

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.

0037960 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	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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	19,865	501	33,430	53,796	8
9	SNF/PED					9
10	ICF	17,050		155	17,205	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,915	501	33,585	71,001	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.06%

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 2,957

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Columbus Park Nrsg. Rehab Ctr.

0037960

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	290,980	33,119	44,532	368,631		368,631	(16,608)	352,023		1
2	Food Purchase		363,983		363,983	(33,945)	330,038	(26)	330,012		2
3	Housekeeping	305,814	61,720		367,534		367,534		367,534		3
4	Laundry	104,263	38,277		142,540		142,540	5,839	148,379		4
5	Heat and Other Utilities			227,975	227,975		227,975	(10,481)	217,494		5
6	Maintenance	55,327	53,157	259,882	368,366		368,366	(31,643)	336,723		6
7	Other (specify):*							11,199	11,199		7
8	TOTAL General Services	756,384	550,256	532,389	1,839,029	(33,945)	1,805,084	(41,719)	1,763,365		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	2,732,291	196,130	87,990	3,016,411		3,016,411	(3,245)	3,013,166		10
10a	Therapy	152,977	21,259	44,440	218,676		218,676	(12,363)	206,313		10a
11	Activities	133,764	11,470	5,049	150,283		150,283		150,283		11
12	Social Services	219,512		2,000	221,512		221,512		221,512		12
13	CNA Training										13
14	Program Transportation			3,372	3,372		3,372		3,372		14
15	Other (specify):*							7,784	7,784		15
16	TOTAL Health Care and Programs	3,238,544	228,859	152,451	3,619,854		3,619,854	(7,824)	3,612,030		16
	C. General Administration										
17	Administrative	170,539		114,048	284,587		284,587	24,542	309,129		17
18	Directors Fees										18
19	Professional Services			402,924	402,924	(25,034)	377,890	(228,280)	149,610		19
20	Dues, Fees, Subscriptions & Promotions			53,825	53,825		53,825	(18,164)	35,661		20
21	Clerical & General Office Expenses	204,705	28,599	654,495	887,799		887,799	(454,996)	432,803		21
22	Employee Benefits & Payroll Taxes			776,778	776,778	33,945	810,723		810,723		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,875	2,875		2,875	1,500	4,375		24
25	Other Admin. Staff Transportation			848	848		848	8,876	9,724		25
26	Insurance-Prop.Liab.Malpractice			184,460	184,460		184,460	14,033	198,493		26
27	Other (specify):*							50,139	50,139		27
28	TOTAL General Administration	375,244	28,599	2,190,253	2,594,096	8,911	2,603,007	(602,350)	2,000,657		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,370,172	807,714	2,875,093	8,052,979	(25,034)	8,027,945	(651,894)	7,376,051		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Columbus Park Nrsg. Rehab Ctr.

#0037960

Report Period Beginning:

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Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			180,410	180,410		180,410	391,921	572,331			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			68,716	68,716		68,716	366,824	435,540			32
33	Real Estate Taxes					25,034	25,034	261,552	286,586			33
34	Rent-Facility & Grounds			1,044,000	1,044,000		1,044,000	(1,044,000)				34
35	Rent-Equipment & Vehicles			3,679	3,679		3,679	8,438	12,117			35
36	Other (specify):*							52,613	52,613			36
37	TOTAL Ownership			1,296,805	1,296,805	25,034	1,321,839	37,348	1,359,187			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		144,399	410,452	554,851		554,851	(1,276)	553,575			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			530,056	530,056		530,056		530,056			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		144,399	940,508	1,084,907		1,084,907	(1,276)	1,083,631			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,370,172	952,113	5,112,406	10,434,691		10,434,691	(615,822)	9,818,869			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 Nrsng. Rehab Ctr.

0037960

Report Period Beginning:

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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	(13,468)	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	90,711	30		9
10	Interest and Other Investment Income	(1,183)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(26)	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	(4,258)	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	(575,164)	21		24
25	Fund Raising, Advertising and Promotional	(5,628)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,400)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(101,923)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (620,338)		\$	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)	4,516		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 4,516		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (615,822)		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

Columbus Park Nrsrg. Rehab Ctr.

ID# 0037960

Report Period Beginning: 01/01/15

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Legal Fees - Collections	\$ (8,642)	21	1
2	Theft & Damage Loss	(563)	21	2
3	Bank Fees	(6,871)	21	3
4	Non Allowable Legal Fees	(24,078)	19	4
5	PAC Dues	(9,246)	20	5
6	2011 Violation Fee	(1,100)	20	6
7	Bldg Co. - Fees	(250)	20	7
8	Bldg Co. - Office Expense	(36)	21	8
9	Bldg Co. - Professional Fees	(8,300)	19	9
10	Bldg Co. - Amortization	(4,624)	36	10
11	Additional R&M	4,701	06	11
12	Captialized R&M	(41,072)	06	12
13	Bldg Co. - Additional R&M	2,123	06	13
14	Bldg Co. - Capitalized R&M	(3,964)	06	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	(101,923)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.# 0037960

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				(16,608)								(16,608)	1
2	Food Purchase	(26)											(26)	2
3	Housekeeping													3
4	Laundry		5,839										5,839	4
5	Heat and Other Utilities	(13,468)			2,987								(10,481)	5
6	Maintenance	(38,212)	6,087	(24,841)	25,323								(31,643)	6
7	Other (specify):*				11,199								11,199	7
8	TOTAL General Services	(51,706)	11,926	(24,841)	22,902								(41,719)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(13,351)	10,269	(163)							(3,245)	10
10a	Therapy				(12,363)								(12,363)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			4,454	3,330								7,784	15
16	TOTAL Health Care and Programs			(8,897)	1,235	(163)							(7,824)	16
	C. General Administration													
17	Administrative			(80,663)	105,205								24,542	17
18	Directors Fees													18
19	Professional Services	(32,378)	8,300	(224,201)	19,999								(228,280)	19
20	Fees, Subscriptions & Promotions	(20,482)	250	2,068									(18,164)	20
21	Clerical & General Office Expenses	(600,676)	36	145,511	133								(454,996)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,500									1,500	24
25	Other Admin. Staff Transportation			8,876									8,876	25
26	Insurance-Prop.Liab.Malpractice		11,074	2,670	289								14,033	26
27	Other (specify):*			27,447	22,692								50,139	27
28	TOTAL General Administration	(653,536)	19,660	(116,792)	148,318								(602,350)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(705,243)	31,586	(150,530)	172,455	(163)							(651,894)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.# 0037960

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	90,711	291,966		9,244								391,921	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,183)	377,669	(17,882)	8,220								366,824	32
33	Real Estate Taxes		250,881		10,671								261,552	33
34	Rent-Facility & Grounds		(1,044,000)										(1,044,000)	34
35	Rent-Equipment & Vehicles			8,438									8,438	35
36	Other (specify):*	(4,624)	57,237										52,613	36
37	TOTAL Ownership	84,904	(66,247)	(9,444)	28,135								37,348	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(1,258)	(18)						(1,276)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers					(1,258)	(18)						(1,276)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(620,338)	(34,661)	(159,974)	200,590	(1,421)	(18)						(615,822)	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 PG6 Supplemental		See PG6 Supplemental		See PG6 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 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%	52,613	52,613	3
4	V	26 Insurance - Property		Columbus Park, LLC	100.00%	11,074	11,074	4
5	V	32 Interest - HUD	89	Columbus Park, LLC	100.00%	377,758	377,669	5
6	V	04 Linen Replacement		Columbus Park, LLC	100.00%	5,839	5,839	6
7	V	21 Office Expense		Columbus Park, LLC	100.00%	36	36	7
8	V	19 Professional Fees		Columbus Park, LLC	100.00%	8,300	8,300	8
9	V	33 Real Estate Taxes	25,119	Columbus Park, LLC	100.00%	276,000	250,881	9
10	V	06 Repairs		Columbus Park, LLC	100.00%	6,087	6,087	10
11	V	36 Amortization - HUD Costs		Columbus Park, LLC	100.00%	4,624	4,624	11
12	V	30 Depreciation		Columbus Park, LLC	100.00%	291,966	291,966	12
13	V							13
14	Total		\$ 1,069,208			\$ 1,034,547	\$ * (34,661)	14

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

Facility Name & ID Number Columbus Park Nrsgr. Rehab Ctr.# 0037960Report Period Beginning: 01/01/15Ending: 12/31/15

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.	\$ 31,104	S.I.R. MANAGEMENT, INC.	100.00%	\$ 6,263	\$ (24,841)
16	V						
17	V	10 NURSING	62,208	S.I.R. MANAGEMENT, INC.	100.00%	48,857	(13,351)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	4,454	4,454
19	V	19 PROFESSIONAL FEES	229,824	S.I.R. MANAGEMENT, INC.	100.00%	5,055	(224,769)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	2,068	2,068
21	V	21 CLERICAL & GENERAL	31,104	S.I.R. MANAGEMENT, INC.	100.00%	158,431	127,327
22	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	1,500	1,500
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	8,876	8,876
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	2,670	2,670
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	8,388	8,388
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(17,882)	(17,882)
27	V	35 AUTO RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	7,173	7,173
28	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,265	1,265
29	V						
30	V	17 ADMINISTRATIVE	114,048	S.I.R. MANAGEMENT, INC.	100.00%	33,385	(80,663)
31	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	568	568
32	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	18,184	18,184
33	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	19,059	19,059
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 468,288			\$ 308,314	\$ * (159,974)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETARY SALARIES	\$ 25,920	S.I.R. MANAGEMENT, INC.	100.00%	\$ 9,312	\$ (16,608)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,298	1,298	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	10,269	10,269	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,422	1,422	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	105,205	105,205	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	19,900	19,900	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	22,692	22,692	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	25,920	S.I.R. MANAGEMENT, INC.	100.00%	13,557	(12,363)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,908	1,908	25
26	V								26
27	V	6	MAINTENANCE SALARIES	42,518	S.I.R. MANAGEMENT, INC.	100.00%	66,163	23,645	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	9,901	9,901	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,987	2,987	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,678	1,678	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	99	99	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	133	133	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	289	289	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	9,244	9,244	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	8,220	8,220	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	10,671	10,671	37
38	V								38
39	Total		\$ 94,358				\$ 294,948	\$ * 200,590	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	\$ 12,321	MAC Rx, LLC	100.00%	\$ 12,159	\$ (163)
16	V	39 Ancillary	95,279	MAC Rx, LLC	100.00%	94,021	(1,258)
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		\$ 107,600			\$ 106,180	\$ * (1,421)

* 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	\$ 2,161	Long Term Care Laboratory, LLC	100.00%	\$ 2,143	\$ (18)	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		\$ 2,161			\$ 2,143	\$ *	(18) 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	MAC RX LLC	DES PLAINES	PHARMACY CONSULT	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 TRUST	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 Nrsng. Rehab Ctr.

0037960

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	Bryan Barrish	Relative	Administrative		See Attached	3.94	8.76%	Alloc. Salary	\$ 19,689	17-7	1	
2	Michael Giannini	Relative	Administrative		See Attached	3.45	8.63%	Alloc. Salary	16,832	17-7	2	
3	Kirsten Schloss	Shareholder	Maintenance	2.04%	See Attached	4.92	9.84%	Alloc. Salary	9,482	6-7	3	
4	Sarah Barrish	Relative	Administrative		See Attached	4.43	9.84%	Alloc. Salary	10,371	17-7	4	
5	Nenita Guzman	Shareholder	Dietary	1.89%	See Attached	4.92	9.84%	Alloc. Salary	9,312	1-7	5	
6	Tom Winter	Shareholder	Administrative	3.77%	See Attached	5.91	9.85%	Alloc. Salary	19,689	17-7	6	
7	Louise Bergthold	Shareholder	Administrative	4.25%	See Attached	5.91	9.85%	Alloc. Salary	19,689	17-7	7	
8	Thomas Bergthold	Relative	Clerical		See Attached	3.94	9.85%	Alloc. Salary	4,070	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											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 109,134		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 Nrsg. Rehab Ctr.

0037960

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 _____

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 Nrsng. Rehab Ctr.

0037960

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 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

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	721,222	14	\$ 63,617	\$ 71,001	\$ 6,263	1	
2									2	
3	10	NURSING	PATIENT DAYS	721,222	14	496,290	496,290	71,001	48,857	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	721,222	14	45,246	71,001	4,454	4	
5	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	51,349	71,001	5,055	5	
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	721,222	14	21,010	71,001	2,068	6	
7	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	1,609,327	1,193,369	71,001	158,431	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	721,222	14	15,238	71,001	1,500	8	
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	721,222	14	90,162	71,001	8,876	9	
10	26	INSURANCE	PATIENT DAYS	721,222	14	27,120	71,001	2,670	10	
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	85,206	71,001	8,388	11	
12	32	INTEREST	PATIENT DAYS	721,222	14	(181,648)	71,001	(17,882)	12	
13	35	AUTO RENTAL	PATIENT DAYS	721,222	14	72,863	71,001	7,173	13	
14	35	EQUIPMENT RENTAL	PATIENT DAYS	721,222	14	12,850	71,001	1,265	14	
15									15	
16	17	ADMINISTRATIVE	PATIENT DAYS	721,222	14	339,119	339,119	71,001	33,385	16
17	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	5,774	71,001	568	17	
18	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	184,716	77,164	71,001	18,184	18
19	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	193,599	71,001	19,059	19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 3,131,838	\$ 2,105,942	\$ 308,314	25	

Facility Name & ID Number Columbus Park Nrsng. Rehab Ctr.

0037960

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 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

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	721,222	14	\$ 94,587	\$ 94,587	71,001	\$ 9,312	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	721,222	14	13,188		71,001	1,298	2
3	10	NURSING SALARIES	PATIENT DAYS	721,222	14	104,315	104,315	71,001	10,269	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	721,222	14	14,440		71,001	1,422	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	721,222	14	1,068,659	1,068,659	71,001	105,205	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	721,222	14	202,147		71,001	19,900	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	721,222	14	230,505		71,001	22,692	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	322,920	13	168,894	168,894	25,920	13,557	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	322,920	13	23,767		25,920	1,908	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	319,657	14	497,427	497,427	42,518	66,163	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	319,657	14	74,439		42,518	9,901	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,878	14	30,338		1,268	2,987	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,878	14	17,037		1,268	1,678	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,878	14	1,002		1,268	99	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,878	14	1,351		1,268	133	19
20	26	INSURANCE	ALLOCATED SQ FT	12,878	14	2,937		1,268	289	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,878	14	93,883		1,268	9,244	21
22	32	INTEREST	ALLOCATED SQ FT	12,878	14	83,486		1,268	8,220	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,878	14	108,372		1,268	10,671	23
24										24
25	TOTALS					\$ 2,830,774	\$ 1,933,882		\$ 294,948	25

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.

0037960

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		\$	\$		\$ 12,159	1
2	39	Ancillary	Direct Allocation					94,021	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				\$	\$		\$ 106,180	25

Facility Name & ID Number Columbus Park Nrsgr. Rehab Ctr.

0037960

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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	Ancillary	Direct Allocation		\$	\$		2,143	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				\$	\$		2,143	25

Facility Name & ID Number Columbus Park Nrsgr. Rehab Ctr.

0037960

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 Columbus Park Nrsgr. Rehab Ctr.

0037960

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 Columbus Park Nrsg. Rehab Ctr.

0037960

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 Columbus Park Nrsg. Rehab Ctr.

0037960 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 Columbus Park Nrsg. Rehab Ctr.

0037960

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

Columbus Park Nrsg. Rehab Ctr.

0037960

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										
										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		9/3/2003	\$	\$ 10,412,667		\$ 377,758	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6	Lake Forest Bank		X	Line of Credit				1,350,000		68,716	6								
7	Allocated from SIR Management	X								8,220	7								
8											8								
9	TOTAL Facility Related						\$	\$ 11,762,667		\$ 454,694	9								
B. Non-Facility Related*																			
10	Interest Income		X							(1,183)	10								
11	Interest Income - Bldg Co.		X							(89)	11								
12	Allocated from SIR Management	X								(17,882)	12								
13											13								
14	TOTAL Non-Facility Related						\$	\$		\$ (19,154)	14								
15	TOTALS (line 9+line14)						\$	\$ 11,762,667		\$ 435,540	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 52,613 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 Nrsg. Rehab Ctr.

0037960

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									7										
Working Capital																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital									14										
B. Non-Facility Related*																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related									20										

* 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.)

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Columbus Park Nrsg. 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 2014 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 2014.

(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>86,419.73</u>	\$ <u>86,419.73</u>
2. <u>16-17-401-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>37,358.70</u>	\$ <u>37,358.70</u>
3. <u>16-17-401-026-0000</u>	<u>Long Term Care Property</u>	\$ <u>139,102.21</u>	\$ <u>139,102.21</u>
4. <u>See Attached</u>	<u>Allocated from S.I.R. Management</u>	\$ <u>118,674.75</u>	\$ <u>9,151.19</u>
5. <u>See Attached</u>	<u>Allocated from Regency Property LLC</u>	\$ <u>862,948.02</u>	\$ <u>1,031.51</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>1,244,503.41</u>	\$ <u>273,063.34</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.**

Facility Name & ID Number Columbus Park Nrsng. Rehab Ctr.

0037960

Report Period Beginning:

01/01/15

Ending:

12/31/15

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.

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an unlabeled column. Row 1: Facility, Square Feet, 2002, \$300,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, (blank), (blank), \$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	\$ 2,644,802	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			46,774	11
12	Various		1995	131,277		20	2,723	2,723	131,275	12
13	Various		1996	62,128		20	3,106	3,106	61,516	13
14	Various		1997	40,477		20	2,024	2,024	37,598	14
15	Various		1998	448,767		20	22,438	22,438	390,560	15
16	Various		1999	202,884		20	10,134	10,134	167,453	16
17	Various		2000	27,418		20	1,371	1,371	21,246	17
18	Various		2001	87,910		20	4,396	4,396	62,629	18
19	Various		2002	35,511		20			35,511	19
20	Various		2003	96,681		20	4,362	4,362	63,279	20
21	Various		2004	77,186		20	3,619	3,619	46,637	21
22	Various		2005	111,165		20	5,105	5,105	64,817	22
23	Various		2006	84,177		20	4,209	4,209	39,719	23
24	Various		2007	305,862		20	15,713	15,713	143,060	24
25	Various		2008	720,628		20	62,405	62,405	503,646	25
26	Various		2009	214,087		20	10,704	10,704	72,121	26
27	Various		2010	118,340		20	11,972	11,972	64,409	27
28	Various		2011	44,289		20	2,214	2,214	9,443	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 Columbus Park Nrsg. Rehab Ctr.

0037960

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		1,309,000	257,870		63,736	(194,134)	412,216	67
68		215,532	5,741		7,833	2,092	110,173	68
69			180,410			(180,410)		69
70		\$ 11,517,026	\$ 444,021		\$ 438,452	\$ (5,569)	\$ 5,252,258	70

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

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.

0037960

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		\$ 11,517,026	\$ 444,021		\$ 438,452	\$ (5,569)	\$ 5,252,258	1
2	Audio Visual Cabinetry	2012			20				2
3	Doors & Windowsills	2012	33,885		20	1,694	1,694	5,506	3
4	Nurse Station Bathrooms - Replace Floor Tile & New Fixtures	2012	11,032		20	552	552	1,793	4
5	Roof Work	2012	9,500		20	475	475	1,504	5
6	Floor Tile & Wall Base	2012	3,726		20	186	186	590	6
7	Hot Water Heater	2012	7,772		20	389	389	1,231	7
8	Sprinkler Heads	2012	6,330		20	317	317	1,002	8
9	Tile Flooring	2012	7,761		20	776	776	2,393	9
10	Tile And Base	2012	3,604		20	240	240	741	10
11	Custom Built-In Cabinets	2012	6,000		20	300	300	950	11
12	Parking Lot Overlay	2012	11,350		20	757	757	2,522	12
13	Boiler Repair	2012	2,950		20	148	148	578	13
14	Replace Mixing Valve	2012	3,875		20	194	194	727	14
15	Outdoor Repairs - Concrete Ramp, Fix Drain, Downspouts, Dryw	2012	8,400		20	420	420	1,365	15
16	Handrail Repair For All Floors	2012	2,785		20	139	139	429	16
17	Elevator Repairs	2012	2,686		20	134	134	436	17
18	Public & Staff Bathroom Floor & Wall Tiles, Toilet, Sink, Faucet	2013	11,000		20	1,100	1,100	3,300	18
19	North Stairwell - Railings Square Tubes	2013	3,250		20	325	325	921	19
20	Fire Alarm Upgrades	2013	8,808		20	881	881	2,496	20
21	Frie Alarm System	2013	6,939		20	694	694	1,908	21
22	Elevator Shaft Floor Drain & Sump Pump	2013	4,300		20	430	430	1,183	22
23	Hvac Compressor	2013	7,124		20	712	712	1,840	23
24	Wall Base	2013	4,216		20	422	422	1,089	24
25	Circulating Pump	2013	2,852		20	285	285	737	25
26	Fire Alarm System	2013	36,051		20	3,605	3,605	9,914	26
27	Elevator Control Room Hvac	2013	9,636		20	964	964	2,570	27
28	Elevator - Special Emergency Service, Keyswitch, Hall Buttons	2013	128,673		20	12,867	12,867	34,313	28
29	Flooring In Vending Area	2013	3,232		20	323	323	754	29
30	Heat Exchanger	2013	8,599		20	860	860	2,006	30
31	3Rd Fl Stairwell Doors Magnetic Door Locks	2013	4,250		20	425	425	1,027	31
32	Remodel Elevator	2013	12,441		20	1,244	1,244	3,110	32
33	Sprinkler Heads	2013	3,503		20	350	350	788	33
34	TOTAL (lines 1 thru 33)		\$ 11,893,556	\$ 444,021		\$ 470,659	\$ 26,638	\$ 5,341,981	34

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

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.

0037960

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 12B, Carried Forward		\$ 11,893,556	\$ 444,021		\$ 470,659	\$ 26,638	\$ 5,341,981	1
2	Televisions Wiremold	2013	28,200		20	2,820	2,820	7,050	2
3	Shower Curtains	2013	3,088		20	309	309	695	3
4	Boiler Upgrades	2013	3,960		20	396	396	825	4
5	Elvator Security Keypad	2013	6,153		20	615	615	1,538	5
6	Therapy Room Drapery	2013	6,420		20	642	642	1,391	6
7	Handrails And Corner Guards	2014	8,326		20	416	416	798	7
8	Vertical Hvac Fan Coil Unit	2014	35,561		20	1,778	1,778	3,260	8
9	Handrails And Crashrails	2014	3,137		20	157	157	170	9
10	Hot Water Heater	2014	4,463		20	223	223	372	10
11	Condenser Coil On Chiller	2014	12,522		20	626	626	1,252	11
12	Caulking & Concrete Patching In West Elevation	2014	2,600		20	130	130	217	12
13	Replace Pauer Supply For Elevator Lighting	2014	4,388		20	219	219	347	13
14	Repair Elevator Hoistway Door Interlock	2014	3,039		20	152	152	165	14
15	Repair Elevator Car Door Vane / Clutch	2014	2,671		20	134	134	145	15
16	Replace Door Closers In Rooms 216, 512, 514	2014	2,985		20	149	149	236	16
17	Repair Nurse Call System	2014	3,794		20	190	190	379	17
18	Upgrade Wifi Network	2015	9,508		20	158	158	158	18
19	New Phone System	2015	9,926		20	165	165	165	19
20	Concrete Replacement At Front Entrance/Driveway	2015	5,500		20	275	275	275	20
21	Repair Boiler Pipe Leak & Replaced Leaking Relief Valves	2015	5,726		20	286	286	286	21
22	Install Circulating Water Pump And Repair Hot Water	2015	4,995		20	250	250	250	22
23	Replace Corroded Horizontal Water Pipe In Ceiling Of Physical T	2015	3,798		20	190	190	190	23
24	Handrail And Crashrail Repairs	2015	3,057		20	153	153	153	24
25	Elevator Hoistway Door Repair	2015	3,258		20	163	163	163	25
26	Install Elevator Hydraulic Machine Oil Tank Heater	2015	3,113		20	156	156	156	26
27	Repair Elevator Door Track Obstruction	2015	2,837		20	142	142	142	27
28	Installed Door Holder & Fire Alarm System	2015	4,993		20	250	250	250	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,081,575	\$ 444,021		\$ 481,803	\$ 37,782	\$ 5,363,008	34

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

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.

0037960

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	
1		\$ 12,081,575	\$ 444,021		\$ 481,803	\$ 37,782	\$ 5,363,008	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)	\$ 12,081,575	\$ 444,021		\$ 481,803	\$ 37,782	\$ 5,363,008	34

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

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.

0037960

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	
1		\$ 12,081,575	\$ 444,021		\$ 481,803	\$ 37,782	\$ 5,363,008	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		\$ 12,081,575	\$ 444,021		\$ 481,803	\$ 37,782	\$ 5,363,008	34

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

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.

0037960

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	Building Company		\$	\$		\$	\$	\$	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	43,862	9
10	Roof Work	2005	98,265		20	4,913	4,913	54,046	10
11	HVAC Chiller	2005	52,295		20	2,615	2,615	28,762	11
12	Rooftop Cooling Tower	2006	23,800		20	2,380	2,380	23,800	12
13	A/C Chiller	2006	48,000		20			48,000	13
14	Carpet	2008	5,496		20			5,496	14
15	Camera / Video System	2008	11,319		20	566	566	4,528	15
16	Draperies and Floors	2009	34,320		20	1,716	1,716	12,012	16
17	Security Camera	2010	3,100		20	310	310	1,860	17
18	Flooring	2010	3,435		20	143	143	858	18
19	Step Construction Therapy	2010	9,538		20	397	397	2,382	19
20	Re-Key Door Locks	2010	6,622		20	193	193	1,158	20
21	Booster Heater	2010	3,306		20	83	83	498	21
22	Elevator Work	2010	3,670		20	184	184	1,101	22
23	Flooring	2010	3,162		20	145	145	870	23
24	Hot Water Heater	2010	4,929		20	205	205	1,230	24
25	Tile Flooring	2011	7,313		20	366	366	1,828	25
26	Chair Rails	2011	7,849		20	392	392	1,962	26
27	Elevator Starter	2011	5,975		20	299	299	1,494	27
28	Baseboard Heater & Repair	2011	2,556		20	128	128	639	28
29	Kitchen Pipe Replacement	2011	3,406		20	170	170	852	29
30	Masonry Repairs, caulking	2012	40,600		20	2,030	2,030	8,120	30
31	Cabinetry-Admin Office	2012	8,980		20	449	449	1,796	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 455,424	\$		\$ 21,058	\$ 21,058	\$ 247,153	34

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

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.

0037960

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 12F, Carried Forward		\$ 455,424	\$		\$ 21,058	\$ 21,058	\$ 247,153	1
2	Sprinkler Coverage & Door Holders	2012	6,612		20	331	331	1,322	2
3	Replace Steps & Risers	2012	16,270		20	814	814	3,254	3
4	Bathroom Remodel 5Th Fl-Sinks, Faucets, Toilets	2012	37,551		20	1,878	1,878	7,510	4
5	Bathroom Remodel 4Th Fl-Sinks, Faucets, Toilets	2012	39,443		20	1,972	1,972	7,889	5
6	Bathroom Remodel 3Th Fl-Sinks, Faucets, Toilets	2012	39,041		20	1,952	1,952	7,808	6
7	Bathroom Remodel 2Nd Fl-Resident Baths	2012	30,760		20	1,538	1,538	6,152	7
8	Custom Cabinets	2012	75,600		20	3,780	3,780	15,120	8
9	Nursing Stations 2Nd&3Rd Fl-Cabinets, Desks, Countertops	2012	12,000		20	600	600	2,400	9
10	Nursing Stations 4Th&5Th Fl-Cabinets, Desks, Countertops	2012	12,000		20	600	600	2,400	10
11	Custom Cabinets	2012	14,000		20	700	700	2,800	11
12	Karndean Van Gogh Flooring for 2nd;4th; and 5th floor resident room	2012	227,960		20	11,398	11,398	45,592	12
13	Karndean Van Gogh Flooring for 3rd floor resident rooms; 2nd, 3rd, 4	2012	158,426		20	7,921	7,921	31,685	13
14	Bathroom Remodel 2Nd Fl	2012	9,000		20	450	450	1,800	14
15	Cabinetry-Admissions	2012	7,400		20	370	370	1,480	15
16	Cabinetry-Activity	2012	2,980		20	149	149	596	16
17	HVAC-Fan Coils; 1st & 5th floors	2012	38,784		20	1,939	1,939	7,757	17
18	Flooring-2,3	2012	60,675		20	3,034	3,034	12,135	18
19	Additional Take up of tile for the flooring work	2012	7,235		20	362	362	1,447	19
20	Hot Water Boiler	2013	12,922		20	646	646	1,938	20
21	Air Conditioning Wiring	2013	2,617		20	131	131	393	21
22	Basement Chiller Repair	2013	2,728		20	136	136	409	22
23	South Dining Room Upholstered Cornice Boards	2013	2,569		20	128	128	385	23
24	Replace Breakers on Chiller	2013	2,925		20	146	146	439	24
25	9 Exit Signs	2013	6,481		20	324	324	972	25
26	Handrail, Crash Rail, and Corner Guards	2015	3,964		20	198	198	198	26
27	Fire Alarm Devices, Door Closures	2015	5,528		20	276	276	276	27
28	Kitchen & Shower Valves	2015	18,105		20	905	905	905	28
29									29
30									30
31	Building Company Improvement Depreciation			257,870			(257,870)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,309,000	\$ 257,870		\$ 63,736	\$ (194,134)	\$ 412,216	34

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

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.

0037960

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	S.I.R. Management	2009	49,231	1,262	39	1,626	364	7,627	3
4	S.I.R. Properties - S.I.R. Management	1993	44,570	1,415	35	1,273	(142)	28,652	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Alloc. - S.I.R. Management	1993	11,300	315	20		(315)	11,300	9
10	Alloc. - S.I.R. Management	1994	35		20			35	10
11	Alloc. - S.I.R. Management	1995	258		20	8	8	258	11
12	Alloc. - S.I.R. Management	1997	17,363	389	20	846	457	16,226	12
13	Alloc. - S.I.R. Management	1999	1,365		20	68	68	1,109	13
14	Alloc. - S.I.R. Management	1999	12,085		20			12,085	14
15	Alloc. - S.I.R. Management	2000	1,612		20	81	81	1,253	15
16	Alloc. - S.I.R. Management	2007	5,179		20	259	259	2,122	16
17	Alloc. - S.I.R. Management	2008	14,273	1,427	20	900	(527)	7,057	17
18	Alloc. - S.I.R. Management	2009	35,467	324	20	1,773	1,449	11,074	18
19	Alloc. - S.I.R. Management	2011	877	88	20	88		388	19
20	Alloc. - S.I.R. Management	2012	2,808	140	20	140		480	20
21	Alloc. - S.I.R. Management	2014	394	39	20	20	(19)	31	21
22									22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2012	2,730	192	20	10	(182)	49	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	2010	2,690		20	134	134	717	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	2009	2,676	119	20	134	15	910	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	2007	780	16	20	39	23	351	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	2002	177		20	9	9	120	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1999	5,648		20	282	282	4,659	28
29	Alloc. - S.I.R. Properties - S.I.R. Management	1998	2,699		20	135	135	2,362	29
30	Alloc. - S.I.R. Properties - S.I.R. Management	1997	168		20	8	8	160	30
31	Alloc. - S.I.R. Properties - S.I.R. Management	1994	424	11	20		(11)	425	31
32	Alloc. - S.I.R. Properties - S.I.R. Management	1993	723	4	20		(4)	723	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 215,532	\$ 5,741		\$ 7,833	\$ 2,092	\$ 110,173	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		\$ 215,532	\$ 5,741		\$ 7,833	\$ 2,092	\$ 110,173
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 215,532	\$ 5,741		\$ 7,833	\$ 2,092	\$ 110,173

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

Facility Name & ID Number Columbus Park Nrsg. Rehab Ctr.

0037960

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	\$ 916,389	\$ 37,296	\$ 89,379	\$ 52,083	10	\$ 595,728	71
72	Current Year Purchases	13,438		772	772	10	772	72
73	Fully Depreciated Assets	1,938,743		6	6	10	1,938,743	73
74								74
75	TOTALS	\$ 2,868,570	\$ 37,296	\$ 90,157	\$ 52,861		\$ 2,535,243	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	2015	\$ 3,461	\$ 302	\$ 370	\$ 68	5	\$ 2,364	76
77										77
78										78
79										79
80	TOTALS			\$ 3,461	\$ 302	\$ 370	\$ 68		\$ 2,364	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)	\$ 15,253,606	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 481,619	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 572,330	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 90,711	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,900,616	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? YES NO

If NO, see instructions.

		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: \$ 4,944 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>7,173</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>7,173</u>	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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 148,529	\$		\$ 148,529	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			95,016			95,016	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			166,907			166,907	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				102,407		102,407	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>						41,992		41,992	13
14	TOTAL			\$		\$ 410,452	\$ 144,399		\$ 554,851	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 Nrsrg. Rehab Ctr.

0037960

Report 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	\$ 48,913	\$ 159,982	1
2	Cash-Patient Deposits	111,037	111,037	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,182,364	2,182,364	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	62,424	62,424	6
7	Other Prepaid Expenses	4,126	5,050	7
8	Accounts Receivable (owners or related parties)	200,000	200,000	8
9	Other(specify):		311,584	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,608,864	\$ 3,032,441	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		8,100,078	14
15	Leasehold Improvements, at Historical Cost	2,521,628	2,521,628	15
16	Equipment, at Historical Cost	1,724,320	3,593,370	16
17	Accumulated Depreciation (book methods)	(2,493,224)	(7,360,939)	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):		119,830	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,752,724	\$ 7,273,967	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,361,588	\$ 10,306,408	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 441,191	\$ 441,191	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	111,038	111,038	28
29	Short-Term Notes Payable	1,350,000	1,350,000	29
30	Accrued Salaries Payable	259,138	259,138	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,571	20,571	31
32	Accrued Real Estate Taxes(Sch.IX-B)		276,000	32
33	Accrued Interest Payable		31,151	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	28,500	28,500	35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,210,438	\$ 2,517,589	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,412,667	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)	\$	\$ 10,412,667	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,210,438	\$ 12,930,256	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,151,150	\$ (2,623,848)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,361,588	\$ 10,306,408	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,222,520	1
2	Restatements (describe):		2
3	Rounding	(8)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,222,512	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	928,638	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)	\$ 928,638	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)	\$ 2,151,150	24 *

* This must agree with page 17, line 47.

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0037960

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,706,827	1
2	Discounts and Allowances for all Levels	(1,468,416)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,238,411	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,565,938	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,565,938	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	84,111	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,239	19
20	Radiology and X-Ray		20
21	Other Medical Services	30,639	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 118,989	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,183	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,183	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	438,808	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 438,808	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,363,329	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,839,029	31
32	Health Care	3,619,854	32
33	General Administration	2,594,096	33
B. Capital Expense			
34	Ownership	1,296,805	34
C. Ancillary Expense			
35	Special Cost Centers	554,851	35
36	Provider Participation Fee	530,056	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,434,691	40
41	Income before Income Taxes (line 30 minus line 40)**	928,638	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 928,638	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,928,359	44
45	Private Pay - Net Inpatient Revenue	75,605	45
46	Medicare - Net Inpatient Revenue	171,106	46
47	Other-(specify) <u>Hospice</u>	29,381	47
48	Other-(specify) <u>HMO, Insurance</u>	4,033,960	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,238,411	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 Nrsg. Rehab Ctr.**

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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	1,830	1,905	\$ 86,736	\$ 45.53	1
2	Assistant Director of Nursing	1,391	1,420	51,996	36.62	2
3	Registered Nurses	14,024	15,185	414,176	27.28	3
4	Licensed Practical Nurses	37,427	39,863	981,529	24.62	4
5	CNAs & Orderlies	89,067	95,061	1,052,050	11.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,925	8,961	152,977	17.07	8
9	Activity Director	10,617	11,614	127,674	10.99	9
10	Activity Assistants					10
11	Social Service Workers	14,493	16,018	219,512	13.70	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,362	26,319	290,980	11.06	15
16	Dishwashers					16
17	Maintenance Workers	3,714	4,023	55,327	13.75	17
18	Housekeepers	27,534	29,511	305,814	10.36	18
19	Laundry	9,178	10,145	104,263	10.28	19
20	Administrator	2,083	2,173	103,459	47.61	20
21	Assistant Administrator	1,845	2,086	67,080	32.16	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,539	15,151	204,705	13.51	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	5,081	5,763	145,804	25.30	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,406	1,406	6,090	4.33	33
34	TOTAL (lines 1 - 33)	265,516	286,604	\$ 4,370,172 *	\$ 15.25	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	\$ 18,612	01-03	35
36	Medical Director	Monthly	9,600	09-03	36
37	Medical Records Consultant	Monthly	4,704	10-03	37
38	Nurse Consultant	Monthly	62,208	10-03	38
39	Pharmacist Consultant	Monthly	5,754	10-03	39
40	Physical Therapy Consultant	113	6,316	10a-03	40
41	Occupational Therapy Consultant	106	6,050	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	103	6,154	10a-03	43
44	Activity Consultant	Monthly	5,049	11-03	44
45	Social Service Consultant				45
46	Other(specify) <u>Dir. Of Food Service</u>	Monthly	25,920	010-03	46
47	<u>Specialized Rehab</u>	Monthly	25,920	12-03	47
48	<u>Psychiatric MD Consultant</u>	Monthly	2,000	12-03	48
49	TOTAL (lines 35 - 48)	321	\$ 178,287		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	337	13,050	10-03	51
52	Certified Nurse Assistants/Aides	88	2,274	10-03	52
53	TOTAL (lines 50 - 52)	425	\$ 15,324		53

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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: \$28,018.89
- (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. \$ 14,008 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. \$ 530,056
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. \$ 33,945 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.