

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

0046177 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26,436	7,085	13,420	46,941	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,436	7,085	13,420	46,941	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.74%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 2/1/2003

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/1/2003 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 150 and days of care provided 6,725

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc # 0046177 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	339,958	69,097	27,234	436,289		436,289	11,443	447,732		1
2	Food Purchase		273,090		273,090		273,090	(1,707)	271,383		2
3	Housekeeping	178,452	33,495		211,947		211,947	1,093	213,040		3
4	Laundry	111,916	35,492		147,408		147,408		147,408		4
5	Heat and Other Utilities			221,017	221,017		221,017	1,616	222,633		5
6	Maintenance	128,712		222,781	351,493		351,493	12,115	363,608		6
7	Other (specify):*							3,023	3,023		7
8	TOTAL General Services	759,038	411,174	471,032	1,641,244		1,641,244	27,583	1,668,827		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,602,260	392,293	1,194,059	4,188,612		4,188,612	43,161	4,231,773		10
10a	Therapy	173,470		169	173,639		173,639		173,639		10a
11	Activities	212,285	44,266		256,551		256,551		256,551		11
12	Social Services	202,760			202,760		202,760	32,037	234,797		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*	54,137			54,137		54,137	10,903	65,040		15
16	TOTAL Health Care and Programs	3,244,912	436,559	1,212,228	4,893,699		4,893,699	86,101	4,979,800		16
	C. General Administration										
17	Administrative	155,819			155,819		155,819	107,757	263,576		17
18	Directors Fees										18
19	Professional Services			621,453	621,453	(298)	621,155	(534,142)	87,013		19
20	Dues, Fees, Subscriptions & Promotions			136,283	136,283		136,283	(25,364)	110,919		20
21	Clerical & General Office Expenses	121,972	40,020	809,032	971,024		971,024	(575,613)	395,411		21
22	Employee Benefits & Payroll Taxes			659,110	659,110		659,110	(15,468)	643,642		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,226	2,226		2,226	1,154	3,380		24
25	Other Admin. Staff Transportation			3,140	3,140		3,140	894	4,034		25
26	Insurance-Prop.Liab.Malpractice			476,364	476,364		476,364	1,818	478,182		26
27	Other (specify):*							47,681	47,681		27
28	TOTAL General Administration	277,791	40,020	2,707,608	3,025,419	(298)	3,025,121	(991,283)	2,033,838		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,281,741	887,753	4,390,868	9,560,362	(298)	9,560,064	(877,600)	8,682,465		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			96,038	96,038		96,038	84,122	180,160			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16	16		16	25,080	25,096			32
33	Real Estate Taxes			88,793	88,793	298	89,091	4,829	93,920			33
34	Rent-Facility & Grounds			691,858	691,858		691,858	(684,000)	7,858			34
35	Rent-Equipment & Vehicles			6,468	6,468		6,468	445	6,913			35
36	Other (specify):*			1,050	1,050		1,050	(1,050)				36
37	TOTAL Ownership			884,223	884,223	298	884,521	(570,574)	313,947			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		263,492	1,301,267	1,564,759		1,564,759	(17,425)	1,547,334			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			304,657	304,657		304,657		304,657			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		263,492	1,605,924	1,869,416		1,869,416	(17,425)	1,851,991			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,281,741	1,151,245	6,881,015	12,314,001		12,314,001	(1,465,599)	10,848,402			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 Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/18

Ending:

12/31/18

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,256)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,012)	30		9
10	Interest and Other Investment Income	(212,399)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(412)	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	(32,607)	21		18
19	Entertainment				19
20	Contributions	(500)	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	(678,243)	21		24
25	Fund Raising, Advertising and Promotional	(16,337)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(55,553)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,009,319)		\$	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)	(456,279)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (456,279)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,465,598)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Chateau Nursing & Rehab Center, Llc

ID# 0046177

Report Period Beginning: 01/01/18

Ending: 12/31/18

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Vending Income	\$ (401)	02	1
2	Bank Charges	(5,415)	21	2
3	Theft Loss	(3,688)	21	3
4	Collection Expense	(7,209)	19	4
5	Amortization	(1,050)	36	5
6	PAC Dues	(11,310)	20	6
7	Non Allowable Legal	(8,577)	19	7
8	Building Company - Management Fees	(7,500)	19	8
9	Building Company - Bank Charges	(350)	21	9
10	Building Company - Filing Fee	(75)	20	10
11	Building Company - Amortization	(7,100)	36	11
12	Collections	(2,624)	19	12
13	Non Allowable Legal	(255)	19	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(55,553)		49

Chateau Nursing & Rehab Center, Llc

Report Period Beginning: ID# 0046177
 Ending: 01/01/18
 12/31/18

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

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/18

Ending:

12/31/18

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			178		11,265							11,443	1
2	Food Purchase	(2,069)		362									(1,707)	2
3	Housekeeping			968		125							1,093	3
4	Laundry													4
5	Heat and Other Utilities			1,446		170							1,616	5
6	Maintenance			3,872	8,181	62							12,115	6
7	Other (specify):*				1,441	1,582							3,023	7
8	TOTAL General Services	(2,069)		6,826	9,622	13,204							27,583	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records					45,616		(2,455)					43,161	10
10a	Therapy													10a
11	Activities													11
12	Social Services					32,037							32,037	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					10,903							10,903	15
16	TOTAL Health Care and Programs					88,556		(2,455)					86,101	16
	C. General Administration													
17	Administrative			1,387	15,930	90,440							107,757	17
18	Directors Fees													18
19	Professional Services	(26,164)	7,500	(386,020)		(129,458)							(534,142)	19
20	Fees, Subscriptions & Promotions	(28,222)	75	1,779		1,004							(25,364)	20
21	Clerical & General Office Expenses	(720,303)	350	9,127	104,320	30,893							(575,613)	21
22	Employee Benefits & Payroll Taxes				(15,468)								(15,468)	22
23	Inservice Training & Education													23
24	Travel and Seminar			337		817							1,154	24
25	Other Admin. Staff Transportation			894									894	25
26	Insurance-Prop.Liab.Malpractice			1,625		193							1,818	26
27	Other (specify):*				30,934	16,747							47,681	27
28	TOTAL General Administration	(774,689)	7,925	(370,871)	135,716	10,636							(991,283)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(776,758)	7,925	(364,045)	145,338	112,396		(2,455)					(877,600)	29

STATE OF ILLINOIS

Summary B

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

0046177

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(12,012)	93,640	2,362		132							84,122	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(212,399)	217,070	20,258		151							25,080	32
33	Real Estate Taxes			4,276		553							4,829	33
34	Rent-Facility & Grounds		(684,000)										(684,000)	34
35	Rent-Equipment & Vehicles			445									445	35
36	Other (specify):*	(8,150)	7,100										(1,050)	36
37	TOTAL Ownership	(232,561)	(366,190)	27,341		836							(570,574)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(17,425)					(17,425)	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							(17,425)					(17,425)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,009,319)	(358,265)	(336,704)	145,338	113,232		(19,880)					(1,465,599)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 684,000	Chateau Willowbrook Property		\$	(684,000)	1
2	V	19 Management Fee		Chateau Willowbrook Property		7,500	7,500	2
3	V	21 Bank Charge		Chateau Willowbrook Property		350	350	3
4	V	20 Filing Fee		Chateau Willowbrook Property		75	75	4
5	V	30 Depreciation		Chateau Willowbrook Property		93,640	93,640	5
6	V	36 Amortization Expense		Chateau Willowbrook Property		7,100	7,100	6
7	V	33 Real Estate Tax	88,793	Chateau Willowbrook Property		88,793		7
8	V	32 Interest Expense		Chateau Willowbrook Property		217,070	217,070	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 772,793			\$ 414,528	\$ * (358,265)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01 Dietary	\$	Extended Care Consulting, LLC		\$ 178	\$	178	15
16	V	02 Food		Extended Care Consulting, LLC		362		362	16
17	V	03 Housekeeping		Extended Care Consulting, LLC		968		968	17
18	V	05 Utilities		Extended Care Consulting, LLC		1,446		1,446	18
19	V	06 Maintenance		Extended Care Consulting, LLC		3,872		3,872	19
20	V	17 Administrative		Extended Care Consulting, LLC		1,387		1,387	20
21	V	19 Professional Fees	391,080	Extended Care Consulting, LLC		5,060		(386,020)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC		1,779		1,779	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC		9,127		9,127	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC		337		337	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC		894		894	25
26	V	26 Insurance		Extended Care Consulting, LLC		1,625		1,625	26
27	V	30 Depreciation		Extended Care Consulting, LLC		2,362		2,362	27
28	V	32 Interest		Extended Care Consulting, LLC		20,258		20,258	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC		4,276		4,276	29
30	V	35 Rent - Equipment		Extended Care Consulting, LLC		445		445	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 391,080			\$ 54,376	\$ *	(336,704)	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 Schedule V	2 Line	3	4	5	6	7	8	
		Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06 Maintenance (Pooled)		Extended Care Consulting, LLC		8,180	\$ 8,180	15
16	V	06 Maintenance (Direct)	6,744	Extended Care Consulting, LLC		6,745	1	16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC		710	710	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC		731	731	18
19	V							19
20	V							20
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC		15,930	15,930	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC		104,320	104,320	22
23	V	21 Office and Clerical (Direct)	44,815	Extended Care Consulting, LLC		44,815		23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC		24,047	24,047	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC		6,887	6,887	25
26	V	22 Employee Benefits	15,468	Extended Care Consulting, LLC			(15,468)	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		\$ 67,027			\$ 212,365	\$ * 145,338	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 Schedule V	2 Line	3	4	5	6	7	8		
		Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)		
15	V	03	Housekeeping	\$	Extended Care Clinical, LLC	\$	125	\$ 125	15
16	V	05	Utilities		Extended Care Clinical, LLC		170	170	16
17	V	06	Maintenance		Extended Care Clinical, LLC		62	62	17
18	V	19	Professional Fees	130,356	Extended Care Clinical, LLC		898	(129,458)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC		1,004	1,004	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC		2,056	2,056	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC		817	817	21
22	V	26	Insurance		Extended Care Clinical, LLC		193	193	22
23	V	30	Depreciation		Extended Care Clinical, LLC		132	132	23
24	V	32	Interest		Extended Care Clinical, LLC		151	151	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC		553	553	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC		11,265	11,265	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC		1,582	1,582	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC		45,616	45,616	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC		32,037	32,037	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC		10,903	10,903	30
31	V	17	Administration Salary		Extended Care Clinical, LLC		90,440	90,440	31
32	V	21	Office Salary		Extended Care Clinical, LLC		28,837	28,837	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC		16,747	16,747	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 130,356			\$	243,588	\$ * 113,232	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	Various Equipment	18,970	Vent Lease LLC		18,970	\$	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			\$ 18,970			\$ 18,970	\$ *	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	28,488	MAC Rx, LLC		26,032	(2,455)	15
16	V	39	Ancillary	202,179	MAC Rx, LLC		184,754	(17,425)	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			\$ 230,667			\$ 210,787	\$ * (19,880)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group		\$ 361,324	\$ 361,324	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	361,324	CCS Employee Benefits Group			(361,324)	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			\$ 361,324			\$ 361,324	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc # 0046177 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Adam Vales	Relative	Clerical	0.00%	See Attached	1.71	4.29%	Alloc Salary	\$ 3,249	22-7	1	
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	0.91	1.65%	Alloc Sal/Fee	7,568	17-7	2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 10,817		13	

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

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

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

0046177

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

0046177

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,389,746	40	\$ 5,386	\$ 45,903	\$ 178	1
2	02	Food	Patient Days	1,389,746	40	10,961	45,903	362	2
3	03	Housekeeping	Patient Days	1,389,746	40	29,295	45,903	968	3
4	05	Utilities	Patient Days	1,389,746	40	43,781	45,903	1,446	4
5	06	Maintenance	Patient Days	1,389,746	40	117,234	45,903	3,872	5
6	17	Administrative	Patient Days	1,389,746	40	42,000	45,903	1,387	6
7	19	Professional Fees	Patient Days	1,389,746	40	153,207	45,903	5,060	7
8	20	Dues and Subscriptions	Patient Days	1,389,746	40	53,847	45,903	1,779	8
9	21	Office and Clerical	Patient Days	1,389,746	40	276,330	45,903	9,127	9
10	24	Seminar and Travel	Patient Days	1,389,746	40	10,217	45,903	337	10
11	25	Other Staff Admin. Trans.	Patient Days	1,389,746	40	27,054	45,903	894	11
12	26	Insurance	Patient Days	1,389,746	40	49,193	45,903	1,625	12
13	30	Depreciation	Patient Days	1,389,746	40	71,516	45,903	2,362	13
14	32	Interest	Patient Days	1,389,746	40	613,328	45,903	20,258	14
15	33	Real Estate Taxes	Patient Days	1,389,746	40	129,471	45,903	4,276	15
16	35	Rent - Equipment	Patient Days	1,389,746	40	13,470	45,903	445	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,646,291	\$	\$ 54,376	25

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

0046177

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	06	Maintenance (Pooled)	Patient Days	1,389,746	40	247,664	247,664	45,903	8,180	1
2	06	Maintenance (Direct)	Direct		25	357,298	357,298		6,745	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,389,746	40	21,482		45,903	710	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		25	47,140			731	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,389,746	40	482,303	482,303	45,903	15,930	7
8	21	Office and Clerical (Pooled)	Patient Days	1,389,746	40	3,158,355	3,158,355	45,903	104,320	8
9	21	Office and Clerical (Direct)	Direct		28	484,472	484,472		44,815	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,389,746	40	728,044		45,903	24,047	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		28	72,742			6,887	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					\$ 5,599,498	\$ 4,730,091		\$ 212,365	25

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

0046177

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	03	Housekeeping	Patient Days	710,509	22	\$ 1,936	\$ 45,903	\$ 125	1	
2	05	Utilities	Patient Days	710,509	22	2,630	45,903	170	2	
3	06	Maintenance	Patient Days	710,509	22	952	45,903	62	3	
4	19	Professional Fees	Patient Days	710,509	22	13,906	45,903	898	4	
5	20	Dues and Subscriptions	Patient Days	710,509	22	15,540	45,903	1,004	5	
6	21	Office & Clerical	Patient Days	710,509	22	31,816	45,903	2,056	6	
7	24	Travel and Seminar	Patient Days	710,509	22	12,645	45,903	817	7	
8	26	Insurance	Patient Days	710,509	22	2,983	45,903	193	8	
9	30	Depreciation	Patient Days	710,509	22	2,046	45,903	132	9	
10	32	Interest	Patient Days	710,509	22	2,330	45,903	151	10	
11	33	Real Estate Taxes	Patient Days	710,509	22	8,555	45,903	553	11	
12	01	Dietary Salary	Patient Days	710,509	22	174,364	174,364	45,903	11,265	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	710,509	22	24,481	45,903	1,582	13	
14	10	Nursing Salary	Patient Days	710,509	22	706,073	706,073	45,903	45,616	14
15	12	Social Service Salary	Patient Days	710,509	22	495,889	495,889	45,903	32,037	15
16	15	Emp. Ben. - Healthcare	Patient Days	710,509	22	168,758	45,903	10,903	16	
17	17	Administration Salary	Patient Days	710,509	22	1,399,873	1,399,873	45,903	90,440	17
18	21	Office Salary	Patient Days	710,509	22	446,345	446,345	45,903	28,837	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	710,509	22	259,213	45,903	16,747	19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 3,770,337	\$ 3,222,544	\$ 243,588	25	

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

0046177

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Vent Lease, LLC

Street Address

2201 Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 674-1180

Fax Number

(847) 673-7741

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	Various Equipment	Direct Allocation					18,970	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					\$	\$	\$	18,970	25

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

0046177

Report Period Beginning:

01/01/18

Ending: 12/31/18

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					26,032	1
2	39	Ancillary	Direct Allocation					184,754	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					\$	\$	\$ 210,787	25

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

0046177

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

CCS Employee Benefits Group, Inc.

Street Address

2201 Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847)905-4000

Fax Number

(847)905-4040

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 361,324	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				\$	\$		\$ 361,324	25

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

0046177

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

0046177 Report Period Beginning: 01/01/18

Ending: 12/31/18

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 Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/18

Ending:

12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Bank Leumi		X	Mortgage			\$	\$ 5,223,725		\$ 217,070	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	Advance HFG II		X	Line of Credit				244,215			16									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$ 5,467,940		\$ 217,086	9									
B. Non-Facility Related*																				
10	Interest Income		X							(212,399)	10									
11	Allocated - EC Consulting	X								20,258	11									
12	Allocated - EC Clinical	X								151	12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (191,990)	14									
15	TOTALS (line 9+line14)						\$	\$ 5,467,940		\$ 25,096	15									

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 report.

\$ 102,891 1

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$ 98,333 2

3. Under or (over) accrual (line 2 minus line 1).

\$ (4,558) 3

4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ 98,180 4

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$ 298 5

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND \$ 730 For 14-16 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$ 6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ 93,920 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2013	<u>56,765</u>	8
2014	<u>90,823</u>	9
2015	<u>96,848</u>	10
2016	<u>97,991</u>	11
2017	<u>93,504</u>	12

2018 accrual = 93,504 x 1.05 = 98,180

Allocated from Extended Care Consulting = \$4,276

Allocated from Extended Care Clinical = \$553

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Chateau Nursing & Rehab Center, Llc COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0046177

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>09-23-407-043</u>	<u>Long Term Care Property</u>	\$ <u>93,504.46</u>	\$ <u>93,504.46</u>
2.	<u>See Attached</u>	<u>Allocated from Care Center Bldg</u>	\$ <u>190,923.89</u>	\$ <u>4,829.08</u>
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>284,428.35</u></u>	\$ <u><u>98,333.54</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Chateau Nursing & Rehab Center, Llc COUNTY Dupage
 FACILITY IDPH LICENSE NUMBER 0046177
 CONTACT PERSON REGARDING THIS REPORT _____
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Chateau Nursing & Rehab Center, Llc

0046177 Report Period Beginning:

01/01/18 Ending:

12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

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

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility	273,121	2003	\$ 295,367	1
2	Allocated from Care Center Building			20,740	2
3	TOTALS			\$ 316,107	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150	2003	1987	\$ 2,658,301	\$ 93,640	39	\$ 68,162	\$ (25,478)	\$ 1,673,396	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		2003	51,953		20	1,589	1,589	40,732	9
10	Various		2004	98,684		20	4,650	4,650	73,646	10
11	Various		2005	69,862		20	3,493	3,493	45,911	11
12	Various		2006	50,399		20	1,814	1,814	37,168	12
13	Various		2007	126,729		20	6,725	6,725	77,921	13
14	Various		2008	30,544		20	1,803	1,803	19,119	14
15	Various		2009	25,582		20	944	944	15,281	15
16	Various		2010	12,771		20	705	705	6,183	16
17	Various		2011	110,418		20	5,830	5,830	43,142	17
18	Various		2012	56,744		20	1,139	1,139	43,431	18
19	Various		2013	176,755		20	8,838	8,838	60,994	19
20	Various		2014	129,172		20	7,532	7,532	35,462	20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

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

0046177

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		238,642			11,932	11,932	154,746	67
68		102,619	1,573		1,573		69,564	68
69			96,038			(96,038)		69
70		\$ 3,939,176	\$ 191,251		\$ 126,728	\$ (64,523)	\$ 2,396,697	70

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

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

0046177

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,939,176	\$ 191,251		\$ 126,728	\$ (64,523)	\$ 2,396,697	1
2	Control Panel And Install Remote Annunciator	2015	17,686		20	884	884	3,537	2
3	Water Heater	2015	7,596		20	380	380	1,329	3
4	Office Phone System	2015	49,620		20	9,924	9,924	33,907	4
5	Dining Room Flooring	2015	26,400		20	5,280	5,280	16,280	5
6	Pump Gasket	2015	3,058		20	153	153	471	6
7	Water Heater	2016	7,596		20	380	380	855	7
8	Security Systems	2016	5,548		20	277	277	601	8
9	Installation Of New Heat Exchanger	2017	4,100		20	205	205	376	9
10	Sprinkler System Modifications	2017	14,995		20	750	750	1,062	10
11	Laundry & Kitchen Boiler Repairs-Damper Motors & Relays	2017	5,943		20	297	297	322	11
12	Elevators - Replaced Relays, Wiring	2017	5,229		20	261	261	349	12
13	Replaced Sprinkler Heads In Laundry, Office, Electric Room	2017	2,757		20	138	138	253	13
14	Revent Boiler & 2 Hot Water Tanks	2018	36,500		20	1,217	1,217	1,217	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,126,204	\$ 191,251		\$ 146,874	\$ (44,377)	\$ 2,457,256	34

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

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

0046177

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,126,204	\$ 191,251		\$ 146,874	\$ (44,377)	\$ 2,457,256	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,126,204	\$ 191,251		\$ 146,874	\$ (44,377)	\$ 2,457,256	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,126,204	\$ 191,251		\$ 146,874	\$ (44,377)	\$ 2,457,256	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,126,204	\$ 191,251		\$ 146,874	\$ (44,377)	\$ 2,457,256	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,126,204	\$ 191,251		\$ 146,874	\$ (44,377)	\$ 2,457,256	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,126,204	\$ 191,251		\$ 146,874	\$ (44,377)	\$ 2,457,256	34

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

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

0046177

Report Period Beginning:

01/01/18

Ending:

12/31/18

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									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Life Safety Code Improvements (Net of Settlement)	2005	231,242		20	11,562	11,562	150,306	9
10	Professional Fees - Architect	2007	7,400		20	370	370	4,440	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 238,642	\$		\$ 11,932	\$ 11,932	\$ 154,746	34

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

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

0046177

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 238,642	\$		\$ 11,932	\$ 11,932	\$ 154,746	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 238,642	\$		\$ 11,932	\$	\$ 154,746	34

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

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

0046177

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from Extended Care Consulting-Care Center Bldg	2002	25,310	649	35	649		10,573	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	7,927	176	35	176		2,019	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	3,271	84	35	84		1,366	5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting-Care Center Bldg	2002	20,908		20			20,908	8
9	Allocated from Extended Care Consulting-Care Center Bldg	2003	24,640		20			24,640	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,224		20			1,224	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2009	221	11	20	11		110	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2014	2,120	106	20	106		530	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2015	348	17	20	17		150	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,376	69	20	69		206	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2017	2,386	119	20	119		239	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2018	1,094	55	20	55		55	16
17	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,702		20			2,702	17
18	Allocated from Extended Care Clinical - Care Center Bldg	2003	3,185		20			3,185	18
19	Allocated from Extended Care Clinical - Care Center Bldg	2005	158		20			158	19
20	Allocated from Extended Care Clinical - Care Center Bldg	2009	29	1	20	1		14	20
21	Allocated from Extended Care Clinical - Care Center Bldg	2014	266	13	20	13		66	21
22	Allocated from Extended Care Clinical - Care Center Bldg	2015	45	2	20	2		19	22
23	Allocated from Extended Care Clinical - Care Center Bldg	2016	178	9	20	9		27	23
24	Allocated from Extended Care Clinical - Care Center Bldg	2017	308	15	20	15		31	24
25	Allocated from Extended Care Clinical - Care Center Bldg	2018	141	7	20	7		7	25
26	Allocated from Extended Care Consulting	2007	152	8	20	8		91	26
27	Allocated from Extended Care Consulting	2009	91	5	20	5		46	27
28	Allocated from Extended Care Consulting	2010	891	45	20	45		401	28
29	Allocated from Extended Care Consulting	2011	321	16	20	16		128	29
30	Allocated from Extended Care Consulting	2012	106	5	20	5		37	30
31	Allocated from Extended Care Consulting	2014	1,465	73	20	73		366	31
32	Allocated from Extended Care Consulting	2016	1,756	88	20	88		263	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 102,619	\$ 1,573		\$ 1,573	\$	\$ 69,564	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		\$ 102,619	\$ 1,573		\$ 1,573	\$	\$ 69,564	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)	\$ 102,619	\$ 1,573		\$ 1,573	\$	\$ 69,564	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 200,104	\$ 753	\$ 32,747	\$ 31,994	10	\$ 167,477	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	601,327				10	601,327	73
74								74
75	TOTALS	\$ 801,430	\$ 753	\$ 32,747	\$ 31,994		\$ 768,804	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2003 FORD ECONO VAN	2003	\$ 33,833	\$	\$	\$	5	\$ 33,833	76
77		TRUCK REPAIR	2004	1,083				5	1,083	77
78		Truck Repairs	2013	5,548		370	370	5	5,548	78
79		See Attached		4,160	168	168	0		4,160	79
80	TOTALS			\$ 44,624	\$ 168	\$ 538	\$ 370		\$ 44,624	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,288,365	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 192,172	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 180,160	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (12,012)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,270,683	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				7,858			5
6								6
7	TOTAL				\$ 7,858			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ 6,912 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)			
			Staff		Outside Practitioner (other than consultant)									
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$			\$	543,967	\$		\$	543,967	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					117,055				117,055	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39 - 03	hrs					630,616				630,616	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						209,000			209,000	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Other (specify):												12	
13	Other (specify):							9,629	54,492			64,121	13	
14	TOTAL			\$				\$	1,301,267	\$	263,492	\$	1,564,759	14

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

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

0046177

Report Period Beginning: 01/01/18

Ending:

12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 13,796	\$ 137,724	1
2	Cash-Patient Deposits	30,431	30,431	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	759,586	759,586	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	70,808	70,808	6
7	Other Prepaid Expenses	7,038	7,038	7
8	Accounts Receivable (owners or related parties)	315,075	4,456,538	8
9	Other(specify): <u>See Attached Schedule</u>	7,129,502	7,129,502	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,326,236	\$ 12,591,627	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		295,367	13
14	Buildings, at Historical Cost		3,805,411	14
15	Leasehold Improvements, at Historical Cost	947,850	947,850	15
16	Equipment, at Historical Cost	468,334	468,334	16
17	Accumulated Depreciation (book methods)	(1,087,115)	(3,864,856)	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): <u>See Attached Schedule</u>	438	438	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 329,507	\$ 1,652,544	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,655,743	\$ 14,244,171	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,176,533	\$ 1,176,533	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,657	21,657	28
29	Short-Term Notes Payable	244,215	244,215	29
30	Accrued Salaries Payable	210,687	210,687	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,078	9,078	31
32	Accrued Real Estate Taxes(Sch.IX-B)	98,180	98,180	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,760,350	\$ 1,760,350	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,223,725	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)	\$	\$ 5,223,725	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,760,350	\$ 6,984,075	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,895,393	\$ 7,260,096	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,655,743	\$ 14,244,171	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,301,641	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,301,638	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	570,084	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	23,671	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)	\$ 593,755	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)	\$ 6,895,393	24 *

* This must agree with page 17, line 47.

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

0046177

Report Period Beginning: 01/01/18

Ending:

12/31/18

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	\$ 12,044,458	1
2	Discounts and Allowances for all Levels	(4,059,024)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,985,434	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,265,323	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,265,323	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,007	13
14	Non-Patient Meals	1,256	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	199,755	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	78,992	19
20	Radiology and X-Ray	9,276	20
21	Other Medical Services	128,242	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 420,528	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	212,399	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 212,399	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	401	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 401	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,884,085	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,641,244	31
32	Health Care	4,893,699	32
33	General Administration	3,025,419	33
B. Capital Expense			
34	Ownership	884,223	34
C. Ancillary Expense			
35	Special Cost Centers	1,564,759	35
36	Provider Participation Fee	304,657	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,314,001	40
41	Income before Income Taxes (line 30 minus line 40)**	570,084	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 570,084	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,788,283	44
45	Private Pay - Net Inpatient Revenue	1,598,256	45
46	Medicare - Net Inpatient Revenue	333,868	46
47	Other-(specify) <u>Hospice</u>	249,124	47
48	Other-(specify) <u>Insurance</u>	15,903	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,985,434	49

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

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

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

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

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

0046177

Report Period Beginning: 01/01/18

Ending: 12/31/18

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	1,999	2,451	\$ 119,730	\$ 48.85	1
2	Assistant Director of Nursing	1,992	2,422	92,047	38.00	2
3	Registered Nurses	22,665	25,346	880,109	34.72	3
4	Licensed Practical Nurses	26,792	29,765	881,883	29.63	4
5	CNAs & Orderlies	34,686	38,679	579,437	14.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,883	8,495	173,470	20.42	8
9	Activity Director	1,533	1,633	30,839	18.89	9
10	Activity Assistants	10,971	12,185	153,618	12.61	10
11	Social Service Workers	7,854	8,464	202,760	23.96	11
12	Dietician					12
13	Food Service Supervisor	2,005	2,272	52,927	23.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,802	6,076	89,250	14.69	15
16	Dishwashers	15,912	17,286	197,781	11.44	16
17	Maintenance Workers	5,203	5,970	128,712	21.56	17
18	Housekeepers	13,927	15,678	178,452	11.38	18
19	Laundry	9,269	10,281	111,916	10.89	19
20	Administrator	1,949	2,117	96,756	45.70	20
21	Assistant Administrator	1,761	1,807	59,063	32.69	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,762	6,497	121,972	18.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,860	2,333	44,944	19.26	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	6,994	7,882	86,076	10.92	33
34	TOTAL (lines 1 - 33)	186,818	207,638	\$ 4,281,742 *	\$ 20.62	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	538	\$ 27,234	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,766	10-03	39
40	Physical Therapy Consultant	2	79	10a-03	40
41	Occupational Therapy Consultant	2	90	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	541	\$ 55,169		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,175	\$ 70,525	10-03	50
51	Licensed Practical Nurses	3,792	166,384	10-03	51
52	Certified Nurse Assistants/Aides	38,864	947,384	10-03	52
53	TOTAL (lines 50 - 52)	43,831	\$ 1,184,293		53

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

0046177

Report Period Beginning: 01/01/18

Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Laura A. Aranda	Administrator	0	\$ 76,014	Workers' Compensation Insurance	\$ 78,052	IDPH License Fee	\$ 3,648	
Jamie Krieps	Administrator	0	20,743	Unemployment Compensation Insurance	22,960	Advertising: Employee Recruitment	73,716	
Robert Petty	Asst Admin	0	31,247	FICA Taxes	316,092	Health Care Worker Background Check		
Christine T. Russel	Asst Admin	0	27,817	Employee Health Insurance	218,015	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	442 4,421	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	14,613	
				Employee Physicals	1,415	Licenses & Fees	11,738	
				Other Employee Benefits	7,108	Allocated from Extended Care Consulting	1,779	
						Allocated from Extended Care Clinical	1,004	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 155,820					
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Marcum LLP	Accounting Fees		\$ 28,954			\$	Out-of-State Travel	\$
Various - See Attached	Legal Fees		3,363					
Extended Care Consulting	Home Office		391,080					
Extended Care Clinical	Home Office		130,356				In-State Travel	
Personnel Planners	Unemployment Tax		2,655					
Pinnacle Quality Insights	Customer Review Analysis		3,259					
Resolute Healthcare	Operations Consultants		2,865					
Benefit Service Group INC	Benefit Administration		806				Seminar Expense	2,226
Paycor	Payroll Services		23,036				Allocated from Extended Care Consulting	337
Achieve Accreditation	Joint Commission		19,891				Allocated from Extended Care Clinical	817
Kelleher, Helmrich	Management Consulting		728					
See Supplemental Schedule			14,460				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 621,453				TOTAL	\$ 3,380

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc# 0046177Report Period Beginning: 01/01/18Ending: 12/31/18**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI / ICLTC \$22,620
- (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. \$ 72,447 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. \$ 304,657
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,256
- (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? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.