

Facility Name & ID Number Colonial Hlthcre & Rehab Ctr

0052167 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 01/29/14

	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	88	Skilled (SNF)	92	33,468	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	88	TOTALS	92	33,468	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	11,856		3,064	14,920	8
9	SNF/PED					9
10	ICF		9,284		9,284	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,856	9,284	3,064	24,204	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.32%

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 01/01/2013

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/01/2013 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 92 and days of care provided 2,626

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL 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

Colonial Hlthcre & Rehab Ctr

0052167

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	207,005	28,574	6,792	242,371		242,371	37	242,408		1
2	Food Purchase		130,040		130,040		130,040	(3,012)	127,028		2
3	Housekeeping	92,717	19,179		111,896		111,896	629	112,525		3
4	Laundry	34,667	9,142	911	44,720		44,720		44,720		4
5	Heat and Other Utilities			106,589	106,589		106,589	(5,096)	101,493		5
6	Maintenance	57,159	8,789	33,357	99,305		99,305	3,937	103,242		6
7	Other (specify):*										7
8	TOTAL General Services	391,548	195,724	147,649	734,921		734,921	(3,505)	731,416		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	3,632	15,632		9
10	Nursing and Medical Records	1,431,968	57,521	33,384	1,522,873		1,522,873	25,675	1,548,548		10
10a	Therapy			1,105	1,105		1,105		1,105		10a
11	Activities	56,484	6,309	816	63,609		63,609	7	63,616		11
12	Social Services	36,344			36,344		36,344	2,466	38,810		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							2,439	2,439		15
16	TOTAL Health Care and Programs	1,524,796	63,830	47,305	1,635,931		1,635,931	34,219	1,670,150		16
	C. General Administration										
17	Administrative	73,859		53,301	127,160		127,160	32,623	159,783		17
18	Directors Fees										18
19	Professional Services			180,438	180,438	(360)	180,078	(89,038)	91,040		19
20	Dues, Fees, Subscriptions & Promotions			65,897	65,897		65,897	(35,846)	30,051		20
21	Clerical & General Office Expenses	99,724	22,254	98,404	220,382		220,382	43,084	263,466		21
22	Employee Benefits & Payroll Taxes			378,266	378,266		378,266		378,266		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,605	1,605		1,605	73	1,678		24
25	Other Admin. Staff Transportation			12,542	12,542		12,542	1,792	14,334		25
26	Insurance-Prop.Liab.Malpractice			49,321	49,321		49,321	324	49,645		26
27	Other (specify):*							20,263	20,263		27
28	TOTAL General Administration	173,583	22,254	839,774	1,035,611	(360)	1,035,251	(26,725)	1,008,526		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,089,927	281,808	1,034,728	3,406,463	(360)	3,406,103	3,989	3,410,092		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

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#0052167

Report Period Beginning:

01/01/14

Ending:

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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			6,793	6,793		6,793	217,442	224,235			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,894	17,894		17,894	527,028	544,922			32
33	Real Estate Taxes			66,252	66,252	360	66,612	1,928	68,540			33
34	Rent-Facility & Grounds			576,858	576,858		576,858	(576,858)				34
35	Rent-Equipment & Vehicles			8,834	8,834		8,834	199	9,033			35
36	Other (specify):*											36
37	TOTAL Ownership			676,631	676,631	360	676,991	169,740	846,731			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		79,682	370,760	450,442		450,442	(1,014)	449,428			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			179,954	179,954		179,954		179,954			42
43	Other (specify):*	23,464		17,440	40,904		40,904	(40,904)	0			43
44	TOTAL Special Cost Centers	23,464	79,682	568,154	671,300		671,300	(41,918)	629,382			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,113,391	361,490	2,279,513	4,754,394		4,754,394	131,811	4,886,205			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	(2,517)	02		4
5	Telephone, TV & Radio in Resident Rooms	(6,024)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(125,115)	30		9
10	Interest and Other Investment Income	(3)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(495)	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	(2,203)	21		18
19	Entertainment				19
20	Contributions	(2,449)	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	(235,611)	21		24
25	Fund Raising, Advertising and Promotional	(31,162)	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	(175,429)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (581,008)		\$	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)	712,819		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 712,819		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 131,811		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

Colonial Hlthre & Rehab Ctr

ID# 0052167

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Miscellaneous Refund	\$ (44)	21	1
2	Prior Period - Dental	(1,014)	39	2
3	Prior Period Expenses	(27,250)	21	3
4	Sequestration	(18,592)	21	4
5	Marketing Consultant	(17,440)	43	5
6	Bank Charges	(8,064)	21	6
7	Marketing Salaries	(23,464)	43	7
8	Theft and Loss	(2,586)	21	8
9	Building Company - Amortization Expense	(70,891)	31	9
10	Building Company - Other Expense	(215)	21	10
11	Additional R&M	1,479	06	11
12	PAC Dues	(4,146)	20	12
13	Non-allowable Legal	(1,936)	19	13
14	Non-allowable Interest	(1,267)	32	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(175,429)	49

Colonial Hlthcare & Rehab Ctr

ID# 0052167

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Colonial Hlthcare & Rehab Ctr

0052167

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			37									37	1
2	Food Purchase	(3,012)											(3,012)	2
3	Housekeeping			629									629	3
4	Laundry													4
5	Heat and Other Utilities	(6,024)		666	262								(5,096)	5
6	Maintenance	1,479		2,357	101								3,937	6
7	Other (specify):*													7
8	TOTAL General Services	(7,557)		3,689	363								(3,505)	8
	B. Health Care and Programs													
9	Medical Director			3,632									3,632	9
10	Nursing and Medical Records			25,675									25,675	10
10a	Therapy													10a
11	Activities			7									7	11
12	Social Services			2,466									2,466	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,439									2,439	15
16	TOTAL Health Care and Programs			34,219									34,219	16
	C. General Administration													
17	Administrative			53,638		(21,015)							32,623	17
18	Directors Fees													18
19	Professional Services	(1,936)		(87,471)	220	149							(89,038)	19
20	Fees, Subscriptions & Promotions	(37,757)		1,905	6								(35,846)	20
21	Clerical & General Office Expenses	(294,565)	283,794	53,817	19	19							43,084	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			73									73	24
25	Other Admin. Staff Transportation			455		1,337							1,792	25
26	Insurance-Prop.Liab.Malpractice			205	119								324	26
27	Other (specify):*			20,263									20,263	27
28	TOTAL General Administration	(334,258)	283,794	42,885	364	(19,510)							(26,725)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(341,815)	283,794	80,793	727	(19,510)							3,989	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Colonial Hlthcare & Rehab Ctr

0052167

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(125,115)	338,512	2,862	1,183								217,442	30
31	Amortization of Pre-Op. & Org.	(70,891)	70,891											31
32	Interest	(1,270)	525,859	60	2,379								527,028	32
33	Real Estate Taxes				1,928								1,928	33
34	Rent-Facility & Grounds		(576,858)	8,494	(8,494)								(576,858)	34
35	Rent-Equipment & Vehicles			199									199	35
36	Other (specify):*													36
37	TOTAL Ownership	(197,275)	358,404	11,615	(3,004)								169,740	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(1,014)											(1,014)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(40,904)											(40,904)	43
44	TOTAL Special Cost Centers	(41,918)											(41,918)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(581,008)	642,198	92,408	(2,277)	(19,510)							131,811	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 Rental Income	\$ 576,858	COHRC Realty, LLC	100.00%	\$	\$ (576,858)	1
2	V	31 Amortization Expense		COHRC Realty, LLC	100.00%	70,891	70,891	2
3	V	30 Depreciation Expense		COHRC Realty, LLC	100.00%	338,512	338,512	3
4	V	32 Interest Expense - Private Bank		COHRC Realty, LLC	100.00%	335,588	335,588	4
5	V	32 Interest Expense - Greystone		COHRC Realty, LLC	100.00%	114,116	114,116	5
6	V	21 Other Expense		COHRC Realty, LLC	100.00%	215	215	6
7	V	32 Interest Expense		COHRC Realty, LLC	100.00%	76,155	76,155	7
8	V	21 Loss on Loan		COHRC Realty, LLC	100.00%	283,579	283,579	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 576,858			\$ 1,219,056	\$ * 642,198	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	1 <u>DIETARY</u>	\$	<u>MANAGCARE, INC.</u>	100.00%	\$ 37	\$	37	15
16	V	3 <u>HOUSEKEEPING</u>		<u>MANAGCARE, INC.</u>	100.00%	629		629	16
17	V	5 <u>UTILITIES</u>		<u>MANAGCARE, INC.</u>	100.00%	666		666	17
18	V	6 <u>REPAIRS AND MAINT.</u>		<u>MANAGCARE, INC.</u>	100.00%	2,357		2,357	18
19	V	9 <u>MEDICAL DIRECTOR</u>		<u>MANAGCARE, INC.</u>	100.00%	3,632		3,632	19
20	V	10 <u>NURSING SALARIES</u>		<u>MANAGCARE, INC.</u>	100.00%	25,675		25,675	20
21	V	11 <u>ACTIVITIES</u>		<u>MANAGCARE, INC.</u>	100.00%	7		7	21
22	V	12 <u>SOCIAL SERVICE SALARIES</u>		<u>MANAGCARE, INC.</u>	100.00%	2,466		2,466	22
23	V	15 <u>NURSING EMP BENS & PR TAXES</u>		<u>MANAGCARE, INC.</u>	100.00%	2,439		2,439	23
24	V	17 <u>ADMINISTRATIVE SALARIES</u>		<u>MANAGCARE, INC.</u>	100.00%	53,638		53,638	24
25	V	19 <u>PROFESSIONAL FEES</u>		<u>MANAGCARE, INC.</u>	100.00%	2,289		2,289	25
26	V	20 <u>FEES, SUBSCRIPTIONS</u>		<u>MANAGCARE, INC.</u>	100.00%	1,905		1,905	26
27	V	21 <u>CLERICAL AND GENERAL SALARIES</u>		<u>MANAGCARE, INC.</u>	100.00%	50,170		50,170	27
28	V	21 <u>CLERICAL AND GENERAL EXP</u>		<u>MANAGCARE, INC.</u>	100.00%	3,647		3,647	28
29	V	24 <u>SEMINARS</u>		<u>MANAGCARE, INC.</u>	100.00%	73		73	29
30	V	25 <u>ADMIN. STAFF TRANS.</u>		<u>MANAGCARE, INC.</u>	100.00%	455		455	30
31	V	26 <u>INSURANCE</u>		<u>MANAGCARE, INC.</u>	100.00%	205		205	31
32	V	27 <u>GEN. ADMIN. EMP. BEN.</u>		<u>MANAGCARE, INC.</u>	100.00%	20,263		20,263	32
33	V	30 <u>DEPRECIATION</u>		<u>MANAGCARE, INC.</u>	100.00%	2,862		2,862	33
34	V	32 <u>INTEREST EXPENSE</u>		<u>MANAGCARE, INC.</u>	100.00%	60		60	34
35	V	34 <u>RENT - BUILDING (RELATED)</u>		<u>MANAGCARE, INC.</u>	100.00%	8,494		8,494	35
36	V	35 <u>EQUIPMENT RENTAL</u>		<u>MANAGCARE, INC.</u>	100.00%	199		199	36
37	V	19 <u>BOOKKEEPING</u>	73,920	<u>MANAGCARE, INC.</u>	100.00%			(73,920)	37
38	V	19 <u>ADMINISTRATIVE CONSULTANT</u>	15,840	<u>MANAGCARE, INC.</u>	100.00%			(15,840)	38
39	Total		\$ 89,760			\$ 182,168	\$ *	92,408	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	5 UTILITIES	\$	4600 TOUHY, LLC	100.00%	\$ 262	\$	262	15
16	V	6 REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	101		101	16
17	V	19 PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	220		220	17
18	V	20 FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	6		6	18
19	V	21 CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	19		19	19
20	V	26 INSURANCE		4600 TOUHY, LLC	100.00%	119		119	20
21	V	30 DEPRECIATION		4600 TOUHY, LLC	100.00%	1,183		1,183	21
22	V	32 INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	2,379		2,379	22
23	V	33 REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	1,928		1,928	23
24	V								24
25	V	34 RENT	8,494	4600 TOUHY, LLC	100.00%			(8,494)	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		\$ 8,494			\$ 6,217	\$ *	(2,277)	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	17 ADMINISTRATIVE SALARY - NATHAN	\$	TETRAD MANAGEMENT, LLC	100.00%	\$ 9,934	\$ 9,934
16	V	17 ADMINISTRATIVE SALARY - JOSH DAVIS		TETRAD MANAGEMENT, LLC	100.00%	9,934	9,934
17	V	17 ADMINISTRATIVE SALARY - MOSHE DAVIS		TETRAD MANAGEMENT, LLC	100.00%	9,934	9,934
18	V	19 PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	149	149
19	V	21 OFFICE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	19	19
20	V	25 TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	1,337	1,337
21	V	17 ADMINISTRATIVE SALARY - ELI DAVIS		TETRAD MANAGEMENT, LLC	100.00%	2,484	2,484
22	V						
23	V	17 MANAGEMENT FEES	53,301	TETRAD MANAGEMENT, LLC	100.00%		(53,301)
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		\$ 53,301			\$ 33,791	\$ * (19,510)

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Colonial Hlthcare & Rehab Ctr

0052167

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	CENTRAL ILLINOIS OPERATIONS, LLC	99.99%	BRIGHTVIEW CARE CENTER, INC	CHICAGO	COHRC REALTY, LLC	LINCOLNWOOD	BUILDING COMPANY	1
2	TETRAD MANAGEMENT, LLC	.01%	LAKE SHORE HEALTHCARE & REHABILITATION CENTRE, LLC	CHICAGO	4600 TOUHY, LLC	LINCOLNWOOD	BUILDING CO.	2
3			MID AMERICA CARE CENTER, L.L.C.	CHICAGO	MANAGCARE, INC.	LINCOLNWOOD	BOOKKEEPING	3
4			CAPITOL HEALTHCARE & REHABILITATION CTR., LLC	SPRINGFIELD	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	ADMIN. CONSULTANT	4
5			COLONIAL HEALTHCARE & REHABILITATION CTR., LLC	PRINCETON				5
6			THE HEIGHTS HEALTHCARE & REHABILITATION CTR, LLC	PEORIA HEIGHTS				6
7			MORTON TERRACE HEALTHCARE & REHAB CTR., LLC	MORTON				7
8			MORTON VILLA HEALTHCARE & REHABILITATION CTR., LLC	MORTON				8
9			RIVERSHORES NURSING & REHABILITATION CENTER, LLC	MARSELLES				9
10			MAYFIELD HEALTHCARE AND REHAB CENTER	CHICAGO				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

Colonial Hlthcre & Rehab Ctr

0052167

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 Colonial Hlthcre & Rehab Ctr # 0052167 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	Moshe Davis	Relative	Mgmt / Admin	0%	See Attached	2.19	4.98%	Alloc. Salary	\$ 9,934	17-7	1
2	Yehoshua Davis	Relative	Mgmt / Admin	0%	See Attached	2.38	4.96%	Alloc. Salary	9,934	17-7	2
3	Nesanel Davis	Relative	Mgmt / Admin	0%	See Attached	2.38	4.96%	Alloc. Salary	9,934	17-7	3
4	Eli Davis	Relative	Mgmt / Admin	0%	See Attached	1.99	4.98%	Alloc. Fees	2,484	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 32,286		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 Colonial Hlthcare & Rehab Ctr

0052167

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Colonial Hlthcare & Rehab Ctr

0052167

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization MANAGCARE, INC.
 Street Address 4600 W. TOUHY AVENUE, SUITE 200
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

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	PATIENT DAYS	487,280	10	\$ 748	\$ 24,204	\$ 37	1	
2	3	HOUSEKEEPING	PATIENT DAYS	487,280	10	12,659	24,204	629	2	
3	5	UTILITIES	PATIENT DAYS	487,280	10	13,409	24,204	666	3	
4	6	REPAIRS AND MAINT.	PATIENT DAYS	487,280	10	47,454	24,204	2,357	4	
5	9	MEDICAL DIRECTOR	PATIENT DAYS	487,280	10	73,125	24,204	3,632	5	
6	10	NURSING SALARIES	PATIENT DAYS	487,280	10	516,890	516,890	24,204	25,675	6
7	11	ACTIVITIES	PATIENT DAYS	487,280	10	136	24,204	7	7	
8	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	487,280	10	49,654	49,654	24,204	2,466	8
9	15	NURSING EMP BENS & PR TA	PATIENT DAYS	487,280	10	49,107	24,204	2,439	9	
10	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	487,280	10	1,079,846	1,079,846	24,204	53,638	10
11	19	PROFESSIONAL FEES	PATIENT DAYS	487,280	10	46,077	24,204	2,289	11	
12	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	487,280	10	38,354	24,204	1,905	12	
13	21	CLERICAL AND GENERAL SA	PATIENT DAYS	487,280	10	1,010,032	1,010,032	24,204	50,170	13
14	21	CLERICAL AND GENERAL EX	PATIENT DAYS	487,280	10	73,419	24,204	3,647	14	
15	24	SEMINARS	PATIENT DAYS	487,280	10	1,473	24,204	73	15	
16	25	ADMIN. STAFF TRANS.	PATIENT DAYS	487,280	10	9,155	24,204	455	16	
17	26	INSURANCE	PATIENT DAYS	487,280	10	4,123	24,204	205	17	
18	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	487,280	10	407,944	24,204	20,263	18	
19	30	DEPRECIATION	PATIENT DAYS	487,280	10	57,614	24,204	2,862	19	
20	32	INTEREST EXPENSE	PATIENT DAYS	487,280	10	1,200	24,204	60	20	
21	34	RENT - BUILDING (RELATED)	PATIENT DAYS	487,280	10	171,000	24,204	8,494	21	
22	35	EQUIPMENT RENTAL	PATIENT DAYS	487,280	10	4,015	24,204	199	22	
23									23	
24									24	
25	TOTALS				\$ 3,667,434	\$ 2,656,422		\$ 182,168	25	

Facility Name & ID Number Colonial Hlthcare & Rehab Ctr

0052167

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 4600 TOUHY, LLC
 Street Address 4600 W. TOUHY AVENUE, SUITE 200
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

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	5	UTILITIES	MNGCR. PATIENT DAYS 487,280	10	\$ 5,277	\$	24,204	\$ 262	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS 487,280	10	2,035		24,204	101	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS 487,280	10	4,429		24,204	220	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS 487,280	10	148		24,204	6	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS 487,280	10	391		24,204	19	5
6	26	INSURANCE	MNGCR. PATIENT DAYS 487,280	10	2,388		24,204	119	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS 487,280	10	23,819		24,204	1,183	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS 487,280	10	47,891		24,204	2,379	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS 487,280	10	38,818		24,204	1,928	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				\$ 125,196	\$		\$ 6,217	25

Facility Name & ID Number Colonial Hlthcare & Rehab Ctr

0052167

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization TETRAD MANAGEMENT, LLC
 Street Address 4600 W. TOUHY AVENUE, SUITE 200
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

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	17	ADMINISTRATIVE SALARY - PATIENT DAYS	487,280	10	\$ 200,000	\$ 200,000	24,204	\$ 9,934	1
2	17	ADMINISTRATIVE SALARY - PATIENT DAYS	487,280	10	200,000	200,000	24,204	9,934	2
3	17	ADMINISTRATIVE SALARY - PATIENT DAYS	487,280	10	200,000	200,000	24,204	9,934	3
4	19	PROFESSIONAL FEES PATIENT DAYS	487,280	10	3,000		24,204	149	4
5	21	OFFICE EXPENSE PATIENT DAYS	487,280	10	374		24,204	19	5
6	25	TRAVEL PATIENT DAYS	487,280	10	26,914		24,204	1,337	6
7	17	ADMINISTRATIVE SALARY - PATIENT DAYS	487,280	10	50,000	50,000	24,204	2,484	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				\$ 680,288	\$ 650,000		\$ 33,791	25

Facility Name & ID Number Colonial Hlthcare & Rehab Ctr

0052167

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Colonial Hlthcare & Rehab Ctr

0052167

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Colonial Hlthcare & Rehab Ctr

0052167

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Colonial Hlthcare & Rehab Ctr

0052167

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Colonial Hlthcare & Rehab Ctr

0052167

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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 Colonial Hlthcare & Rehab Ctr

0052167

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
A. Directly Facility Related																
Long-Term																
1	Private Bank		X	Mortgage			\$	\$			\$ 335,588					
2	Greystone		X	Mortgage							114,116					
3																
4																
5																
Working Capital																
6	Private Bank		X	Line of Credit							16,627					
7	Allocated from Managcare		X								60					
8	See Supplemental Schedule										2,379					
9	TOTAL Facility Related						\$	\$			\$ 468,770					
B. Non-Facility Related*																
10	Interest Expense - Bldg Co										76,155					
11	Interest Income		X								(3)					
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$ 76,152					
15	TOTALS (line 9+line14)						\$	\$			\$ 544,922					

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

Colonial Hlthcare & Rehab Ctr

0052167

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8	Allocated from 4600 Touhy, LLC		X				\$	\$			\$ 2,379					
9																
10																
11																
12																
13																
14	TOTAL Working Capital										2,379					
	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.		\$	64,953		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.)		\$	34,382		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(30,571)		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	98,752		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.)		\$	360		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 \$ 1,080 For 2011 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.		\$	68,541		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	61,605			8
	2010	63,256			9
	2011	60,975			10
	2012	63,679			11
	2013	32,454			12
Allocated from 4600 Touhy, LLC \$1,928					
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

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 Colonial Hlthcre & Rehab Ctr COUNTY Bureau
 FACILITY IDPH LICENSE NUMBER 0052167
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>16-15-301-008</u>	<u>Long Term Care Property</u>	\$ <u>528.92</u>	\$ <u>528.92</u>
2. <u>16-15-301-009</u>	<u>Long Term Care Property</u>	\$ <u>528.92</u>	\$ <u>528.92</u>
3. <u>16-15-303-020</u>	<u>Long Term Care Property</u>	\$ <u>31,395.84</u>	\$ <u>31,395.84</u>
4. <u>See Attached</u>	<u>Alloc. From 4600 Touhy</u>	\$ <u>84,567.54</u>	\$ <u>2,100.30</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>117,021.22</u></u>	\$ <u><u>34,553.98</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Colonial Hlthcre & Rehab Ctr

0052167 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,295 B. General Construction Type: Exterior Brick Frame _____ 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.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2013	\$ 372,705	1
2	Allocated from 4600 Touhy			4,470	2
3	TOTALS			\$ 377,175	3

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	92		2013	1973	\$ 2,866,814	\$ 338,512	35	\$ 81,909	\$ (256,603)	\$ 156,577	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			52,076	1,678	2,178	500	6,276	68
69				6,793		(6,793)		69
70			\$ 2,918,890	\$ 346,983		\$ 84,087	\$ (262,896)	\$ 162,853 70

**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 12A, Carried Forward		\$ 2,918,890	\$ 346,983		\$ 84,087	\$ (262,896)	\$ 162,853	1
2	Installed New 5 Ton Condensing Unit For North A/C	2013	2,734		20	273	273	410	2
3	Installed New Building Signage	2013	6,896		20	690	690	977	3
4	Installed New Window Treatments And Flooring In Therapy Gym	2014	6,268		20	313	313	313	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,934,788	\$ 346,983		\$ 85,363	\$ (261,620)	\$ 164,553	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward								
2		\$ 2,934,788	\$ 346,983		\$ 85,363	\$ (261,620)	\$ 164,553		1
3									2
4									3
5									4
6									5
7									6
8									7
9									8
10									9
11									10
12									11
13									12
14									13
15									14
16									15
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24									23
25									24
26									25
27									26
28									27
29									28
30									29
31									30
32									31
33									32
34	TOTAL (lines 1 thru 33)	\$ 2,934,788	\$ 346,983		\$ 85,363	\$ (261,620)	\$ 164,553		33
									34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,934,788	\$ 346,983		\$ 85,363	\$ (261,620)	\$ 164,553	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
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)		\$ 2,934,788	\$ 346,983		\$ 85,363	\$ (261,620)	\$ 164,553	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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,934,788	\$ 346,983		\$ 85,363	\$ (261,620)	\$ 164,553	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,934,788	\$ 346,983		\$ 85,363	\$ (261,620)	\$ 164,553	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 4600 Touhy, LLC	2012	25,504	654	30	850	196	2,550	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Managcare	2013	428	114	20	21	(93)	43	9
10	Allocated from Managcare	2012	5,325	381	20	266	(115)	799	10
11									11
12									12
13	Allocated from 4600 Touhy, LLC	2012	16,425	425	20	821	396	2,464	13
14	Allocated from 4600 Touhy, LLC	2013	3,997	94	20	200	106	400	14
15	Allocated from 4600 Touhy, LLC	2014	397	10	20	20	10	20	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)		\$ 52,076	\$ 1,678		\$ 2,178	\$ 500	\$ 6,276	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 12H, Carried Forward		\$ 52,076	\$ 1,678		\$ 2,178	\$ 500	\$ 6,276	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)		\$ 52,076	\$ 1,678		\$ 2,178	\$ 500	\$ 6,276	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	\$ 1,306,625	\$ 2,076	\$ 132,563	\$ 130,487	10	\$ 264,485	71
72	Current Year Purchases	52,421		5,628	5,628	10	5,628	72
73	Fully Depreciated Assets	12,234				10	12,234	73
74								74
75	TOTALS	\$ 1,371,280	\$ 2,076	\$ 138,191	\$ 136,115		\$ 282,347	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		Allocated from Managcare	2013	\$ 6,003	\$ 291	\$ 681	\$ 390	5	\$ 5,489	76
77										77
78										78
79										79
80	TOTALS			\$ 6,003	\$ 291	\$ 681	\$ 390		\$ 5,489	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)	\$ 4,689,246	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 349,350	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 224,235	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (125,115)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 452,389	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 Colonial Hlthre & Rehab Ctr

0052167

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: \$ 2,041

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	Facility	2014 Ford	\$ 938.00	\$ 6,992	17
18					18
19					19
20					20
21	TOTAL		\$ 938.00	\$ 6,992	21

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

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

Facility Name & ID Number Colonial Hlthcare & Rehab Ctr # 0052167 Report Period Beginning: 01/01/14 Ending: 12/31/14
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	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	\$		\$	126,167	\$		\$	126,167	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				51,833				51,833	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				181,663				181,663	4
5	Physician Care		visits									5
6	Dental Care	39 - 03	visits				1,014				1,014	6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					72,153			72,153	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>						10,083	7,529			17,612	13
14	TOTAL			\$		\$	370,760	79,682		\$	450,442	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 Colonial Hlthcare & Rehab Ctr# 0052167Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 140,198	\$	1
2	Cash-Patient Deposits	13,653		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	974,790		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	86,241		6
7	Other Prepaid Expenses	90,295		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	127,180		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,432,357	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	19,256		15
16	Equipment, at Historical Cost	83,760		16
17	Accumulated Depreciation (book methods)	(10,724)		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):	475,613		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 567,905	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,000,262	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 439,936	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,653		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	144,192		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,740		31
32	Accrued Real Estate Taxes(Sch.IX-B)	98,752		32
33	Accrued Interest Payable	1,034		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	58,505		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 772,812	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	912,854		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 912,854	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,685,666	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 314,596	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,000,262	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 53,914	1
2	Restatements (describe):		2
3	Rounding	6	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 53,920	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	260,676	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 260,676	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)	\$ 314,596	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,125,088	1
2	Discounts and Allowances for all Levels	(85,851)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,039,237	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	811,827	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 811,827	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,517	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	62,924	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,733	19
20	Radiology and X-Ray	10,604	20
21	Other Medical Services	72,127	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 153,905	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,826	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,826	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	8,275	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,275	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,015,070	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	734,921	31
32	Health Care	1,635,931	32
33	General Administration	1,035,611	33
B. Capital Expense			
34	Ownership	676,631	34
C. Ancillary Expense			
35	Special Cost Centers	491,346	35
36	Provider Participation Fee	179,954	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,754,394	40
41	Income before Income Taxes (line 30 minus line 40)**	260,676	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 260,676	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,783,890	44
45	Private Pay - Net Inpatient Revenue	1,586,134	45
46	Medicare - Net Inpatient Revenue	569,992	46
47	Other-(specify) <u>Hospice</u>	37,306	47
48	Other-(specify) <u>Insurance</u>	61,915	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,039,237	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 Colonial Hlthcare & Rehab Ctr

0052167

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	1,896	2,080	\$ 76,555	\$ 36.81	1
2	Assistant Director of Nursing	1,957	2,120	65,858	31.07	2
3	Registered Nurses	14,508	15,933	444,294	27.89	3
4	Licensed Practical Nurses	10,413	11,330	236,933	20.91	4
5	CNAs & Orderlies	44,233	48,361	578,942	11.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,860	2,076	29,652	14.28	9
10	Activity Assistants	2,837	3,008	26,832	8.92	10
11	Social Service Workers	2,321	2,583	36,344	14.07	11
12	Dietician					12
13	Food Service Supervisor	2,750	3,052	50,773	16.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,939	16,923	156,232	9.23	15
16	Dishwashers					16
17	Maintenance Workers	1,880	2,080	57,159	27.48	17
18	Housekeepers	9,400	10,056	92,717	9.22	18
19	Laundry	3,627	3,919	34,667	8.85	19
20	Administrator	1,550	1,754	73,859	42.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,113	7,613	99,724	13.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,903	2,078	29,386	14.14	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,199	1,239	23,464	18.94	33
34	TOTAL (lines 1 - 33)	125,386	136,205	\$ 2,113,391 *	\$ 15.52	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 6,792	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant	Quarterly	1,960	10-03	37
38	Nurse Consultant	Monthly	26,400	10-03	38
39	Pharmacist Consultant	785	5,024	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Quarterly	1,105	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	816	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	801	\$ 54,097		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
LouAnne Kenwick	Administrator	0	\$ 73,859	Workers' Compensation Insurance	\$ 33,408	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	27,784	Advertising: Employee Recruitment	17,486	
				FICA Taxes	161,674	Health Care Worker Background Check		
				Employee Health Insurance	98,213	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	186	
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	1,863	
				Other Employee Benefits	14,600	Licenses & Permits	433	
				Safe Harbor Match Expense	37,994	Allocated from Managcare	1,905	
				Holiday Expense	4,588	Allocated from 4600 Touhy, LLC	6	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 73,859					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount					
Management Fees - Tetrad			\$ 53,301				Less: Public Relations Expense ()	
							Non-allowable advertising ()	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 53,301					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Frost, Ruttenberg & Rothblatt	Accounting		\$ 14,625				Out-of-State Travel	\$
Legal	See Attached		20,409					
Personnel Planners	Unemployment Consulting		3,391					
Managcare, Inc.	Bookkeeping		73,920				In-State Travel	
Managcare, Inc.	Administrative Consulting		15,840					
Prospect Resources	Natural Gas Procurement		600					
ProvINET Solutions	IT Consulting		3,371					
Onward Consulting	IT Consulting		7,576				Seminar Expense	1,605
Management and Network Srv	Care Coordination Software		500				Allocated from Managcare	73
FRS Healthcare Consultants	Healthcare Consulting		1,500					
MDI Achieve	E.H.R. Solutions		191					
See Supplemental Schedule			38,514				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 180,438				TOTAL \$ 1,678	

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number Colonial Hlthcre & Rehab Ctr

0052167

Report Period Beginning:

01/01/14

Ending:

12/31/14

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$12,565
- (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. \$ 16,220 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 179,954
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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,517
- (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? N/A
- 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.