depreciation	Patient Days	31	113,642		50,732	4,606	13
14	32	Interest	Patient Days	31	26,010		50,732	1,054	14
15	33	Real Estate Taxes	Patient Days	31	66,240		50,732	2,685	15
16	35	Rent - Equipment & Auto	Patient Days	31	20,168		50,732	818	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,170,816	\$		\$ 47,458	25

Facility Name & ID Number Chateau Nrsg & Rehab Center

0046177

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	06	Maintenance (Pooled)	Patient Days	1,251,572	31	217,811	217,811	50,732	8,829	1
2	06	Maintenance (Direct)	Direct		31	252,781	252,781		39,011	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,251,572	31	20,665		50,732	838	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	33,212			6,454	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,251,572	31	454,189	454,189	50,732	18,410	7
8	21	Office and Clerical (Pooled)	Patient Days	1,251,572	31	2,664,951	2,664,951	50,732	108,023	8
9	21	Office and Clerical (Direct)	Direct		31	385,321	385,321		44,948	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,251,572	31	574,509		50,732	23,287	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	59,282			9,251	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					\$ 4,662,721	\$ 3,975,053		\$ 259,051	25

Facility Name & ID Number Chateau Nrsg & Rehab Center

0046177

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

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

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

1	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	03	Housekeeping	Patient Days	758,409	19	\$ 1,549	\$ 50,732	\$ 104	1
2	05	Utilities	Patient Days	758,409	19	2,849	50,732	191	2
3	06	Maintenance	Patient Days	758,409	19	2,348	50,732	157	3
4	19	Professional Fees	Patient Days	758,409	19	15,090	50,732	1,009	4
5	20	Dues and Subscriptions	Patient Days	758,409	19	4,042	50,732	270	5
6	21	Office & Clerical	Patient Days	758,409	19	23,285	50,732	1,558	6
7	24	Travel and Seminar	Patient Days	758,409	19	21,158	50,732	1,415	7
8	26	Insurance	Patient Days	758,409	19	8,431	50,732	564	8
9	30	Depreciation	Patient Days	758,409	19	19,889	50,732	1,330	9
10	32	Interest	Patient Days	758,409	19	563,670	50,732	37,705	10
11	33	Real Estate Taxes	Patient Days	758,409	19	7,558	50,732	506	11
12	01	Dietary Salary	Patient Days	758,409	19	75,731	50,732	5,066	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	758,409	19	8,645	50,732	578	13
14	10	Nursing Salary	Patient Days	758,409	19	697,742	50,732	46,674	14
15	12	Social Service Salary	Patient Days	758,409	19	316,078	50,732	21,143	15
16	15	Emp. Ben. - Healthcare	Patient Days	758,409	19	115,731	50,732	7,742	16
17	17	Administration Salary	Patient Days	758,409	19	1,104,097	50,732	73,856	17
18	21	Office Salary	Patient Days	758,409	19	427,044	50,732	28,566	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	758,409	19	174,785	50,732	11,692	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,589,719	\$ 2,620,691	\$ 240,126	25

Facility Name & ID Number Chateau Nrsg & Rehab Center

0046177

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

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

Name of Related Organization Vent Lease, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

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	39	Various Equipment	Direct Allocation					17,619	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				\$	\$		\$ 17,619	25

Facility Name & ID Number Chateau Nrsg & Rehab Center

0046177

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

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

Name of Related Organization TriCare Rehab
 Street Address 240 Fencil Lane
 City / State / Zip Code Hillside, IL 60162
 Phone Number (773) 449-9400
 Fax Number (773) 449-9700

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	39	Therapy	Direct Allocation		\$	\$		\$ 899,226	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				\$	\$		\$ 899,226	25

Facility Name & ID Number Chateau Nrsg & Rehab Center

0046177

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 294,517	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				\$	\$		\$ 294,517	25

Facility Name & ID Number Chateau Nrsg & Rehab Center

0046177

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Care Centers Health Systems, Inc.

Street Address

200 Howard

City / State / Zip Code

Des Plaines, Illinois 60018

Phone Number

(224) 612-5662

Fax Number

(224) 612-5862

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

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

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	Dietary Supplies, Supplements	Direct Allocation		\$	\$		\$ 4,676	1
2	39	Ancillary Expense	Direct Allocation					2,437	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				\$	\$		\$ 7,114	25

Facility Name & ID Number Chateau Nrsg & Rehab Center

0046177

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

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

Name of Related Organization Reliable Medical of the Midwest, LLC
 Street Address 200 Howard Avenue
 City / State / Zip Code Des Plaines, Illinois 60018-5909
 Phone Number (847) 566-0800
 Fax Number ()

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	10	Nursing Supplies / Nursing Equip.	Direct Allocation					6,747	1
2	39	Ancillary Expense	Direct Allocation					18,397	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					\$	\$	25,144	25

Facility Name & ID Number Chateau Nrsg & Rehab Center

0046177

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	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

Chateau Nrsg & Rehab Center

0046177

Report Period Beginning:

01/01/14

Ending:

12/31/14

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		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Bank Leumi		X	Mortgage			\$	\$ 6,659,504			\$	329,462						
2	Working Capital		X					501,672										
3																		
4																		
5																		
Working Capital																		
6	Advance HFGII		X	Line of Credit				244,215										
7	Note Payable-Mattresses		X					43,564										
8	See Supplemental Schedule							26,925										
9	TOTAL Facility Related						\$	\$ 7,475,880			\$	329,462						
B. Non-Facility Related*																		
10	Interest Income		X									(72,029)						
11	Alloc from Extended Care Consulting											1,054						
12	Allocated from Extended Care Clinical LLC											37,705						
13																		
14	TOTAL Non-Facility Related						\$	\$			\$	(33,270)						
15	TOTALS (line 9+line14)						\$	\$ 7,475,880			\$	296,192						

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.)

Facility Name & ID Number

Chateau Nrsg & Rehab Center

0046177

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
6																				
7	TOTAL Long-Term																			
Working Capital																				
8	Note Payable- Computers		X				\$	26,925		\$										
9																				
10																				
11																				
12																				
13																				
14	TOTAL Working Capital									26,925										
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.)

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 2013 report.			\$	58,915	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.)			\$	59,956	2																			
3. Under or (over) accrual (line 2 minus line 1).			\$	1,041	3																			
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	59,603	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.			\$	60,644	7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2009	81,456	8	<table border="1"> <tr> <td colspan="3" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2013	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2013	\$	13																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																					
15	LESS REFUND FROM LINE 6	\$	15																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
	2010	49,008	9																					
	2011	53,521	10																					
	2012	56,110	11																					
	2013	56,765	12																					
2014 Accrual = \$56,764 x 1.05 = \$59,603																								
Allocated from Extended Care Consulting LLC: \$2,685																								
Allocated from Extended Care Clinical LLC: \$506																								

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Chateau Nrsng & Rehab Center COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0046177

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</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-23-407-043</u>	<u>Long Term Care Property</u>	\$ <u>56,764.62</u>	\$ <u>56,764.62</u>
2. <u>See Attached</u>	<u>Alloc from 2201 Main/Care Center</u>	\$ <u>162,082.08</u>	\$ <u>3,038.72</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>218,846.70</u></u>	\$ <u><u>59,803.34</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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Chateau Nrsng & Rehab Center COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0046177

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 2000 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 2000.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 Chateau Nrsg & Rehab Center

0046177 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,447 B. General Construction Type: Exterior Brick Frame Masonry & Steel Number of Stories 1

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: 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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for index. Rows include Facility, Allocated from 2201 Main LLC/Care Centers Building LLC, and TOTALS.

Facility Name & ID Number Chateau Nrsg & Rehab Center

0046177

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	150	2003	1987	\$ 2,658,301	\$ 82,755	39	\$ 68,162	\$ (14,593)	\$ 1,400,748	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various	2003		51,953		20	1,641	1,641	34,220	9
10	Various	2004		98,684		20	4,650	4,650	55,046	10
11	Various	2005		69,862		20	3,493	3,493	31,939	11
12	Various	2006		50,399		20	3,226	3,226	27,357	12
13	Various	2007		126,729		20	6,725	6,725	51,023	13
14	Various	2008		30,544		20	1,803	1,803	11,905	14
15	Various	2009		25,582		20	1,503	1,503	11,507	15
16	Various	2010		12,771		20	705	705	3,362	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 Chateau Nrsg & Rehab Center

0046177

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	
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		238,642			11,932	11,932	107,018	67
68		67,184	4,243		4,243		46,488	68
69			95,593			(95,593)		69
70		\$ 3,430,651	\$ 182,591		\$ 108,083	\$ (74,508)	\$ 1,780,612	70

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

Facility Name & ID Number Chateau Nrsg & Rehab Center

0046177

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		\$ 3,430,651	\$ 182,591		\$ 108,083	\$ (74,508)	\$ 1,780,612	1
2	Xcel - Cubicle Curtains	2011	6,191		20	619	619	2,115	2
3	John Williams Interiors Amtico Solid Vinyl Wood Look Flooring	2011	15,060		20	753	753	2,761	3
4	Shower Rooms - New Showers, Water Lines, Floor, Walls, Grab B	2011	57,000		20	2,850	2,850	9,738	4
5	On-Line Communication Cable To Extend Nurse Call Audio	2011	2,832		20	142	142	472	5
6	Fox Valley Fire - Pulled Fire, Built Relays, Programming	2011	18,362		20	918	918	2,984	6
7	Paint - Labor	2011	7,443		20	372	372	1,147	7
8	New Sidewall Sprinkler Head In Elevator Shaft	2011	3,530		20	177	177	603	8
9	Pipe And Fittings	2012	3,900		20	195	195	553	9
10	Resurfacing-Paving	2012	5,800		20	387	387	1,063	10
11	Water Heater	2012	8,500		20	425	425	1,063	11
12	Medium Grade Vinyl Plank Flooring	2012	13,250		20	2,650	2,650	6,183	12
13	Remote E-Stop - Install Conduit And Wiring	2012	2,644		20	132	132	297	13
14	Nurses Station	2012	22,650		20	4,530	4,530	10,193	14
15	Corridors On All Floors - Paint, Wallpaper	2013	3,921		20	196	196	359	15
16	Rehab Dining Room - Flooring	2013	17,000		20	3,400	3,400	5,950	16
17	New 20 Ampere 208 & 30 Ampere 120 Volt Circuits & Outlets	2013	5,500		20	275	275	413	17
18	Main Entrance Doors - New Vertical Rod Panic Devices	2013	4,435		20	222	222	333	18
19	Rear Entrance Doors - New Panic Device	2013	4,030		20	202	202	285	19
20	Repaired Concrete Staircase Walls, Concrete Curbs, Brick Paver	2013	6,910		20	346	346	432	20
21	Ice Cream, Gift Shop - Architectural, Framing, Drywall, Masonry	2013	129,000		20	6,450	6,450	9,675	21
22	Corridors On All Floors - Wallpaper	2013	5,959		20	298	298	546	22
23	Nurse Station Rehab:Remove Old Millwork,Electrical & Plumbin	2014	49,000		20	1,633	1,633	1,633	23
24	New Cabinetry,Lighting,Plumbing,Electrical, Flooring For Beauty	2014	34,500		20	1,150	1,150	1,150	24
25	Fire Alarm System	2014	4,694		20	215	215	215	25
26	Blinds	2014	7,155		20	1,073	1,073	1,073	26
27	Elevator Door Restrictor	2014	3,635		20	106	106	106	27
28	Doors- Basement, 1St Floor And Kitchen	2014	10,700		20	446	446	446	28
29	New Lawler Model 802 Thermostatic Mixing Valve	2014	2,700		20	124	124	124	29
30	Exhaust Fan	2014	11,788		20	442	442	442	30
31	Replace Boiler & Relocate Storage Tank	2014	5,000		20	250	250	250	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,903,741	\$ 182,591		\$ 139,059	\$ (43,532)	\$ 1,843,217	34

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

Facility Name & ID Number Chateau Nrsg & Rehab Center

0046177

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		\$ 3,903,741	\$ 182,591		\$ 139,059	\$ (43,532)	\$ 1,843,217	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		\$ 3,903,741	\$ 182,591		\$ 139,059	\$ (43,532)	\$ 1,843,217	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	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		\$ 3,903,741	\$ 182,591		\$ 139,059	\$ (43,532)	\$ 1,843,217	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		\$ 3,903,741	\$ 182,591		\$ 139,059	\$ (43,532)	\$ 1,843,217	34

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

Facility Name & ID Number Chateau Nrsg & Rehab Center

0046177

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		\$ 3,903,741	\$ 182,591		\$ 139,059	\$ (43,532)	\$ 1,843,217	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		\$ 3,903,741	\$ 182,591		\$ 139,059	\$ (43,532)	\$ 1,843,217	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	Life Safety Code Improvements (Net of Settlement)	2005	231,242		20	11,562	11,562	104,058	9
10	Professional Fees-Architect	2007	7,400		20	370	370	2,960	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)		\$ 238,642	\$		\$ 11,932	\$ 11,932	\$ 107,018	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	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		\$ 238,642	\$		\$ 11,932	\$ 11,932	\$ 107,018	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)	\$ 238,642	\$		\$ 11,932	\$ 11,932	\$ 107,018	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 12G, Carried Forward								1
2	Buildings:								2
3	Allocated from 2201 Main LLC/Care Centers Building LLC	2002	17,828	457	20	457		5,619	3
4	Allocated from Extended Care Clinical LLC	2002	3,357	86	20	86		1,058	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Extended Care Consulting LLC	2007	186	9	20	9		75	9
10	Allocated from Extended Care Consulting LLC	2009	111	6	20	6		34	10
11	Allocated from Extended Care Consulting LLC	2010	1,094	55	20	55		273	11
12	Allocated from Extended Care Consulting LLC	2011	394	20	20	20		79	12
13	Allocated from Extended Care Consulting LLC	2012	130	6	20	6		19	13
14	Allocated from Extended Care Consulting LLC	2014	1,798	90	20	90		90	14
15									15
16	Allocated from 2201 Main LLC/Care Centers Building LLC	2002	14,727	1,255	20	1,255		14,727	16
17	Allocated from 2201 Main LLC/Care Centers Building LLC	2003	17,356	1,479	20	1,479		17,356	17
18	Allocated from 2201 Main LLC/Care Centers Building LLC	2005	862	92	20	92		769	18
19	Allocated from 2201 Main LLC/Care Centers Building LLC	2009	156	8	20	8		47	19
20	Allocated from 2201 Main LLC/Care Centers Building LLC	2014	2,485	124	20	124		124	20
21									21
22	Allocated from Extended Care Clinical LLC	2002	2,773	236	20	236		2,773	22
23	Allocated from Extended Care Clinical LLC	2003	3,268	279	20	279		3,268	23
24	Allocated from Extended Care Clinical LLC	2005	162	17	20	17		145	24
25	Allocated from Extended Care Clinical LLC	2009	29	1	20	1		9	25
26	Allocated from Extended Care Clinical LLC	2014	468	23	20	23		23	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 67,184	\$ 4,243		\$ 4,243	\$	\$ 46,488	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	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		\$ 67,184	\$ 4,243		\$ 4,243	\$	\$ 46,488	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
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16								16
17								17
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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)	\$ 67,184	\$ 4,243		\$ 4,243	\$	\$ 46,488	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	\$ 98,295	\$ 499	\$ 16,105	\$ 15,606	10	\$ 54,438	71
72	Current Year Purchases	134,128	300	7,250	6,950	10	7,250	72
73	Fully Depreciated Assets	576,841				10	576,841	73
74								74
75	TOTALS	\$ 809,263	\$ 799	\$ 23,355	\$ 22,556		\$ 638,529	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		2003 FORD ECONO VAN	2003	\$ 33,833	\$	\$	\$	5	\$ 33,833	76
77		TRUCK REPAIR	2004	1,083				5	1,083	77
78		Truck Repairs	2013	5,548		1,110	1,110	5	1,849	78
79		See supplemental	2014	10,752	894	894		5	8,192	79
80	TOTALS			\$ 51,216	\$ 894	\$ 2,004	\$ 1,110		\$ 44,957	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,074,960	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 184,284	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 164,418	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (19,866)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,526,703	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 Chateau Nrsg & Rehab Center

0046177

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: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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: \$ 12,933 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.

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			
		1	2	3	4
		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		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs				\$ 374,913				\$ 374,913	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				107,510				107,510	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				507,540				507,540	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					478,521			478,521	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>						27,320	149,229			176,549	13
14	TOTAL				\$		\$ 1,017,283	\$ 627,750			\$ 1,645,033	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 Chateau Nrsg & Rehab Center

0046177

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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 3,331	\$ 52,878	1
2	Cash-Patient Deposits	43,823	43,823	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	956,108	956,108	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	281,299	281,299	6
7	Other Prepaid Expenses	18,517	18,517	7
8	Accounts Receivable (owners or related parties)	705,411	5,220,419	8
9	Other(specify):	1,933,580	1,933,580	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,942,069	\$ 8,506,624	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		295,367	13
14	Buildings, at Historical Cost		3,805,411	14
15	Leasehold Improvements, at Historical Cost	813,678	813,678	15
16	Equipment, at Historical Cost	422,422	422,422	16
17	Accumulated Depreciation (book methods)	(655,674)	(2,642,423)	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):		168,360	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 580,426	\$ 2,862,815	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,522,495	\$ 11,369,439	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,542,201	\$ 2,542,202	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	49,957	49,957	28
29	Short-Term Notes Payable	314,704	314,704	29
30	Accrued Salaries Payable	158,376	158,376	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,719	19,719	31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,603	59,603	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36			17,244	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,144,560	\$ 3,161,805	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,161,176	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)	\$	\$ 7,161,176	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,144,560	\$ 10,322,981	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,377,935	\$ 1,046,458	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,522,495	\$ 11,369,439	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 892,927	1
2	Restatements (describe):		2
3	Prior Year Bad Debt Adjustment	(34,696)	3
4	Rounding	9	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 858,240	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	532,629	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	(12,934)	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)	\$ 519,695	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)	\$ 1,377,935	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Chateau Nrsg & Rehab Center

0046177

Report Period Beginning: 01/01/14

Ending: 12/31/14

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,972,521	1
2	Discounts and Allowances for all Levels	(4,363,119)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,609,402	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,823,285	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,823,285	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	2,899	13
14	Non-Patient Meals	1,415	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,500	16
17	Sale of Drugs	480,741	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	70,357	19
20	Radiology and X-Ray	32,814	20
21	Other Medical Services	88,828	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 678,554	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	72,029	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 72,029	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	10,500	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,500	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,193,770	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,926,552	31
32	Health Care	4,463,199	32
33	General Administration	2,499,199	33
B. Capital Expense			
34	Ownership	849,161	34
C. Ancillary Expense			
35	Special Cost Centers	1,645,049	35
36	Provider Participation Fee	277,981	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,661,141	40
41	Income before Income Taxes (line 30 minus line 40)**	532,629	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 532,629	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 5,203,815	44
45	Private Pay - Net Inpatient Revenue	1,702,877	45
46	Medicare - Net Inpatient Revenue	251,333	46
47	Other-(specify) <u>Hospice</u>	436,963	47
48	Other-(specify) <u>Insurance</u>	14,414	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,609,402	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 Chateau Nrsg & Rehab Center

0046177

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	1,932	2,138	\$ 100,173	\$ 46.85	1
2	Assistant Director of Nursing	1,893	2,151	89,735	41.72	2
3	Registered Nurses	33,687	36,845	1,168,658	31.72	3
4	Licensed Practical Nurses	26,459	29,813	828,207	27.78	4
5	CNAs & Orderlies	83,742	91,906	1,161,598	12.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,567	12,671	235,940	18.62	8
9	Activity Director	1,568	1,761	30,660	17.41	9
10	Activity Assistants	12,790	14,167	161,178	11.38	10
11	Social Service Workers	8,509	9,229	205,788	22.30	11
12	Dietician	1,019	1,134	22,205	19.58	12
13	Food Service Supervisor	1,991	2,199	47,393	21.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,344	6,857	88,970	12.98	15
16	Dishwashers	15,307	16,594	161,212	9.72	16
17	Maintenance Workers	5,432	6,256	118,262	18.90	17
18	Housekeepers	17,306	19,385	194,931	10.06	18
19	Laundry	12,507	13,977	146,350	10.47	19
20	Administrator	1,887	2,066	84,704	41.00	20
21	Assistant Administrator	1,941	2,120	44,486	20.98	21
22	Other Administrative					22
23	Office Manager	1,128	1,321	18,157	13.74	23
24	Clerical	2,900	3,289	38,914	11.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,752	3,161	52,534	16.62	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	4,812	5,427	113,100	20.84	33
34	TOTAL (lines 1 - 33)	257,473	284,467	\$ 5,113,155 *	\$ 17.97	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	444	\$ 21,705	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,471	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	444	\$ 50,176		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	235	10,007	10-03	51
52	Certified Nurse Assistants/Aides	981	24,626	10-03	52
53	TOTAL (lines 50 - 52)	1,216	\$ 34,633		53

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

0046177

Report Period Beginning: **01/01/14**

Ending: **12/31/14**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Stephanie Mohr	Administrator	0.00%	\$ 84,704	Workers' Compensation Insurance	\$ 112,930	IDPH License Fee	\$ 1,990		
Domencia Turner	Asst Administrator	0.00%	44,486	Unemployment Compensation Insurance	77,111	Advertising: Employee Recruitment	8,388		
				FICA Taxes	366,414	Health Care Worker Background Check	1,850		
				Employee Health Insurance	154,251	(Indicate # of checks performed <u>110</u>)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	15,529		
				Employee Physicals	14,803	Licenses	14,710		
				Holiday Expense	1,910	Alloc from Extended Care Consulting	1,809		
				Other Employee Benefits	5,164	Alloc from Extended Care Clinical	270		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 129,190	TOTAL (agree to Schedule V, line 22, col.8)		\$ 732,583	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 44,546
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Seminar Expense	1,818	
C. Professional Services							Alloc from Extended Care Consulting		283
Vendor/Payee	Type		Amount				Alloc from Extended Care Clinical		1,415
Frost, Rothblatt, Ruttenberg	Accounting		\$ 25,450				Entertainment Expense		()
Pro Payroll Solutions	Payroll Services		26,967				(agree to Sch. V, line 24, col. 8)		
E-Health Data Solutions	MDS Software Fee		2,385				TOTAL		\$ 3,516
AIS Assessment & Intelligence	Customer Service Satisf.		1,329						
Ability Network	Medicare Billing		874						
National Datacare Corporation	Resident Fund Processing		1,616						
Personal Planners	Unemployment Consultant		3,038						
See Attached	Legal		12,223						
PeiVip Medical Staffing	Medical Staffing		573						
Hamlin & Burton Liability	Litigation Services		994						
Online MSDS	MSDS Management		629						
See Supplemental Schedule			554,651						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 630,729						

* 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	Amount of Expense Amortized Per Year								
					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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC \$15,030
- (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. \$ 74,168 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. \$ 277,981
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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,415
- (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? None
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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