

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	30,889	9,328	9,524	49,741	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,889	9,328	9,524	49,741	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.85%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 02/01/2003

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/01/2003 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 150 and days of care provided 8,643

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number

Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	325,162	74,745	21,987	421,894		421,894	9,283	431,177		1
2	Food Purchase		312,499		312,499		312,499	(1,236)	311,263		2
3	Housekeeping	205,733	49,357		255,090		255,090	1,280	256,370		3
4	Laundry	145,540	32,301		177,841		177,841	(52,000)	125,841		4
5	Heat and Other Utilities			247,409	247,409		247,409	1,924	249,333		5
6	Maintenance	129,729		212,085	341,814		341,814	11,588	353,402		6
7	Other (specify):*							2,457	2,457		7
8	TOTAL General Services	806,164	468,902	481,481	1,756,547		1,756,547	(26,704)	1,729,843		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	3,381,839	327,055	226,126	3,935,020		3,935,020	42,284	3,977,304		10
10a	Therapy	265,164			265,164		265,164		265,164		10a
11	Activities	212,694	67,175		279,869		279,869		279,869		11
12	Social Services	205,732	753		206,485		206,485	26,017	232,502		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							8,922	8,922		15
16	TOTAL Health Care and Programs	4,065,429	394,983	244,126	4,704,538		4,704,538	77,223	4,781,761		16
	C. General Administration										
17	Administrative	139,028			139,028		139,028	91,404	230,432		17
18	Directors Fees										18
19	Professional Services			642,037	642,037	(1,056)	640,981	(540,971)	100,009		19
20	Dues, Fees, Subscriptions & Promotions			72,791	72,791		72,791	(16,781)	56,010		20
21	Clerical & General Office Expenses	148,803	41,486	367,582	557,871		557,871	(115,536)	442,335		21
22	Employee Benefits & Payroll Taxes			752,213	752,213		752,213	(13,162)	739,051		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,160	2,160		2,160	1,520	3,680		24
25	Other Admin. Staff Transportation			7,394	7,394		7,394	1,404	8,798		25
26	Insurance-Prop.Liab.Malpractice			334,430	334,430		334,430	2,005	336,435		26
27	Other (specify):*							37,785	37,785		27
28	TOTAL General Administration	287,831	41,486	2,178,607	2,507,924	(1,056)	2,506,868	(552,333)	1,954,535		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,159,424	905,371	2,904,214	8,969,009	(1,056)	8,967,953	(501,814)	8,466,139		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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			111,444	111,444		111,444	74,421	185,865			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10	10		10	274,890	274,900			32
33	Real Estate Taxes			126,584	126,584	1,056	127,640	5,082	132,722			33
34	Rent-Facility & Grounds			684,000	684,000		684,000	(684,000)				34
35	Rent-Equipment & Vehicles			12,795	12,795		12,795	843	13,638			35
36	Other (specify):*											36
37	TOTAL Ownership			934,833	934,833	1,056	935,889	(328,764)	607,125			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		461,011	1,221,368	1,682,379		1,682,379	(2,388)	1,679,991			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			327,632	327,632		327,632		327,632			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		461,011	1,549,000	2,010,011		2,010,011	(2,388)	2,007,623			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,159,424	1,366,382	5,388,047	11,913,853		11,913,853	(832,966)	11,080,887			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(637)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(31,064)	30		9
10	Interest and Other Investment Income	(47,570)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(577)	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	(14,142)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(130,496)	21		24
25	Fund Raising, Advertising and Promotional	(10,467)	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	(222,991)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (457,944)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(375,022)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (375,022)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (832,966)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Chateau Nursing & Rehab Center, Llc

ID# 0046177

Report Period Beginning: 01/01/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Vending Income	\$ (460)	02	1
2	Rental Income	(4,500)	06	2
3	Laundry Services	(52,000)	04	3
4	Patient Clothing	(2,063)	10	4
5	Theft Loss	(3,535)	21	5
6	Collection Expense	(5,606)	21	6
7	Additional R&M	863	06	7
8	PAC Dues	(7,532)	20	8
9	Building Company - Management Fees	(7,500)	17	9
10	Building Company - Bank Service Charge	(269)	21	10
11	Building Company - Filing Fee	(250)	21	11
12	Building Company - Amortization	(12,172)	36	12
13	Non-Allowable Expense	(102,216)	21	13
14	Non-Allowable Legal	(25,741)	19	14
15	Prior Period Auto	(9)	25	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	(222,991)		49

Chateau Nursing & Rehab Center, Llc

Report Period Beginning: 01/01/15
 Ending: 12/31/15

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc# 0046177

Report Period Beginning:

01/01/15

Ending:

12/31/15

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			165		9,118							9,283	1
2	Food Purchase	(1,674)		438									(1,236)	2
3	Housekeeping			1,156		124							1,280	3
4	Laundry	(52,000)											(52,000)	4
5	Heat and Other Utilities			1,752		172							1,924	5
6	Maintenance	(3,637)		5,042	10,054	129							11,588	6
7	Other (specify):*				1,305	1,152							2,457	7
8	TOTAL General Services	(57,311)		8,553	11,359	10,695							(26,704)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,063)				44,593				(246)			42,284	10
10a	Therapy													10a
11	Activities													11
12	Social Services					26,017							26,017	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					8,922							8,922	15
16	TOTAL Health Care and Programs	(2,063)				79,532				(246)			77,223	16
	C. General Administration													
17	Administrative	(7,500)	7,500	3,151	17,629	70,624							91,404	17
18	Directors Fees													18
19	Professional Services	(25,741)		(385,512)		(129,718)							(540,971)	19
20	Fees, Subscriptions & Promotions	(17,999)		1,033		185							(16,781)	20
21	Clerical & General Office Expenses	(256,514)	519	12,898	105,587	21,974							(115,536)	21
22	Employee Benefits & Payroll Taxes				(13,162)								(13,162)	22
23	Inservice Training & Education													23
24	Travel and Seminar			355		1,165							1,520	24
25	Other Admin. Staff Transportation	(9)		1,413									1,404	25
26	Insurance-Prop.Liab.Malpractice			1,441		564							2,005	26
27	Other (specify):*				26,284	11,501							37,785	27
28	TOTAL General Administration	(307,764)	8,019	(365,221)	136,338	(23,705)							(552,333)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(367,137)	8,019	(356,668)	147,697	66,522				(246)			(501,814)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc# 0046177

Report Period Beginning:

01/01/15 Ending:12/31/15

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(31,064)	102,442	2,285		758							74,421	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(47,570)	313,055	9,189		216							274,890	32
33	Real Estate Taxes			4,605		477							5,082	33
34	Rent-Facility & Grounds		(684,000)										(684,000)	34
35	Rent-Equipment & Vehicles			843									843	35
36	Other (specify):*	(12,172)	12,172											36
37	TOTAL Ownership	(90,806)	(256,331)	16,922		1,451							(328,764)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(2,388)			(2,388)	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									(2,388)			(2,388)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(457,944)	(248,312)	(339,746)	147,697	67,973				(2,634)			(832,966)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 684,000	Chateau Willowbrook Property	100.00%	\$	(684,000)	1
2	V	17 Management Fees		Chateau Willowbrook Property	100.00%	7,500	7,500	2
3	V	21 Bank Service Charges		Chateau Willowbrook Property	100.00%	269	269	3
4	V	21 Filing Fee		Chateau Willowbrook Property	100.00%	250	250	4
5	V	30 Depreciation		Chateau Willowbrook Property	100.00%	102,442	102,442	5
6	V	36 Amortization		Chateau Willowbrook Property	100.00%	12,172	12,172	6
7	V	32 Interest		Chateau Willowbrook Property	100.00%	313,055	313,055	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 684,000			\$ 435,688	\$ * (248,312)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 165	\$	165	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	438		438	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	1,156		1,156	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,752		1,752	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	5,042		5,042	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	3,151		3,151	20
21	V	19 Professional Fees	391,080	Extended Care Consulting, LLC	100.00%	5,568		(385,512)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,033		1,033	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	12,898		12,898	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	355		355	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,413		1,413	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	1,441		1,441	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	2,285		2,285	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	9,189		9,189	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	4,605		4,605	29
30	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	843		843	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 391,080			\$ 51,334	\$ *	(339,746)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	10,053	\$	10,053	15
16	V	06 Maintenance (Direct)	4,850	Extended Care Consulting, LLC	100.00%	4,851		1	16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	865		865	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	440		440	18
19	V								19
20	V								20
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	17,629		17,629	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	105,587		105,587	22
23	V	21 Office and Clerical (Direct)	39,023	Extended Care Consulting, LLC	100.00%	39,023			23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	21,152		21,152	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	5,132		5,132	25
26	V	22 Employee Benefits	13,162	Extended Care Consulting, LLC	100.00%			(13,162)	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		\$ 57,035			\$ 204,732	\$ *	147,697	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 124	\$	124	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	172		172	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	129		129	17
18	V	19 Professional Fees	130,356	Extended Care Clinical, LLC	100.00%	638		(129,718)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	185		185	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	1,579		1,579	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,165		1,165	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	564		564	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	758		758	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	216		216	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	477		477	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	9,118		9,118	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,152		1,152	27
28	V	10 Nursing Salary		Extended Care Clinical, LLC	100.00%	44,593		44,593	28
29	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%	26,017		26,017	29
30	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	8,922		8,922	30
31	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	70,624		70,624	31
32	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	20,395		20,395	32
33	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	11,501		11,501	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 130,356			\$ 198,329	\$ *	67,973	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Various Equipment	17,600	Vent Lease LLC	100.00%	17,600	\$	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		\$ 17,600			\$ 17,600	\$ *	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 Therapy	\$ 683,826	Tri Care Rehab	100.00%	\$ 683,826	\$	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		\$ 683,826			\$ 683,826	\$ *	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	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 320,805	\$ 320,805	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	320,805	CCS Employee Benefits Group	100.00%		(320,805)	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		\$ 320,805			\$ 320,805	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 Nursing and Medical Records	\$ 18,645	MAC Rx, LLC	100.00%	\$ 18,399	\$ (246)
16	V	39 Ancillary	180,837	MAC Rx, LLC	100.00%	178,449	(2,388)
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 199,483			\$ 196,849	\$ * (2,634)

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	Adam Vales	Owner	Clerical	11.00%	See Attached	2.03	5.08%	Alloc Salary	\$ 3,442	22-7	1	
2	Mark Steinberg	Relative	Administrative	0%	See Attached	2.87	5.22%	Alloc Sal/Fee	10,604	17-7	2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 14,046		13	

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

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

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

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

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	31	\$ 4,390	\$	49,741	\$ 165	1
2	02	Food	Patient Days	31	11,689		49,741	438	2
3	03	Housekeeping	Patient Days	31	30,827		49,741	1,156	3
4	05	Utilities	Patient Days	31	46,718		49,741	1,752	4
5	06	Maintenance	Patient Days	31	134,435		49,741	5,042	5
6	17	Administrative	Patient Days	31	84,000		49,741	3,151	6
7	19	Professional Fees	Patient Days	31	148,456		49,741	5,568	7
8	20	Dues and Subscriptions	Patient Days	31	27,539		49,741	1,033	8
9	21	Office and Clerical	Patient Days	31	343,869		49,741	12,898	9
10	24	Seminar and Travel	Patient Days	31	9,455		49,741	355	10
11	25	Other Staff Admin. Trans.	Patient Days	31	37,668		49,741	1,413	11
12	26	Insurance	Patient Days	31	38,431		49,741	1,441	12
13	30	Depreciation	Patient Days	31	60,912		49,741	2,285	13
14	32	Interest	Patient Days	31	244,990		49,741	9,189	14
15	33	Real Estate Taxes	Patient Days	31	122,786		49,741	4,605	15
16	35	Rent - Equipment & Auto	Patient Days	31	22,475		49,741	843	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,368,640	\$		\$ 51,334	25

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	06	Maintenance (Pooled)	Patient Days	1,326,152	31	268,019	268,019	49,741	10,053	1
2	06	Maintenance (Direct)	Direct		31	325,218	325,218		4,851	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,326,152	31	23,065		49,741	865	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	38,919			440	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,326,152	31	470,018	470,018	49,741	17,629	7
8	21	Office and Clerical (Pooled)	Patient Days	1,326,152	31	2,815,061	2,815,061	49,741	105,587	8
9	21	Office and Clerical (Direct)	Direct		31	402,441	402,441		39,023	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,326,152	31	563,937		49,741	21,152	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	58,253			5,132	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,964,932	\$ 4,280,758		\$ 204,732	25

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Extended Care Clinical, LLC

Street Address

2201 Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905-3000

Fax Number

(847) 905-3030

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	03	Housekeeping	Patient Days	794,254	19	\$ 1,974	\$ 49,741	\$ 124	1
2	05	Utilities	Patient Days	794,254	19	2,745	49,741	172	2
3	06	Maintenance	Patient Days	794,254	19	2,053	49,741	129	3
4	19	Professional Fees	Patient Days	794,254	19	10,180	49,741	638	4
5	20	Dues and Subscriptions	Patient Days	794,254	19	2,961	49,741	185	5
6	21	Office & Clerical	Patient Days	794,254	19	25,207	49,741	1,579	6
7	24	Travel and Seminar	Patient Days	794,254	19	18,605	49,741	1,165	7
8	26	Insurance	Patient Days	794,254	19	9,008	49,741	564	8
9	30	Depreciation	Patient Days	794,254	19	12,096	49,741	758	9
10	32	Interest	Patient Days	794,254	19	3,455	49,741	216	10
11	33	Real Estate Taxes	Patient Days	794,254	19	7,615	49,741	477	11
12	01	Dietary Salary	Patient Days	794,254	19	145,601	49,741	9,118	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	794,254	19	18,397	49,741	1,152	13
14	10	Nursing Salary	Patient Days	794,254	19	712,051	49,741	44,593	14
15	12	Social Service Salary	Patient Days	794,254	19	415,434	49,741	26,017	15
16	15	Emp. Ben. - Healthcare	Patient Days	794,254	19	142,463	49,741	8,922	16
17	17	Administration Salary	Patient Days	794,254	19	1,127,702	49,741	70,624	17
18	21	Office Salary	Patient Days	794,254	19	325,657	49,741	20,395	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	794,254	19	183,638	49,741	11,501	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,166,842	\$ 2,726,445	\$ 198,329	25

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Vent Lease, LLC

Street Address

2201 Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 674-1180

Fax Number

(847) 673-7741

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Various Equipment	Direct Allocation					17,600	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$	\$	\$ 17,600	25

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

TriCare Rehab

Street Address

240 Fencil Lane

City / State / Zip Code

Hillside, IL 60162

Phone Number

(773) 449-9400

Fax Number

(773) 449-9700

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy	Direct Allocation		\$	\$		\$ 683,826	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				\$	\$		\$ 683,826	25

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 320,805	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				\$	\$		\$ 320,805	25

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

MAC Rx, LLC

Street Address

2307 S. Mount Prospect Road

City / State / Zip Code

Des Plaines, IL 60018

Phone Number

(224)220-2700

Fax Number

(224)220-2730

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation		\$	\$		\$ 18,399	1
2	39	Ancillary	Direct Allocation					178,449	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				\$	\$		\$ 196,849	25

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177 Report Period Beginning: 01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

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

Facility Name & ID Number

Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	2	3	4	5	6	7	8	9	10												
												Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
													YES	NO				Original	Balance			
	A. Directly Facility Related																					
	Long-Term																					
1	Bank Leumi		X	Mortgage			\$	\$ 6,309,846			\$ 313,055	1										
2												2										
3												3										
4												4										
5												5										
	Working Capital																					
6	Advance HFGII		X	Line of Credit				244,215				6										
7	Notes Payable-Mattresses		X					21,924				7										
8	See Supplemental Schedule							50,760				8										
9	TOTAL Facility Related						\$	\$ 6,626,744			\$ 313,055	9										
	B. Non-Facility Related*																					
10	Interest Income		X								(47,559)	10										
11	Allocated - EC Consulting	X									9,189	11										
12	Allocated - EC Clinical	X									216	12										
13												13										
14	TOTAL Non-Facility Related						\$	\$			\$ (38,154)	14										
15	TOTALS (line 9+line14)						\$	\$ 6,626,744			\$ 274,901	15										

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending:

12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term																			
Working Capital																				
8	Notes Payable-Computers		X			\$	\$	2,223		\$	8									
9	Working Capital - Bldg. Co.		X					48,537			9									
10											10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital																			
B. Non-Facility Related*																				
15						\$	\$			\$	15									
16											16									
17											17									
18											18									
19											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 2014 report.		\$	59,603	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.)		\$	95,905	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	36,302	3	
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	95,364	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.)		\$	1,056	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	132,722	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	49,008	8	FOR BHF USE ONLY	
	2011	53,521	9	13	FROM R. E. TAX STATEMENT FOR 2014 \$
	2012	56,110	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2013	56,765	11	15	LESS REFUND FROM LINE 6 \$
	2014	90,823	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
2015 Accrual = \$90,823 x 1.05 = \$95,364					
Allocated from Extended Care Consulting = \$4,605					
Allocated from Extended Care Clinical = \$477					

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.

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>273,121</u>	<u>2003</u>	<u>\$ 295,367</u>	<u>1</u>
2	<u>Allocated from 2201 W. Main, LLC / Clinical</u>			<u>23,825</u>	<u>2</u>
3	TOTALS	273,121		\$ 319,192	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	150	2003	1987	\$ 2,658,301	\$ 102,442	39	\$ 68,162	\$ (34,280)	\$ 1,468,910	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		2003	51,953		20	1,641	1,641	35,862	9
10	Various		2004	98,684		20	4,650	4,650	59,696	10
11	Various		2005	69,862		20	3,493	3,493	35,432	11
12	Various		2006	50,399		20	3,226	3,226	30,583	12
13	Various		2007	126,729		20	6,725	6,725	57,747	13
14	Various		2008	30,544		20	1,803	1,803	13,709	14
15	Various		2009	25,582		20	944	944	12,450	15
16	Various		2010	12,771		20	705	705	4,067	16
17	Various		2011	110,418		20	5,830	5,830	25,651	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		238,642			11,932	11,932	118,950	67
68		100,344	1,351		1,351		72,948	68
69			111,444			(111,444)		69
70		\$ 3,574,230	\$ 215,237		\$ 110,463	\$ (104,775)	\$ 1,936,005	70

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

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,574,230	\$ 215,237		\$ 110,463	\$ (104,775)	\$ 1,936,005	1
2	Pipe And Fittings	2012	3,900		20	195	195	748	2
3	Resurfacing-Paving	2012	5,800		20	387	387	1,450	3
4	Water Heater	2012	8,500		20	425	425	1,488	4
5	Medium Grade Vinyl Plank Flooring	2012	13,250		20	2,650	2,650	8,833	5
6	Remote E-Stop - Install Conduit And Wiring	2012	2,644		20	132	132	430	6
7	Nurses Station	2012	22,650		20	4,530	4,530	14,723	7
8	Corridors On All Floors - Paint, Wallpaper	2013	3,921		20	196	196	556	8
9	Rehab Dining Room - Flooring	2013	17,000		20	3,400	3,400	9,350	9
10	New 20 Ampere 208 & 30 Ampere 120 Volt Circuits & Outlets	2013	5,500		20	275	275	688	10
11	Main Entrance Doors - New Vertical Rod Panic Devices	2013	4,435		20	222	222	554	11
12	Rear Entrance Doors - New Panic Device	2013	4,030		20	202	202	487	12
13	Repaired Concrete Staircase Walls, Concrete Curbs, Brick Paver	2013	6,910		20	346	346	777	13
14	Ice Cream, Gift Shop - Architectural, Framing, Drywall, Masonry	2013	129,000		20	6,450	6,450	16,125	14
15	Corridors On All Floors - Wallpaper	2013	5,959		20	298	298	844	15
16	Nurse Station Rehab-Remove Millwork, Electric, Plumbing, New	2014	49,000		20	2,450	2,450	4,083	16
17	Cabinetry, Lighting, Plumbing, Electrical, Floor - Beauty Shop &	2014	34,500		20	1,725	1,725	2,875	17
18	Fire Alarm System	2014	4,694		20	235	235	450	18
19	Blinds	2014	7,155		20	1,431	1,431	2,504	19
20	Elevator Door Restrictor	2014	3,635		20	182	182	288	20
21	Doors - Basement, 1St Floor & Kitchen	2014	10,700		20	535	535	981	21
22	New Lawler Thermostatic Mixing Valve	2014	2,700		20	135	135	259	22
23	Exhaust Fan	2014	11,788		20	589	589	1,031	23
24	Replace Boiler & Relocate Storage Tank	2014	5,000		20	250	250	396	24
25	Control Panel And Install Remote Annunciator	2015	17,686		20	884	884	884	25
26	Water Heater	2015	7,596		20	190	190	190	26
27	Office Phone System	2015	49,620		20	4,135	4,135	4,135	27
28	Dining Room Flooring	2015	26,400		20	440	440	440	28
29	Pump Gasket	2015	3,058		20	13	13	13	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,041,261	\$ 215,237		\$ 143,363	\$ (71,874)	\$ 2,011,585	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,041,261	\$ 215,237		\$ 143,363	\$ (71,874)	\$ 2,011,585	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)	\$ 4,041,261	\$ 215,237		\$ 143,363	\$ (71,874)	\$ 2,011,585	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,041,261	\$ 215,237		\$ 143,363	\$ (71,874)	\$ 2,011,585	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)	\$ 4,041,261	\$ 215,237		\$ 143,363	\$ (71,874)	\$ 2,011,585	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,041,261	\$ 215,237		\$ 143,363	\$ (71,874)	\$ 2,011,585	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)	\$ 4,041,261	\$ 215,237		\$ 143,363	\$ (71,874)	\$ 2,011,585	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Life Safety Code Improvements (Net of Settlement)	2005	231,242		20	11,562	11,562	115,620	9
10	Professional Fees - Architect	2007	7,400		20	370	370	3,330	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 238,642	\$		\$ 11,932	\$ 11,932	\$ 118,950	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 238,642	\$		\$ 11,932	\$ 11,932	\$ 118,950	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 238,642	\$		\$ 11,932	\$ 11,932	\$ 118,950	34

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

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 2201 W. Main, LLC	2002	29,661	761	39	761		10,109	3
4									4
5	Allocated from Extended Care Clinical, LLC	2002	3,171	81	39	81		1,081	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	173	9	20	9		78	9
10	Allocated from Extended Care Consulting, LLC	2009	103	5	20	5		36	10
11	Allocated from Extended Care Consulting, LLC	2010	1,012	51	20	51		304	11
12	Allocated from Extended Care Consulting, LLC	2011	364	18	20	18		91	12
13	Allocated from Extended Care Consulting, LLC	2012	120	6	20	6		24	13
14	Allocated from Extended Care Consulting, LLC	2014	1,664	83	20	83		166	14
15									15
16									16
17	Allocated from 2201 W. Main, LLC	2002	24,503		20			24,503	17
18	Allocated from 2201 W. Main, LLC	2003	28,875		20			28,875	18
19	Allocated from 2201 W. Main, LLC	2005	1,435	152	20	152		1,432	19
20	Allocated from 2201 W. Main, LLC	2009	259	13	20	13		91	20
21	Allocated from 2201 W. Main, LLC	2014	2,408	120	20	120		241	21
22	Allocated from 2201 W. Main, LLC	2015	408	20	20	20		20	22
23									23
24	Allocated from Extended Care Clinical, LLC	2002	2,619		20			2,619	24
25	Allocated from Extended Care Clinical, LLC	2003	3,087		20			3,087	25
26	Allocated from Extended Care Clinical, LLC	2005	153	16	20	16		153	26
27	Allocated from Extended Care Clinical, LLC	2009	28	1	20	1		10	27
28	Allocated from Extended Care Clinical, LLC	2014	257	13	20	13		26	28
29	Allocated from Extended Care Clinical, LLC	2015	44	2	20	2		2	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 100,344	\$ 1,351		\$ 1,351	\$	\$ 72,948	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 100,344	\$ 1,351		\$ 1,351	\$	\$ 72,948	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)	\$ 100,344	\$ 1,351		\$ 1,351	\$	\$ 72,948	34

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

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	\$ 218,073	\$ 739	\$ 40,440	\$ 39,701	10	\$ 86,650	71
72	Current Year Purchases	1,156	116	116		10	116	72
73	Fully Depreciated Assets	585,238				10	585,238	73
74								74
75	TOTALS	\$ 804,467	\$ 855	\$ 40,556	\$ 39,701		\$ 672,004	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2003 FORD ECONO VAN	2003	\$ 33,833	\$	\$	\$	5	\$ 33,833	76
77		TRUCK REPAIR	2004	1,083				5	1,083	77
78		Truck Repairs	2013	5,548		1,110	1,110	5	2,959	78
79		See Supplemental		9,987	835	834	(1)	5	8,433	79
80	TOTALS			\$ 50,451	\$ 835	\$ 1,944	\$ 1,109		\$ 46,308	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,215,371	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 216,927	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 185,863	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (31,064)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,729,897	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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

**

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: \$ 13,638 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. 2016 \$ _____

13. 2017 \$ _____

14. 2018 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Staff		Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	478,895	\$			\$	478,895	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				118,385					118,385	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	39 - 03	hrs				582,505					582,505	4
5	Physician Care		visits										5
6	Dental Care		visits										6
7	Work Related Program		hrs										7
8	Habilitation		hrs										8
9	Pharmacy	39 - 02	# of prescripts						378,039			378,039	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>						41,583		82,972			124,555	13
14	TOTAL			\$			\$ 1,221,368	\$	461,011			\$ 1,682,379	14

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

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc# 0046177Report Period Beginning: 01/01/15

Ending:

12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(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	\$ 2,909	\$ 66,559	1
2	Cash-Patient Deposits	47,854	47,854	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	752,502	752,502	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	232,761	232,761	6
7	Other Prepaid Expenses	12,808	12,808	7
8	Accounts Receivable (owners or related parties)	298,795	4,398,795	8
9	Other(specify):	3,390,745	3,390,745	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,738,374	\$ 8,902,024	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		295,367	13
14	Buildings, at Historical Cost		3,805,411	14
15	Leasehold Improvements, at Historical Cost	879,112	879,112	15
16	Equipment, at Historical Cost	459,568	459,568	16
17	Accumulated Depreciation (book methods)	(767,118)	(3,246,346)	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):		31,444	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 571,562	\$ 2,224,556	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,309,936	\$ 11,126,580	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,839,612	\$ 1,839,612	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,684	44,684	28
29	Short-Term Notes Payable	268,362	316,899	29
30	Accrued Salaries Payable	193,526	193,526	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,200	6,200	31
32	Accrued Real Estate Taxes(Sch.IX-B)	95,364	95,364	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	54,187	54,187	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,501,935	\$ 2,550,472	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,309,846	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)	\$	\$ 6,309,846	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,501,935	\$ 8,860,318	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,808,001	\$ 2,266,262	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,309,936	\$ 11,126,580	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,377,935	1
2	Restatements (describe):		2
3	Rounding	(7)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,377,928	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,430,073	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)	\$ 1,430,073	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)	\$ 2,808,001	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning: 01/01/15

Ending:

12/31/15

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

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,841,565	1
2	Discounts and Allowances for all Levels	(4,777,228)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,064,337	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,452,882	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,452,882	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	3,096	13
14	Non-Patient Meals	637	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	4,500	16
17	Sale of Drugs	374,252	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	116,427	19
20	Radiology and X-Ray	35,116	20
21	Other Medical Services	159,649	21
22	Laundry	85,000	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 778,677	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	47,570	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 47,570	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	460	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 460	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,343,926	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,756,547	31
32	Health Care	4,704,538	32
33	General Administration	2,507,924	33
B. Capital Expense			
34	Ownership	934,833	34
C. Ancillary Expense			
35	Special Cost Centers	1,682,379	35
36	Provider Participation Fee	327,632	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,913,853	40
41	Income before Income Taxes (line 30 minus line 40)**	1,430,073	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,430,073	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,146,584	44
45	Private Pay - Net Inpatient Revenue	2,278,501	45
46	Medicare - Net Inpatient Revenue	376,641	46
47	Other-(specify) Hospice	218,330	47
48	Other-(specify) Insurance	44,281	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,064,337	49

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

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

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

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

Facility Name & ID Number **Chateau Nursing & Rehab Center, Llc**

0046177

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	1,841	2,092	\$ 101,802	\$ 48.66	1
2	Assistant Director of Nursing	1,866	2,126	92,106	43.32	2
3	Registered Nurses	27,575	30,299	1,019,875	33.66	3
4	Licensed Practical Nurses	33,448	36,761	1,036,071	28.18	4
5	CNAs & Orderlies	75,578	82,926	1,084,922	13.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,187	13,284	265,164	19.96	8
9	Activity Director	1,535	1,646	28,882	17.55	9
10	Activity Assistants	12,752	13,839	164,328	11.87	10
11	Social Service Workers	8,145	9,084	205,732	22.65	11
12	Dietician	358	381	7,003	18.38	12
13	Food Service Supervisor	1,975	2,304	50,889	22.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,369	4,618	65,081	14.09	15
16	Dishwashers	17,609	19,209	202,189	10.53	16
17	Maintenance Workers	5,687	6,388	129,729	20.31	17
18	Housekeepers	18,227	19,883	205,733	10.35	18
19	Laundry	12,250	13,737	145,540	10.59	19
20	Administrator	1,935	2,149	92,878	43.22	20
21	Assistant Administrator	1,910	2,148	46,150	21.49	21
22	Other Administrative					22
23	Office Manager	1,818	2,029	29,593	14.59	23
24	Clerical	1,877	2,081	20,624	9.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,639	2,819	47,063	16.69	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	4,893	5,469	118,070	21.59	33
34	TOTAL (lines 1 - 33)	250,474	275,272	\$ 5,159,424 *	\$ 18.74	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	446	\$ 21,987	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,370	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	446	\$ 48,357		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	70	\$ 4,193	10-03	50
51	Licensed Practical Nurses	389	16,354	10-03	51
52	Certified Nurse Assistants/Aides	7,948	197,209	10-03	52
53	TOTAL (lines 50 - 52)	8,407	\$ 217,756		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	
Stephanie Hunter	Administrator	0	\$ 92,878	Workers' Compensation Insurance	\$ 104,896	IDPH License Fee	\$ 3,814	
Domencia Turner	Asst. Administrator	0	46,150	Unemployment Compensation Insurance	70,509	Advertising: Employee Recruitment	13,437	
				FICA Taxes	394,591	Health Care Worker Background Check	2,786	
				Employee Health Insurance	156,595	(Indicate # of checks performed <u>240</u>)		
				Employee Meals		<u>Patient Background Checks</u>		
				Illinois Municipal Retirement Fund (IMRF)*		<u>Dues and Subscriptions</u>	25,569	
				Employee Physicals	6,697	<u>Licenses and Fees</u>	9,185	
				Other Employee Benefits	3,580	<u>Allocated from Extended Care Consulting</u>	1,033	
				Holiday Expense	2,183	<u>Allocated from Extended Care Clinical</u>	185	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 139,028					
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Pro Payroll Solutions	Payroll Services		\$ 27,043				Out-of-State Travel	\$
eHealth Data Solutions	MDS Software		3,180					
AIS Assessment & Intelligence	Customer Satisfaction		1,319					
Ability Network	Medicare Billing		2,488				In-State Travel	
National Datacare Corporation	Resident Fund Processing		1,438					
FRR / Marcum	Accounting		24,100					
Plante & Moran	Accounting		249					
Extended Care Consulting LLC	Home Office Allocation		391,080				Seminar Expense	2,160
Extended Care Clinical LLC	Home Office Allocation		130,356				<u>Allocated from Extended Care Consulting</u>	355
Personnel Planners	Unemployment Consulting		2,180				<u>Allocated from Extended Care Clinical</u>	1,165
Pinnacle Quality Insight	Customer Service		4,352					
See Supplemental Schedule			54,251				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(For legal fee disclosure, see page 39 of instructions)			\$ 642,036				line 24, col. 8)	\$ 3,680

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/15

Ending:

12/31/15

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$22,825
- (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. \$ 77,446 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. \$ 327,632
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. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 637
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.