

Facility Name & ID Number Columbus Park N & Rehab Ctr

0037960 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3	108	Intermediate (ICF)	108	39,420	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	216	TOTALS	216	78,840	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	25,546	399	22,521	48,466	8
9	SNF/PED					9
10	ICF	21,926		94	22,020	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,472	399	22,615	70,486	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.40%

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 1/1/1992

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

YES Date 1/1/1992 NO

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

YES NO If YES, enter number of beds certified 108 and days of care provided 4,012

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number

Columbus Park N & Rehab Ctr

0037960

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	275,984	51,562	43,968	371,514		371,514	(19,011)	352,503		1
2	Food Purchase		373,311		373,311	(35,040)	338,271	(21)	338,250		2
3	Housekeeping	285,818	56,817		342,635		342,635		342,635		3
4	Laundry	103,633	31,105		134,738		134,738		134,738		4
5	Heat and Other Utilities			249,694	249,694		249,694	(9,105)	240,589		5
6	Maintenance	54,256	73,375	273,312	400,943		400,943	9,169	410,112		6
7	Other (specify):*							19,286	19,286		7
8	TOTAL General Services	719,691	586,170	566,974	1,872,835	(35,040)	1,837,795	318	1,838,113		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	2,816,159	177,318	74,661	3,068,138		3,068,138	(15,089)	3,053,049		10
10a	Therapy	168,744	21,719	23,507	213,970		213,970	(11,983)	201,987		10a
11	Activities	130,917	18,054	4,590	153,561		153,561		153,561		11
12	Social Services	287,831		32,568	320,399		320,399		320,399		12
13	CNA Training										13
14	Program Transportation			1,305	1,305		1,305		1,305		14
15	Other (specify):*							7,268	7,268		15
16	TOTAL Health Care and Programs	3,403,651	217,091	143,831	3,764,573		3,764,573	(19,804)	3,744,769		16
	C. General Administration										
17	Administrative	166,082		103,680	269,762		269,762	24,806	294,568		17
18	Directors Fees										18
19	Professional Services			221,956	221,956	(19,220)	202,736	(110,273)	92,463		19
20	Dues, Fees, Subscriptions & Promotions			50,433	50,433		50,433	(13,894)	36,539		20
21	Clerical & General Office Expenses	160,904	26,861	592,925	780,690		780,690	(374,520)	406,170		21
22	Employee Benefits & Payroll Taxes			776,653	776,653	35,040	811,693		811,693		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,928	4,928		4,928	972	5,900		24
25	Other Admin. Staff Transportation			1,629	1,629		1,629	12,051	13,680		25
26	Insurance-Prop.Liab.Malpractice			199,920	199,920		199,920	13,543	213,463		26
27	Other (specify):*							49,647	49,647		27
28	TOTAL General Administration	326,986	26,861	1,952,124	2,305,971	15,820	2,321,791	(397,668)	1,924,123		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,450,328	830,122	2,662,929	7,943,379	(19,220)	7,924,159	(417,155)	7,507,004		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.

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			176,163	176,163		176,163	404,692	580,855			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			93,143	93,143		93,143	369,460	462,603			32
33	Real Estate Taxes					19,220	19,220	287,095	306,315			33
34	Rent-Facility & Grounds			1,044,000	1,044,000		1,044,000	(1,044,000)				34
35	Rent-Equipment & Vehicles			3,566	3,566		3,566	7,684	11,250			35
36	Other (specify):*							53,784	53,784			36
37	TOTAL Ownership			1,316,872	1,316,872	19,220	1,336,092	78,715	1,414,807			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		160,051	453,801	613,852		613,852	(5,405)	608,447			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			530,970	530,970		530,970		530,970			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		160,051	984,771	1,144,822		1,144,822	(5,405)	1,139,417			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,450,328	990,173	4,964,572	10,405,073		10,405,073	(343,845)	10,061,228			45

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

Facility Name & ID Number Columbus Park N & Rehab Ctr

0037960

Report Period Beginning: 01/01/14

Ending: 12/31/14

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(11,467)	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	103,710	30		9
10	Interest and Other Investment Income	(125)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(21)	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				18
19	Entertainment				19
20	Contributions	(3,749)	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	(488,765)	21		24
25	Fund Raising, Advertising and Promotional	(7,700)	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	(57,655)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (465,772)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	121,927		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 121,927		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (343,845)		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

Columbus Park N & Rehab Ctr

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Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Legal Fees - Collections	\$ (7,065)	21	1
2	Bank Fees	(7,009)	21	2
3	Theft & Damage Loss	(478)	21	3
4	Miscellaneous Income	(52)	21	4
5	Bldg Co. - Fees	(250)	20	5
6	Bldg Co. - Office Expense	(36)	21	6
7	Bldg Co. - Professional Fees	(8,000)	19	7
8	Bldg Co. - Amortization	(4,624)	36	8
9	Capitalized R&M	(15,683)	06	9
10	PPA - Pharmacy	(5,405)	39	10
11	Non Allowable Legal Fees	(3,143)	19	11
12	PAC Dues	(5,810)	20	12
13	Annual Report	(100)	20	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(57,655)	49

Columbus Park N & Rehab Ctr

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Report Period Beginning: 01/01/14

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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 Columbus Park N & Rehab Ctr# 0037960

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				(19,011)								(19,011)	1
2	Food Purchase	(21)											(21)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(11,467)			2,362								(9,105)	5
6	Maintenance	(15,683)	1,979	(12,739)	35,612								9,169	6
7	Other (specify):*			827	18,459								19,286	7
8	TOTAL General Services	(27,171)	1,979	(11,912)	37,422								318	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(24,650)	9,561								(15,089)	10
10a	Therapy				(11,983)								(11,983)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			4,211	3,057								7,268	15
16	TOTAL Health Care and Programs			(20,439)	635								(19,804)	16
	C. General Administration													
17	Administrative			(71,904)	96,710								24,806	17
18	Directors Fees													18
19	Professional Services	(11,143)	8,000	(126,519)	19,389								(110,273)	19
20	Fees, Subscriptions & Promotions	(17,609)	250	3,465									(13,894)	20
21	Clerical & General Office Expenses	(503,404)	36	128,763	85								(374,520)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			972									972	24
25	Other Admin. Staff Transportation			12,051									12,051	25
26	Insurance-Prop.Liab.Malpractice		10,859	2,515	169								13,543	26
27	Other (specify):*			29,678	19,969								49,647	27
28	TOTAL General Administration	(532,156)	19,145	(20,979)	136,322								(397,668)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(559,328)	21,124	(53,330)	174,379								(417,155)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Columbus Park N & Rehab Ctr

0037960

Report Period Beginning:

01/01/14

Ending:

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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	103,710	294,106		6,876								404,692	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(125)	386,072	(23,966)	7,479								369,460	32
33	Real Estate Taxes		278,081		9,014								287,095	33
34	Rent-Facility & Grounds		(1,044,000)										(1,044,000)	34
35	Rent-Equipment & Vehicles			7,684									7,684	35
36	Other (specify):*	(4,624)	58,408										53,784	36
37	TOTAL Ownership	98,961	(27,333)	(16,282)	23,369								78,715	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(5,405)											(5,405)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(5,405)											(5,405)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(465,772)	(6,209)	(69,612)	197,748								(343,845)	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 6-Supplemental		See 6-Supplemental		See 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	\$ 1,044,000	Columbus Park LLC	100.00%	\$	\$ (1,044,000)	1
2	V	20 Fees		Columbus Park LLC	100.00%	250	250	2
3	V	36 Insurance - MIP		Columbus Park LLC	100.00%	53,784	53,784	3
4	V	26 Insurance - Property		Columbus Park LLC	100.00%	10,859	10,859	4
5	V	32 Interest - HUD	97	Columbus Park LLC	100.00%	386,169	386,072	5
6	V	21 Office Expense		Columbus Park LLC	100.00%	36	36	6
7	V	19 Professional Fees		Columbus Park LLC	100.00%	8,000	8,000	7
8	V	33 Real Estate Taxes	9,919	Columbus Park LLC	100.00%	288,000	278,081	8
9	V	06 Repairs		Columbus Park LLC	100.00%	1,979	1,979	9
10	V	36 Amortization - HUD Costs		Columbus Park LLC	100.00%	4,624	4,624	10
11	V	30 Depreciation		Columbus Park LLC	100.00%	294,106	294,106	11
12	V							12
13	V							13
14	Total		\$ 1,054,016			\$ 1,047,807	\$ * (6,209)	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	6 REPAIRS AND MAINT.	\$ 25,920	S.I.R. MANAGEMENT, INC.	100.00%	\$ 13,181	\$ (12,739)
16	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	827	827
17	V	10 NURSING	54,432	S.I.R. MANAGEMENT, INC.	100.00%	29,782	(24,650)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	4,211	4,211
19	V	19 PROFESSIONAL FEES	147,456	S.I.R. MANAGEMENT, INC.	100.00%	12,485	(134,971)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	3,465	3,465
21	V	21 CLERICAL & GENERAL	51,840	S.I.R. MANAGEMENT, INC.	100.00%	55,473	3,633
22	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	972	972
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	12,051	12,051
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	2,515	2,515
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	8,749	8,749
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(23,966)	(23,966)
27	V	35 AUTO RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,392	6,392
28	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,292	1,292
29	V						
30	V	17 ADMINISTRATIVE	103,680	S.I.R. MANAGEMENT, INC.	100.00%	31,776	(71,904)
31	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	8,452	8,452
32	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	125,130	125,130
33	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	20,929	20,929
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 383,328			\$ 313,716	\$ * (69,612)

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

Facility Name & ID Number

Columbus Park N & Rehab Ctr

0037960

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETARY SALARIES	\$ 25,920	S.I.R. MANAGEMENT, INC.	100.00%	\$ 6,909	\$ (19,011)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,019	1,019	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	9,561	9,561	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,363	1,363	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	96,710	96,710	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	18,472	18,472	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	19,969	19,969	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	23,328	S.I.R. MANAGEMENT, INC.	100.00%	11,345	(11,983)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,694	1,694	25
26	V								26
27	V	6	MAINTENANCE SALARIES	77,752	S.I.R. MANAGEMENT, INC.	100.00%	111,509	33,757	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	17,440	17,440	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,362	2,362	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,855	1,855	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	917	917	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	85	85	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	169	169	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	6,876	6,876	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	7,479	7,479	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	9,014	9,014	37
38	V								38
39	Total		\$ 127,000				\$ 324,748	\$ * 197,748	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Ancillary	\$ 10,395	Long Term Care Laboratory, LLC	100.00%	\$ 10,395	\$	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		\$ 10,395			\$ 10,395	\$ *	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: 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

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	ADAM VALES	2.830%	ALBANY CARE INC	EVANSTON	COLUMBUS PARK, LLC	LINCOLNWOOD	BUILDING CO.	1
2	ARI WOLFF	0.943%	APPLEWOOD REHABILITATION CENTER,LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	ASHLEY BARRISH	2.044%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	B. BART BARRISH II	2.044%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	LONG TERM CARE LABORATO	ELK GROVE VILLAGE	LABORATORY	4
5	B.G. TRUST	2.319%	ELMWOOD CARE, INC.	ELMWOOD PARK	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	5
6	BRYAN BARRISH TRUST	7.193%	GREENWOOD CARE, INC.	EVANSTON				6
7	CELESTE GIANNINI TRUST	6.604%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				7
8	CHERYL MAGENCE	0.943%	REGENCY REHABILITATION CENTER,LLC	NILES				8
9	DANIEL ROTHNER	4.717%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				9
10	DARCEY BARRISH	2.044%	WILSON CARE, INC.	CHICAGO				10
11	ERIC ROTHNER	3.774%	WESLEY HEALTHCARE & REHAB CENTER	AUBURN, IN				11
12	GALE ROTHNER	3.774%	OAKTON PAVILION	DES PLAINES				12
13	GLENDA STRICKLAND	0.943%						13
14	JULIANA R BARRISH TRUST	7.193%						14
15	KATHRYN VALES	2.830%						15
16	KIMBERLY VALES ACCUMULATION TRUST	3.459%						16
17	KIRSTEN BARRISH	2.044%						17
18	L.G. TRUST	2.319%						18
19	LAURI WOLFF POLEN	0.943%						19
20	LOUISE BERGTHOLD	4.245%						20
21	MARILYN WOLFF REV. TRUST	4.245%						21
22	MELISSA ROTHNER	4.717%						22
23	MICHAEL R GIANNINI	6.604%						23
24	NENITA GUZMAN	1.887%						24
25	NOAH WOLFF REV. TRUST	4.245%						25
26	RACHEL ROTHNER	4.717%						26
27	RANAN WOLFF	0.943%						27
28	THOMAS WINTER	3.774%						28
29	TZIONA ZEFFREN	0.943%						29
30	WILLIAM ROTHNER	4.717%						30

Facility Name & ID Number

Columbus Park N & Rehab Ctr

0037960

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 Columbus Park N & Rehab Ctr # 0037960 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	Bryan Barrish	Relative	Administrative	0	See Attached	3.75	8.33%	Alloc. Salary	\$ 18,758	17-7	1
2	Michael Giannini	Shareholder	Administrative	6.60%	See Attached	3.28	8.20%	Alloc. Salary	15,656	17-7	2
3	Kirsten Barrish	Shareholder	Clerical	2.04%	See Attached	4.69	9.38%	Alloc. Salary	8,652	21-7	3
4	Sarah Barrish	Relative	Administrative	0	See Attached	4.22	9.38%	Alloc. Salary	11,411	17-7	4
5	Nenita Guzman	Shareholder	Dietary	1.89%	See Attached	4.69	9.38%	Alloc. Salary	6,909	1-7	5
6	Tom Winter	Shareholder	Administrative	3.77%	See Attached	5.63	9.38%	Alloc. Salary	18,758	17-7	6
7	Louise Bergthold	Shareholder	Administrative	4.25%	See Attached	5.63	9.38%	Alloc. Salary	18,758	17-7	7
8	Thomas Bergthold	Relative	Clerical	0	See Attached	3.75	9.38%	Alloc. Salary	3,787	21-7	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 anticipated to be considered allowable by the IL. Dept. of HFS.										11
12											12
13	TOTAL								\$ 102,689		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 Columbus Park N & Rehab Ctr

0037960

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 Columbus Park N & Rehab Ctr

0037960

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 S.I.R. MANAGEMENT, INC.
 Street Address 6840 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 675 -7979
 Fax Number (847) 675 -0555

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	6	REPAIRS AND MAINT.	PATIENT DAYS	751,530	16	\$ 140,542	\$ 58,090	70,486	\$ 13,181	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	751,530	16	8,819		70,486	827	2
3	10	NURSING	PATIENT DAYS	751,530	16	317,539	317,539	70,486	29,782	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	751,530	16	44,898		70,486	4,211	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	751,530	16	133,120	89,849	70,486	12,485	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	751,530	16	36,940		70,486	3,465	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	751,530	16	591,459	531,411	70,486	55,473	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	751,530	16	10,362		70,486	972	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	751,530	16	128,491		70,486	12,051	9
10	26	INSURANCE	PATIENT DAYS	751,530	16	26,818		70,486	2,515	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	751,530	16	93,282		70,486	8,749	11
12	32	INTEREST	PATIENT DAYS	751,530	16	(255,531)		70,486	(23,966)	12
13	35	AUTO RENTAL	PATIENT DAYS	751,530	16	68,150		70,486	6,392	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	751,530	16	13,772		70,486	1,292	14
15										15
16	17	ADMINISTRATIVE	PATIENT DAYS	751,530	16	338,802	338,802	70,486	31,776	16
17	19	PROFESSIONAL FEES	PATIENT DAYS	751,530	16	90,119		70,486	8,452	17
18	21	CLERICAL & GENERAL	PATIENT DAYS	751,530	16	1,334,152	1,203,304	70,486	125,130	18
19	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	751,530	16	223,152		70,486	20,929	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,344,886	\$ 2,538,995		\$ 313,716	25

Facility Name & ID Number Columbus Park N & Rehab Ctr

0037960

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 S.I.R. MANAGEMENT, INC.
 Street Address 6840 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 675 -7979
 Fax Number (847) 675 -0555

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 SALARIES	PATIENT DAYS	751,530	16	\$ 73,669	\$ 73,669	70,486	\$ 6,909	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	751,530	16	10,866	70,486	70,486	1,019	2
3	10	NURSING SALARIES	PATIENT DAYS	751,530	16	101,941	101,941	70,486	9,561	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	751,530	16	14,528	70,486	70,486	1,363	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	751,530	16	1,031,137	1,031,137	70,486	96,710	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	751,530	16	196,950	70,486	70,486	18,472	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	751,530	16	212,914	70,486	70,486	19,969	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	274,680	15	133,582	133,582	23,328	11,345	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	274,680	15	19,951	23,328	23,328	1,694	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	395,144	15	566,698	566,698	77,752	111,509	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	395,144	15	88,633	77,752	77,752	17,440	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,880	15	25,179	1,208	1,208	2,362	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,880	15	19,781	1,208	1,208	1,855	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,880	15	9,777	1,208	1,208	917	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,880	15	907	1,208	1,208	85	19
20	26	INSURANCE	ALLOCATED SQ FT	12,880	15	1,804	1,208	1,208	169	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,880	15	73,312	1,208	1,208	6,876	21
22	32	INTEREST	ALLOCATED SQ FT	12,880	15	79,739	1,208	1,208	7,479	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,880	15	96,114	1,208	1,208	9,014	23
24										24
25	TOTALS					\$ 2,757,482	\$ 1,907,027		\$ 324,748	25

Facility Name & ID Number Columbus Park N & Rehab Ctr

0037960

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 Long Term Care Laboratory, LLC
 Street Address 2458 Elmhurst Road
 City / State / Zip Code Elk Grove Village, IL 60007
 Phone Number (630)422-7800
 Fax Number (847)422-1360

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	39	Ancillary	Direct Allocation		\$	\$		\$ 10,395	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				\$	\$		\$ 10,395	25

Facility Name & ID Number Columbus Park N & Rehab Ctr

0037960

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 Columbus Park N & Rehab Ctr

0037960

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 Columbus Park N & Rehab Ctr

0037960

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 Columbus Park N & Rehab Ctr

0037960

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 Columbus Park N & Rehab Ctr

0037960

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 Columbus Park N & Rehab Ctr

0037960

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	HUD		X	Mortgage		9/3/03	\$	\$ 10,650,811			\$ 386,169	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6	Lake Forest Bank		X	Line of Credit				1,365,000			93,143	6					
7	Allocated from SIR Management	X									7,479	7					
8												8					
9	TOTAL Facility Related						\$	\$ 12,015,811			\$ 486,791	9					
B. Non-Facility Related*																	
10	Interest Income		X								(125)	10					
11	Interest Income - Bldg Co.		X								(97)	11					
12	Allocated from SIR Management	X									(23,966)	12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (24,188)	14					
15	TOTALS (line 9+line14)						\$	\$ 12,015,811			\$ 462,603	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 53,784 Line # 36

* 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

Columbus Park N & Rehab Ctr

0037960

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							\$	\$			\$					
9																
10																
11																
12																
13																
14	TOTAL Working Capital															
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.		\$	284,000		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.)		\$	283,095		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(905)		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	288,000		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.)		\$	19,220		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 \$ 55,179 For 2010 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.		\$	306,315		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	276,310			8
	2010	288,339			9
	2011	287,140			10
	2012	270,421			11
	2013	274,081			12
2014 Accrual = \$274,081 x 1.05 = \$288,000 (Rounded)					
Allocated from SIR Management = \$9,014					
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 Columbus Park N & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037960

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>16-17-401-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>90,182.20</u>	\$ <u>90,182.20</u>
2. <u>16-17-401-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>38,931.54</u>	\$ <u>38,931.54</u>
3. <u>16-17-401-026-0000</u>	<u>Long Term Care Property</u>	\$ <u>144,967.05</u>	\$ <u>144,967.05</u>
4. <u>See Attached</u>	<u>Allocated from S.I.R. Management</u>	\$ <u>116,016.54</u>	\$ <u>8,521.56</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>390,097.33</u></u>	\$ <u><u>282,602.35</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 Columbus Park N & Rehab Ctr

0037960 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,685 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 6

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	<u>Facility</u>		<u>2002</u>	<u>\$ 300,000</u>	1
2					2
3	TOTALS			\$ 300,000	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	216		1976	\$ 7,013,521	\$	35	\$ 200,386	\$ 200,386	\$ 2,444,415	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1992	51,845		20			51,823	9
10	Various		1993	71,558		20			71,551	10
11	Various		1994	46,784		20	624	624	46,774	11
12	Various		1995	131,277		20	6,445	6,445	128,552	12
13	Various		1996	62,128		20	3,106	3,106	58,409	13
14	Various		1997	40,477		20	2,024	2,024	35,574	14
15	Various		1998	448,767		20	22,438	22,438	368,122	15
16	Various		1999	202,884		20	10,134	10,134	157,319	16
17	Various		2000	27,418		20	1,371	1,371	19,875	17
18	Various		2001	87,910		20	4,396	4,396	58,234	18
19	Various		2002	35,511		20	132	132	35,511	19
20	Various		2003	96,681		20	4,362	4,362	58,917	20
21	Various		2004	77,186		20	4,060	4,060	43,018	21
22	Various		2005	111,165		20	6,181	6,181	59,711	22
23	Various		2006	84,177		20	4,209	4,209	35,510	23
24	Various		2007	305,862		20	15,713	15,713	127,348	24
25	Various		2008	720,628		20	62,405	62,405	441,241	25
26	Various		2009	214,087		20	10,704	10,704	61,417	26
27	Various		2010	118,340		20	12,033	12,033	52,437	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		1,281,403	248,567		73,056	(175,511)	389,081	67
68		182,429	4,602		6,525	1,923	95,367	68
69			176,163			(176,163)		69
70		\$ 11,412,037	\$ 429,332		\$ 450,304	\$ 20,972	\$ 4,840,206	70

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

Facility Name & ID Number Columbus Park N & Rehab Ctr

0037960

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 11,412,037	\$ 429,332		\$ 450,304	\$ 20,972	\$ 4,840,206	1
2	Fire Alarm Upgrades	2011	7,534		20	377	377	1,256	2
3	Masonry, Caulking, Tuckpointing	2011	36,755		20	1,838	1,838	5,973	3
4	Doors & Windowsills	2012	33,885		20	1,694	1,694	3,812	4
5	Nurse Station Bathrooms - Replace Floor Tile & New Fixtures	2012	11,032		20	552	552	1,241	5
6	Roof Work	2012	9,500		20	475	475	1,029	6
7	Floor Tile & Wall Base	2012	3,726		20	186	186	404	7
8	Hot Water Heater	2012	7,772		20	389	389	842	8
9	Sprinkler Heads	2012	6,330		20	317	317	686	9
10	Tile Flooring	2012	7,761		20	776	776	1,617	10
11	Tile And Base	2012	3,604		20	240	240	501	11
12	Custom Built-In Cabinets	2012	6,000		20	300	300	650	12
13	Parking Lot Overlay	2012	11,350		20	757	757	1,766	13
14	Boiler Repair	2012	2,950		20	148	148	430	14
15	Replace Mixing Valve	2012	3,875		20	194	194	533	15
16	Outdoor Repairs - Concrete Ramp, Fix Drain, Downspouts, Drywa	2012	8,400		20	420	420	945	16
17	Handrail Repair For All Floors	2012	2,785		20	139	139	290	17
18	Elevator Repairs	2012	2,686		20	134	134	302	18
19	Public & Staff Bathroom Floor & Wall Tiles, Toilet, Sink, Faucet	2013	11,000		20	1,100	1,100	2,200	19
20	North Stairwell - Railings Square Tubes	2013	3,250		20	325	325	596	20
21	Fire Alarm Upgrades	2013	8,808		20	881	881	1,615	21
22	Frie Alarm System	2013	6,939		20	694	694	1,214	22
23	Elevator Shaft Floor Drain & Sump Pump	2013	4,300		20	430	430	753	23
24	Hvac Compressor	2013	7,124		20	712	712	1,128	24
25	Wall Base	2013	4,216		20	422	422	668	25
26	Circulating Pump	2013	2,852		20	285	285	452	26
27	Fire Alarm System	2013	36,051		20	3,605	3,605	6,309	27
28	Elevator Control Room Hvac	2013	9,636		20	964	964	1,606	28
29	Elevator - Special Emergency Service, Keyswitch, Hall Buttons	2013	128,673		20	12,867	12,867	21,446	29
30	Flooring In Vending Area	2013	3,232		20	323	323	431	30
31	Heat Exchanger	2013	8,599		20	860	860	1,147	31
32	3Rd Fl Stairwell Doors Magnetic Door Locks	2013	4,250		20	425	425	602	32
33	Remodel Elevator	2013	12,441		20	1,244	1,244	1,866	33
34	TOTAL (lines 1 thru 33)		\$ 11,829,353	\$ 429,332		\$ 484,376	\$ 55,044	\$ 4,904,512	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 12B, Carried Forward		\$ 11,829,353	\$ 429,332		\$ 484,376	\$ 55,044	\$ 4,904,512	1
2	Sprinkler Heads	2013	3,503		20	350	350	438	2
3	Televisions Wiremold	2013	28,200		20	2,820	2,820	4,230	3
4	Shower Curtains	2013	3,088		20	309	309	386	4
5	Boiler Upgrades	2013	3,960		20	396	396	429	5
6	Elvator Security Keypad	2013	6,153		20	615	615	923	6
7	Therapy Room Drapery	2013	6,420		20	642	642	749	7
8	Handrails And Corner Guards	2014	8,326		20	763	763	763	8
9	Vertical Hvac Fan Coil Unit	2014	35,561		20	2,963	2,963	2,963	9
10	Handrails And Crashrails	2014	3,137		20	26	26	26	10
11	Hot Water Heater	2014	4,463		20	298	298	298	11
12	Condenser Coil On Chiller	2014	12,522		20	1,252	1,252	1,252	12
13	Caulking & Concrete Patching In West Elevation	2014	2,600		20	130	130	130	13
14	Replace Power Supply For Elevator Lighting	2014	4,388		20	219	219	219	14
15	Repair Elevator Hoistway Door Interlock	2014	3,039		20	152	152	152	15
16	Repair Elevator Car Door Vane/Clutch	2014	2,671		20	134	134	134	16
17	Replace Door Closers In Rm 216, 512, 514	2014	2,985		20	149	149	149	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)		\$ 11,960,369	\$ 429,332		\$ 495,595	\$ 66,263	\$ 4,917,753	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		\$ 11,960,369	\$ 429,332		\$ 495,595	\$ 66,263	\$ 4,917,753	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)		\$ 11,960,369	\$ 429,332		\$ 495,595	\$ 66,263	\$ 4,917,753	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward								
2		\$ 11,960,369	\$ 429,332		\$ 495,595	\$ 66,263	\$ 4,917,753		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
17									16
18									17
19									18
20									19
21									20
22									21
23									22
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)	\$ 11,960,369	\$ 429,332		\$ 495,595	\$ 66,263	\$ 4,917,753		33
									34

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

Facility Name & ID Number Columbus Park N & Rehab Ctr

0037960

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Elevator Work	2003	67,488		20	3,374	3,374	40,488	9
10	Roof Work	2005	98,265		20	4,913	4,913	49,130	10
11	HVAC Chiller	2005	52,295		20	2,615	2,615	26,150	11
12	Rooftop Cooling Tower	2006	23,800		20	2,380	2,380	21,420	12
13	A/C Chiller	2006	48,000		20	9,600	9,600	86,400	13
14	Carpet	2008	5,496		20	1,099	1,099	7,693	14
15	Camera / Video System	2008	11,319		20	566	566	3,962	15
16	Draperies and Floors	2009	34,320		20	1,716	1,716	10,296	16
17	Security Camera	2010	3,100		20	310	310	1,550	17
18	Flooring	2010	3,435		20	143	143	715	18
19	Step Construction Therapy	2010	9,538		20	397	397	1,985	19
20	Re-Key Door Locks	2010	6,622		20	193	193	965	20
21	Booster Heater	2010	3,306		20	83	83	415	21
22	Elevator Work	2010	3,670		20	184	184	920	22
23	Flooring	2010	3,162		20	145	145	725	23
24	Hot Water Heater	2010	4,929		20	205	205	1,025	24
25	Tile Flooring	2011	7,313		20	366	366	1,464	25
26	Chair Rails	2011	7,849		20	392	392	1,568	26
27	Elevator Starter	2011	5,975		20	299	299	1,196	27
28	Baseboard Heater & Repair	2011	2,556		20	128	128	511	28
29	Kitchen Pipe Replacement	2011	3,406		20	170	170	681	29
30	Masonry Repairs, caulking	2012	40,600		20	2,030	2,030	6,090	30
31	Cabinetry-Admin Office	2012	8,980		20	449	449	1,347	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 455,424	\$		\$ 31,757	\$ 31,757	\$ 266,696	34

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

Facility Name & ID Number Columbus Park N & Rehab Ctr

0037960

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 455,424	\$		\$ 31,757	\$ 31,757	\$ 266,696	1
2	Sprinkler Coverage & Door Holders	2012	6,612		20	331	331	992	2
3	Replace Steps & Risers	2012	16,270		20	814	814	2,441	3
4	Bathroom Remodel 5Th Fl-Sinks, Faucets, Toilets	2012	37,551		20	1,878	1,878	5,633	4
5	Bathroom Remodel 4Th Fl-Sinks, Faucets, Toilets	2012	39,443		20	1,972	1,972	5,916	5
6	Bathroom Remodel 3Th Fl-Sinks, Faucets, Toilets	2012	39,041		20	1,952	1,952	5,856	6
7	Bathroom Remodel 2Nd Fl-Resident Baths	2012	30,760		20	1,538	1,538	4,614	7
8	Custom Cabinets	2012	75,600		20	3,780	3,780	11,340	8
9	Nursing Stations 2Nd&3Rd Fl-Cabinets, Desks, Countertops	2012	12,000		20	600	600	1,800	9
10	Nursing Stations 4Th&5Th Fl-Cabinets, Desks, Countertops	2012	12,000		20	600	600	1,800	10
11	Custom Cabinets	2012	14,000		20	700	700	2,100	11
12	Karndean Van Gogh Flooring for 2nd;4th; and 5th floor resident r	2012	227,960		20	11,398	11,398	34,194	12
13	Karndean Van Gogh Flooring for 3rd floor resident rooms; 2nd, 3r	2012	158,426		20	7,921	7,921	23,764	13
14	Bathroom Remodel 2Nd Fl	2012	9,000		20	450	450	1,350	14
15	Cabinetry-Admissions	2012	7,400		20	370	370	1,110	15
16	Cabinetry-Activity	2012	2,980		20	149	149	447	16
17	HVAC-Fan Coils; 1st & 5th floors	2012	38,784		20	1,939	1,939	5,818	17
18	Flooring-2,3	2012	60,675		20	3,034	3,034	9,101	18
19	Additional Take up of tile for the flooring work	2012	7,235		20	362	362	1,085	19
20	Hot Water Boiler	2013	12,922		20	646	646	1,292	20
21	Air Conditioning Wiring	2013	2,617		20	131	131	262	21
22	Basement Chiller Repair	2013	2,728		20	136	136	273	22
23	South Dining Room Upholstered Cornice Boards	2013	2,569		20	128	128	257	23
24	Replace Breakers on Chiller	2013	2,925		20	146	146	293	24
25	9 Exit Signs	2013	6,481		20	324	324	648	25
26									26
27									27
28	Building Company Improvement Depreciation			248,567			(248,567)		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,281,403	\$ 248,567		\$ 73,056	\$ (175,511)	\$ 389,081	34

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

Facility Name & ID Number Columbus Park N & Rehab Ctr

0037960

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	S.I.R. Management	2009	23,447		39	601	601	3,031	3
4	S.I.R. Properties - S.I.R. Management	1993	42,455	1,348	35	1,213	(135)	26,079	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Alloc. - S.I.R. Management	1993	10,764	300	20		(300)	10,764	9
10	Alloc. - S.I.R. Management	1994	34		20			34	10
11	Alloc. - S.I.R. Management	1995	246		20	12	12	239	11
12	Alloc. - S.I.R. Management	1997	16,539	370	20	806	436	14,649	12
13	Alloc. - S.I.R. Management	1999	1,300		20	65	65	991	13
14	Alloc. - S.I.R. Management	1999	12,085		20			12,085	14
15	Alloc. - S.I.R. Management	2000	1,535		20	77	77	1,116	15
16	Alloc. - S.I.R. Management	2007	4,933	337	20	247	(90)	1,774	16
17	Alloc. - S.I.R. Management	2008	13,596	1,299	20	857	(442)	5,865	17
18	Alloc. - S.I.R. Management	2009	33,783	309	20	1,689	1,380	8,859	18
19	Alloc. - S.I.R. Management	2011	836	84	20	84		286	19
20	Alloc. - S.I.R. Management	2012	2,675	134	20	134		323	20
21	Alloc. - S.I.R. Management	2014	375		20	11	11	11	21
22									22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2012	2,601	256	20	13	(243)	34	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	2010	2,562		20	128	128	555	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	2009	2,549	114	20	127	13	739	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	2007	743	37	20	37		297	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	2002	168		20	8	8	106	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1999	5,380		20	269	269	4,169	28
29	Alloc. - S.I.R. Properties - S.I.R. Management	1998	2,571		20	129	129	2,121	29
30	Alloc. - S.I.R. Properties - S.I.R. Management	1997	160		20	8	8	148	30
31	Alloc. - S.I.R. Properties - S.I.R. Management	1994	404	10	20	10		404	31
32	Alloc. - S.I.R. Properties - S.I.R. Management	1993	688	4	20		(4)	688	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 182,429	\$ 4,602		\$ 6,525	\$ 1,923	\$ 95,367	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		\$ 182,429	\$ 4,602		\$ 6,525	\$ 1,923	\$ 95,367	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)		\$ 182,429	\$ 4,602		\$ 6,525	\$ 1,923	\$ 95,367	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	\$ 860,990	\$ 45,064	\$ 80,692	\$ 35,628	10	\$ 521,657	71
72	Current Year Purchases	70,357	2,452	4,218	1,766	10	4,218	72
73	Fully Depreciated Assets	1,917,504				10	1,917,504	73
74								74
75	TOTALS	\$ 2,848,851	\$ 47,516	\$ 84,911	\$ 37,395		\$ 2,443,379	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 SIR Management	2014	\$ 3,297	\$ 299	\$ 352	\$ 53	5	\$ 1,900	76
77										77
78										78
79										79
80	TOTALS			\$ 3,297	\$ 299	\$ 352	\$ 53		\$ 1,900	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 15,112,517	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 477,147	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 580,857	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 103,710	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,363,032	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 Columbus Park N & Rehab Ctr

0037960

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: \$ 4,858

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	<u>Allocated from SIR Management</u>		\$	\$ <u>6,392</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>6,392</u>	21

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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	\$		\$	164,683	\$		\$	164,683	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				61,848				61,848	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				227,270				227,270	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					125,759			125,759	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>							34,292			34,292	13
14	TOTAL			\$		\$	453,801	\$	160,051	\$	613,852	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 Columbus Park N & Rehab Ctr# 0037960Report 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	\$ 5,390	\$ 97,604	1
2	Cash-Patient Deposits	74,413	74,413	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,669,589	1,669,589	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	64,496	64,496	6
7	Other Prepaid Expenses	6,118	7,032	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	286,732	615,543	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,106,738	\$ 2,528,677	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		300,000	13
14	Buildings, at Historical Cost		8,076,445	14
15	Leasehold Improvements, at Historical Cost	2,502,194	2,502,194	15
16	Equipment, at Historical Cost	1,706,181	3,573,108	16
17	Accumulated Depreciation (book methods)	(2,312,814)	(6,888,563)	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):		124,454	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,895,561	\$ 7,687,638	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,002,299	\$ 10,216,315	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 536,936	\$ 536,936	26
27	Officer's Accounts Payable	460,000	460,000	27
28	Accounts Payable-Patient Deposits	74,428	74,428	28
29	Short-Term Notes Payable	1,365,000	1,365,000	29
30	Accrued Salaries Payable	287,247	287,247	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,468	33,468	31
32	Accrued Real Estate Taxes(Sch.IX-B)		288,000	32
33	Accrued Interest Payable		31,864	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	22,700	22,700	35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,779,779	\$ 3,099,643	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,650,811	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 10,650,811	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,779,779	\$ 13,750,454	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,222,520	\$ (3,534,139)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,002,299	\$ 10,216,315	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,029,686	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,029,687	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	192,833	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)	\$ 192,833	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,222,520	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,129,786	1
2	Discounts and Allowances for all Levels	(1,558,592)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,571,194	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,510,608	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,510,608	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	110,846	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,022	19
20	Radiology and X-Ray		20
21	Other Medical Services	27,069	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 142,937	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	125	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 125	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	373,042	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 373,042	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,597,906	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,872,835	31
32	Health Care	3,764,573	32
33	General Administration	2,305,971	33
B. Capital Expense			
34	Ownership	1,316,872	34
C. Ancillary Expense			
35	Special Cost Centers	613,852	35
36	Provider Participation Fee	530,970	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,405,073	40
41	Income before Income Taxes (line 30 minus line 40)**	192,833	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 192,833	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,733,227	44
45	Private Pay - Net Inpatient Revenue	59,215	45
46	Medicare - Net Inpatient Revenue	476,593	46
47	Other-(specify) <u>Hospice</u>	43,095	47
48	Other-(specify) <u>HMO, Insurance</u>	2,259,064	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,571,194	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 Columbus Park N & Rehab Ctr

0037960

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	1,948	2,100	\$ 100,901	\$ 48.05	1
2	Assistant Director of Nursing	1,786	2,053	75,262	36.66	2
3	Registered Nurses	15,488	16,415	435,926	26.56	3
4	Licensed Practical Nurses	35,552	38,957	973,799	25.00	4
5	CNAs & Orderlies	95,538	101,461	1,088,442	10.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,706	10,618	168,744	15.89	8
9	Activity Director	1,899	2,078	35,176	16.93	9
10	Activity Assistants	10,240	11,017	95,741	8.69	10
11	Social Service Workers	17,544	19,503	287,831	14.76	11
12	Dietician					12
13	Food Service Supervisor	1,880	1,973	29,370	14.89	13
14	Head Cook	5,405	5,833	55,548	9.52	14
15	Cook Helpers/Assistants	17,073	18,716	191,066	10.21	15
16	Dishwashers					16
17	Maintenance Workers	3,869	4,108	54,256	13.21	17
18	Housekeepers	26,627	28,788	285,818	9.93	18
19	Laundry	9,598	10,534	103,633	9.84	19
20	Administrator	1,907	2,111	98,822	46.81	20
21	Assistant Administrator	1,989	2,086	67,260	32.24	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,894	12,794	160,904	12.58	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	5,263	5,912	141,829	23.99	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	275,206	297,057	\$ 4,450,328 *	\$ 14.98	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 18,048	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant	Monthly	4,616	10-03	37
38	Nurse Consultant	Monthly	54,432	10-03	38
39	Pharmacist Consultant	Monthly	15,325	10-03	39
40	Physical Therapy Consultant	295	16,533	10a-03	40
41	Occupational Therapy Consultant	68	3,854	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	58	3,120	10a-03	43
44	Activity Consultant	Monthly	4,590	11-03	44
45	Social Service Consultant	4	240	12-03	45
46	Other(specify) <u>Dir. Of Food Service</u>	Monthly	25,920	01-03	46
47	<u>Psychiatric MD Consultant</u>	Monthly	9,000	12-03	47
48	<u>Specialized Services Consultant</u>	Monthly	23,328	12-03	48
49	TOTAL (lines 35 - 48)	425	\$ 186,206		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	8	288	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8	\$ 288		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	
Patrick Baalke	Administrator	0	\$ 97,491	Workers' Compensation Insurance	\$ 64,651	IDPH License Fee	\$ 1,992	
Prentice Dixon	Administrator	0	1,331	Unemployment Compensation Insurance	119,491	Advertising: Employee Recruitment	3,870	
Denise Jackson	Asst. Admin.	0	67,260	FICA Taxes	335,996	Health Care Worker Background Check		
				Employee Health Insurance	205,628	(Indicate # of checks performed <u>684.4</u>)	6,844	
				Employee Meals	35,040	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	12,246	
				Union Pension Plan	30,572	Licenses & Fees	8,122	
				401K Contribution	9,275	Allocated from SIR Management	3,465	
				Other Employee Benefits	11,040			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 166,082					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount					
SIR Management - Director of Administrative Services			\$ 51,840				Less: Public Relations Expense ()	
SIR Management - Ancillary Administrative			51,840				Non-allowable advertising ()	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 103,680				TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)							\$ 36,539	
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		\$ 12,835				Out-of-State Travel	\$
Plante & Moran	Accounting		7,225					
McGladrey	Accounting		2,900				In-State Travel	
SIR Management	Director of Financial Services		36,000					
SIR Management	Dir. Of Regulatory Services		25,920				Seminar Expense	4,928
SIR Management	Bookkeeping		85,536				Allocated from SIR Management	972
Personnel Planners	Unemployment Tax Consult		4,101					
E-Health Data	MDS Software		3,300				Entertainment Expense ()	
Pinnacle	Customer Satisfaction		3,252				(agree to Sch. V, line 24, col. 8)	
Achieve Accreditation	Accreditation		10,289				TOTAL	\$ 5,900
HK Payroll Services	WOTC Program		1,376					
See Supplemental Schedule			29,223					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				
(For legal fee disclosure, see page 39 of instructions)			\$ 221,958					

* 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 Columbus Park N & Rehab Ctr

0037960

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: \$17,606
- (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. \$ 9,705 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. \$ 530,970
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. \$ 35,040 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 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.