FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0052183

Facility Name: Capitol Hlthcare & Rehab Ctr

Address: 555 West Carpenter (Number) Springfield (City) 62702 (Zip Code)

County: Sangamon

Telephone Number: (217) 525-1880 **Fax #** (217) 525-7762

HFS ID Number:

Date of Initial License for Current Owners: 1/1/2013

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/13 to 12/31/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Cary Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	251	Skilled (SNF)	251	91,615	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	251	TOTALS	251	91,615	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	42,075		11,394	53,469	8
9	SNF/PED					9
10	ICF		3,969		3,969	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,075	3,969	11,394	57,438	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.69%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 01/01/2013

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 251 and days of care provided 10,105

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	461,239	61,259	18,446	540,944		540,944	23	540,967			1
2	Food Purchase		425,183		425,183		425,183	(1,387)	423,796			2
3	Housekeeping	308,682	61,120		369,802		369,802	1,404	371,206			3
4	Laundry	139,873	26,823	1,366	168,062		168,062		168,062			4
5	Heat and Other Utilities			345,767	345,767		345,767	(24,107)	321,660			5
6	Maintenance	177,603	41,871	96,580	316,054		316,054	35,875	351,929			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,087,397	616,256	462,159	2,165,812		2,165,812	11,808	2,177,620			8
	B. Health Care and Programs											
9	Medical Director			47,500	47,500		47,500	15,888	63,388			9
10	Nursing and Medical Records	3,103,768	175,064	193,727	3,472,559		3,472,559	67,079	3,539,638			10
10a	Therapy	146,684		9,610	156,294		156,294		156,294			10a
11	Activities	123,703	19,370		143,073		143,073		143,073			11
12	Social Services	184,203		15,942	200,145		200,145	1,924	202,069			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							11,657	11,657			15
16	**TOTAL Health Care and Programs**	3,558,358	194,434	266,779	4,019,571		4,019,571	96,548	4,116,119			16
	C. General Administration											
17	Administrative	113,199		166,139	279,338		279,338	(51,603)	227,735			17
18	Directors Fees											18
19	Professional Services			318,595	318,595	(181)	318,414	(243,591)	74,823			19
20	Dues, Fees, Subscriptions & Promotions			73,252	73,252		73,252	6,566	79,818			20
21	Clerical & General Office Expenses	281,382	57,904	618,199	957,485		957,485	(383,955)	573,530			21
22	Employee Benefits & Payroll Taxes			873,968	873,968		873,968		873,968			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,703	4,703		4,703	379	5,082			24
25	Other Admin. Staff Transportation			36,955	36,955		36,955	1,794	38,749			25
26	Insurance-Prop.Liab.Malpractice			66,970	66,970		66,970	729	67,699			26
27	Other (specify):*							39,972	39,972			27
28	**TOTAL General Administration**	394,581	57,904	2,158,781	2,611,266	(181)	2,611,085	(629,707)	1,981,378			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,040,336	868,594	2,887,719	8,796,649	(181)	8,796,468	(521,351)	8,275,118			29

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

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr #0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			15,359	15,359		15,359	449,321	464,680			30
31	Amortization of Pre-Op. & Org.							(1)	(1)			31
32	Interest			41,025	41,025		41,025	1,006,184	1,047,209			32
33	Real Estate Taxes			75,619	75,619	181	75,800	3,045	78,844			33
34	Rent-Facility & Grounds			1,364,651	1,364,651		1,364,651	(1,364,651)	(0)			34
35	Rent-Equipment & Vehicles			29,663	29,663		29,663	(19,671)	9,992			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,526,317	1,526,317	181	1,526,498	74,226	1,600,724			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		468,516	1,925,411	2,393,927		2,393,927		2,393,927			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			424,825	424,825		424,825		424,825			42
43	Other (specify):*	25,017		6,909	31,926		31,926	(31,926)	0			43
44	**TOTAL Special Cost Centers**	25,017	468,516	2,357,145	2,850,678		2,850,678	(31,926)	2,818,752			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,065,353	1,337,110	6,771,181	13,173,644		13,173,644	(479,050)	12,694,594			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(26,367)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(212,768)	30		9
10	Interest and Other Investment Income	(2,837)	32		10
11	Discounts, Allowances, Rebates & Refunds	(32)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(293)	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	(482)	21		18
19	Entertainment	(347)	21		19
20	Contributions	(125)	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	(465,138)	21		24
25	Fund Raising, Advertising and Promotional	(7,312)	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	(198,395)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (914,096)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 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)	435,046		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 435,046		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (479,050)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

Capitol Hlthcare & Rehab Ctr

ID# 0052183

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (1,094)	02	1
2	Sequester	(69,658)	21	2
3	Marketing Consultant	(6,877)	43	3
4	Bank Charges	(8,848)	21	4
5	Marketing Salaries	(25,017)	43	5
6	Theft and Loss	(641)	21	6
7	Additional R&M	30,479	06	7
8	Non-allowable Auto Lease	(23,739)	35	8
9	COPE Dues	(1,971)	20	9
10	Marketing	(32)	43	10
11	Non-allowable Seminar	(300)	24	11
12	Non-allowable Legal	(5,039)	19	12
13	Building Company - Amortization	(84,017)	31	13
14	Building Company - Accounting Fees	(1,642)	19	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**	(198,395)		49

Capitol Hlthcare & Rehab Ctr

ID# 0052183

Report Period Beginning: 01/01/13

Ending: 12/31/13

	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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			23									23	1
2	Food Purchase	(1,387)											(1,387)	2
3	Housekeeping			1,404									1,404	3
4	Laundry													4
5	Heat and Other Utilities	(26,367)		1,703		557							(24,107)	5
6	Maintenance	30,479		4,376		1,020							35,875	6
7	Other (specify):*													7
8	**TOTAL General Services**	2,725		7,507		1,577							11,808	8
	B. Health Care and Programs													
9	Medical Director			15,888									15,888	9
10	Nursing and Medical Records			67,079									67,079	10
10a	Therapy													10a
11	Activities													11
12	Social Services			1,924									1,924	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			11,657									11,657	15
16	**TOTAL Health Care and Programs**			96,548									96,548	16
	C. General Administration													
17	Administrative			41,845	(93,448)								(51,603)	17
18	Directors Fees													18
19	Professional Services	(6,681)	1,642	(239,446)	178	716							(243,591)	19
20	Fees, Subscriptions & Promotions	(9,408)		15,856		119							6,566	20
21	Clerical & General Office Expenses	(545,146)	(1,792)	162,918	30	36							(383,955)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(300)		679									379	24
25	Other Admin. Staff Transportation			1,792	3								1,794	25
26	Insurance-Prop.Liab.Malpractice			456		273							729	26
27	Other (specify):*			33,333	6,639								39,972	27
28	**TOTAL General Administration**	(561,535)	(150)	17,434	(86,599)	1,143							(629,707)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(558,810)	(150)	121,488	(86,599)	2,720							(521,351)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(212,768)	647,304	11,458		3,327							449,321	30
31	Amortization of Pre-Op. & Org.	(84,017)	84,016										(1)	31
32	Interest	(2,837)	1,002,822	41		6,158							1,006,184	32
33	Real Estate Taxes					3,045							3,045	33
34	Rent-Facility & Grounds		(1,364,651)	18,003		(18,003)							(1,364,651)	34
35	Rent-Equipment & Vehicles	(23,739)		189	3,879								(19,671)	35
36	Other (specify):*													36
37	TOTAL Ownership	(323,360)	369,491	29,691	3,879	(5,473)							74,226	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(31,926)											(31,926)	43
44	TOTAL Special Cost Centers	(31,926)											(31,926)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(914,096)	369,341	151,179	(82,720)	(2,754)							(479,050)	45

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. [X] 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 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,364,651	CAHRC Realty, LLC	100.00%	$	$ (1,364,651)	1
2	V	19	Accounting Fees		CAHRC Realty, LLC	100.00%	1,642	1,642	2
3	V	21	Other Income	1,792	CAHRC Realty, LLC	100.00%		(1,792)	3
4	V	31	Amortization Expense		CAHRC Realty, LLC	100.00%	84,016	84,016	4
5	V	30	Depreciation Expense		CAHRC Realty, LLC	100.00%	647,304	647,304	5
6	V	32	Interest Expense		CAHRC Realty, LLC	100.00%	1,002,822	1,002,822	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,366,443			$ 1,735,784	$ * 369,341	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. [X] 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 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	MANAGCARE, INC.	100.00%	$ 23	$ 23	15
16	V	3	HOUSEKEEPING		MANAGCARE, INC.	100.00%	1,404	1,404	16
17	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,703	1,703	17
18	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	4,376	4,376	18
19	V	9	MEDICAL DIRECTOR		MANAGCARE, INC.	100.00%	15,888	15,888	19
20	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%	67,079	67,079	20
21	V	12	SOCIAL SERVICE SALARIES		MANAGCARE, INC.	100.00%	1,924	1,924	21
22	V	15	NURSING EMP BENS & PR TAXES		MANAGCARE, INC.	100.00%	11,657	11,657	22
23	V	17	ADMINISTRATIVE SALARIES		MANAGCARE, INC.	100.00%	41,845	41,845	23
24	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	1,514	1,514	24
25	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	15,856	15,856	25
26	V	21	CLERICAL AND GENERAL SALARIES		MANAGCARE, INC.	100.00%	122,605	122,605	26
27	V	21	CLERICAL AND GENERAL EXP		MANAGCARE, INC.	100.00%	40,313	40,313	27
28	V	24	SEMINARS		MANAGCARE, INC.	100.00%	679	679	28
29	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	1,792	1,792	29
30	V	26	INSURANCE		MANAGCARE, INC.	100.00%	456	456	30
31	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	33,333	33,333	31
32	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	11,458	11,458	32
33	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	41	41	33
34	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	18,003	18,003	34
35	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	189	189	35
36	V								36
37	V	19	BOOKKEEPING	240,960	MANAGCARE, INC.	100.00%		(240,960)	37
38	V								38
39	Total			$ 240,960			$ 392,139	$ * 151,179	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. [X] 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 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE SALARY - NATH	$	TETRAD MANAGEMENT, LLC	100.00%	$ 22,557	$ 22,557	15
16	V	17	ADMINISTRATIVE SALARY - JOSH DAVIS		TETRAD MANAGEMENT, LLC	100.00%	7,753	7,753	16
17	V	17	ADMINISTRATIVE SALARY - MOSHE DAVIS		TETRAD MANAGEMENT, LLC	100.00%	22,557	22,557	17
18	V	17	ADMINISTRATIVE FEES - YOSEF DAVIS		TETRAD MANAGEMENT, LLC	100.00%	19,824	19,824	18
19	V								19
20	V	19	PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	178	178	20
21	V	21	OFFICE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	30	30	21
22	V	25	TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	3	3	22
23	V	27	EMPLOYEE BEENFITS- PAYROLL TAXES		TETRAD MANAGEMENT, LLC	100.00%	6,639	6,639	23
24	V	35	AUTO LEASE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	3,879	3,879	24
25	V								25
26	V	17	MANAGEMENT FEES	166,139	TETRAD MANAGEMENT, LLC	100.00%		(166,139)	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			$ 166,139			$ 83,419	$ * (82,720)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. [X] 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 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	4600 TOUHY, LLC	100.00%	$ 557	$ 557	15
16	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	1,020	1,020	16
17	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	716	716	17
18	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	119	119	18
19	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	36	36	19
20	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	273	273	20
21	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	3,327	3,327	21
22	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	6,158	6,158	22
23	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	3,045	3,045	23
24	V								24
25	V								25
26	V	34	RENT	18,003	4600 TOUHY, LLC	100.00%		(18,003)	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			$ 18,003			$ 15,249	$ * (2,754)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	EVAN MICHAEL STERN 2005 TRUST	0.51%	BRIGHTVIEW CARE CENTER, INC	CHICAGO	CAHRC REALTY, LLC	LINCOLNWOOD	BUILDING COMPANY	1
2	ILANA AARON	1.00%	LAKE SHORE HEALTHCARE & REHABILITATION CENTRE,LLC	CHICAGO	4600 TOUHY, LLC	LINCOLNWOOD	BUILDING CO.	2
3	JONATHAN BRYAN STERN 2001 TRUST	0.50%	MID AMERICA CARE CENTER, L.L.C.	CHICAGO	MANAGCARE, INC.	LINCOLNWOOD	BOOKKEEPING	3
4	ABRAHAM J. STERN	3.00%	COLONIAL HEALTHCARE & REHABILITATION CTR., LLC	PRINCETON	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	ADMIN. CONSULTANT	4
5	AHARON SHKOP	1.43%	THE HEIGHTS HEALTHCARE & REHABILITATION CTR, LLC	PEORIA HEIGHTS				5
6	ARISTA HOLDINGS GROUP LLC	4.76%	MORTON TERRACE HEALTHCARE & REHAB CTR., LLC	MORTON				6
7	BASSMAN FAMILY LP	4.76%	MORTON VILLA HEALTHCARE & REHABILITATION CTR., LLC	MORTON				7
8	CENTRAL IL YD DELTA	61.90%	RIVERSHORES NURSING & REHABILITATION CENTER, LLC	MARSEILLES				8
9	CENTRAL IL YD DELTA	0.05%	MAYFIELD HEALTHCARE AND REHAB CENTER	CHICAGO				9
10	DIAMOND INVESTMENT GROUP LLC	4.76%						10
11	EFRAIM M. LEVIN	1.00%						11
12	EMMA AARON	1.00%						12
13	LARRY MANDEL	0.95%						13
14	PERL GROUP LLC	1.43%						14
15	ROSEN FAMILY INVESTMENTS LLC	1.43%						15
16	TEED EQUITY HOLDINGS LLC	9.52%						16
17	TODD A. STERN	2.00%						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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Davis	Relative	Mgmt /Admin		See Attached	2.13	7.10%	Alloc. Fees	$ 19,824	17-7	1
2	Moshe Davis	Relative	Mgmt /Admin		See Attached	5.21	11.84%	Alloc. Salary	22,557	17-7	2
3	Yehoshua Davis	Relative	Mgmt /Admin		See Attached	5.69	11.85%	Alloc. Salary	7,753	17-7	3
4	Nesanel Davis	Relative	Mgmt /Admin		See Attached	5.69	11.85%	Alloc. Salary	22,557	17-7	4
5	Eli Davis	Relative	Mgmt /Admin		See Attached	4.74	11.85%	Alloc. Fees	829	17-7	5
6	Archie Shkop	Shareholder	Administrative	1.43%	See Attached	5.33	11.84%	Alloc. Salary	16,427	17-7	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	$ 89,947		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	486,626	10	$ 198	$	57,635	$ 23	1
2	3	HOUSEKEEPING	PATIENT DAYS	486,626	10	11,856		57,635	1,404	2
3	5	UTILITIES	PATIENT DAYS	486,626	10	14,381		57,635	1,703	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	486,626	10	36,948		57,635	4,376	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	486,626	10	134,142		57,635	15,888	5
6	10	NURSING SALARIES	PATIENT DAYS	486,626	10	566,366	566,366	57,635	67,079	6
7	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	486,626	10	16,247	16,247	57,635	1,924	7
8	15	NURSING EMP BENS & PR TA	PATIENT DAYS	486,626	10	98,421		57,635	11,657	8
9	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	486,626	10	353,309	353,309	57,635	41,845	9
10	19	PROFESSIONAL FEES	PATIENT DAYS	486,626	10	12,785		57,635	1,514	10
11	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	486,626	10	133,874		57,635	15,856	11
12	21	CLERICAL AND GENERAL SA	PATIENT DAYS	486,626	10	1,035,183	1,035,183	57,635	122,605	12
13	21	CLERICAL AND GENERAL EX	PATIENT DAYS	486,626	10	340,374		57,635	40,313	13
14	24	SEMINARS	PATIENT DAYS	486,626	10	5,737		57,635	679	14
15	25	ADMIN. STAFF TRANS.	PATIENT DAYS	486,626	10	15,128		57,635	1,792	15
16	26	INSURANCE	PATIENT DAYS	486,626	10	3,851		57,635	456	16
17	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	486,626	10	281,440		57,635	33,333	17
18	30	DEPRECIATION	PATIENT DAYS	486,626	10	96,741		57,635	11,458	18
19	32	INTEREST EXPENSE	PATIENT DAYS	486,626	10	346		57,635	41	19
20	34	RENT - BUILDING (RELATED)	PATIENT DAYS	486,626	10	152,000		57,635	18,003	20
21	35	EQUIPMENT RENTAL	PATIENT DAYS	486,626	10	1,597		57,635	189	21
22										22
23										23
24										24
25	TOTALS					$ 3,310,923	$ 1,971,105		$ 392,139	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	486,626	10	$ 190,457	$ 190,457	57,635	$ 22,557	1
2	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	486,626	10	65,457	65,457	57,635	7,753	2
3	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	486,626	10	190,457	190,457	57,635	22,557	3
4	17	ADMINISTRATIVE FEES - YO	PATIENT DAYS	486,626	10	167,375		57,635	19,824	4
5	17	TOTAL MANAGEMENT FEES	PATIENT DAYS	486,626	10			57,635		5
6	19	PROFESSIONAL FEES	PATIENT DAYS	486,626	10	1,500		57,635	178	6
7	21	OFFICE EXPENSE	PATIENT DAYS	486,626	10	253		57,635	30	7
8	25	TRAVEL	PATIENT DAYS	486,626	10	23		57,635	3	8
9	27	EMPLOYEE BEENFITS- PAYE	PATIENT DAYS	486,626	10	56,057		57,635	6,639	9
10	35	AUTO LEASE EXPENSE	PATIENT DAYS	486,626	10	32,750		57,635	3,879	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					$ 704,328	$ 446,371		$ 83,419	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. PATIENT DAYS	486,626	10	$ 4,702	$	57,635	$ 557	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	486,626	10	8,610		57,635	1,020	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	486,626	10	6,043		57,635	716	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	486,626	10	1,001		57,635	119	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	486,626	10	300		57,635	36	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	486,626	10	2,308		57,635	273	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	486,626	10	28,092		57,635	3,327	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	486,626	10	51,990		57,635	6,158	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	486,626	10	25,708		57,635	3,045	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					$ 128,752	$		$ 15,249	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Private Bank		X	Mortgage			$	$ 13,293,413			$ 749,416	1
2	Greystone		X	Mortgage				1,661,677			253,406	2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Line of Credit				625,000		5.2500	34,496	6
7	Allocated from Managcare		X								41	7
8	See Supplemental Schedule										6,158	8
9	TOTAL Facility Related						$	$ 15,580,090			$ 1,043,517	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,837)	10
11	Interest Expense		X								6,529	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 3,691	14
15	TOTALS (line 9+line14)						$	$ 15,580,090			$ 1,047,209	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated from Tetrad Mgmt		X				$	$			$ 6,158	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										6,158	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 74,136	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.)		$ 77,181	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,045	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 75,619	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.)**		$ 181	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 78,844	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008		8
2009		9
2010		10
2011		11
2012	74,136	12

2013 Accrual = $74,136 x 1.02 = $75,619

Allocated from Tetrad Mgmt = $3,045

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Capitol Hlthcare & Rehab Ctr COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0052183

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-28.0-401-018	Long Term Care Property	$ 70,175.84	$ 70,175.84
2.	14-28.0-401-006	Long Term Care Property	$ 3,960.36	$ 3,960.36
3.	See Attached	Alloc. 4600 Touhy, LLC	$ 48,715.81	$ 2,884.90
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 122,852.01	$ 77,021.10

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. 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 Office of Health Finance at (217) 782-1630.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Capitol Hlthcare & Rehab Ctr COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0052183

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236 - 1111 FAX #: (847) 236 - 1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 61,806 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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 [X] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2013	$ 895,459	1
2					2
3	TOTALS			$ 895,459	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	251		2013	1975	$ 7,724,626	$ 204,961	35	$ 220,704	$ 15,743	$ 220,704	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		123,223	5,270		5,147	(123)	9,767	68
69	Financial Statement Depreciation			15,359			(15,359)		69
70	TOTAL (lines 4 thru 69)		$ 7,847,849	$ 225,590		$ 225,851	$ 261	$ 230,471	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,847,849	$ 225,590		$ 225,851	$ 261	$ 230,471	1
2	Painting Of South Elevation	2013	7,940		20	463	463	463	2
3	Installed (10) New 2 In. Copper Clad Boiler Tubes	2013	9,375		20	625	625	625	3
4	Rebranding Of Signage	2013	4,407		20	401	401	401	4
5	Installed Dome Camera At Dock Door And Delayed Egress System	2013	2,795		20	233	233	233	5
6	Water Heater	2013	12,989		20	433	433	433	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)		$ 7,885,355	$ 225,590		$ 228,005	$ 2,415	$ 232,626	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,885,355	$ 225,590		$ 228,005	$ 2,415	$ 232,626	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)		$ 7,885,355	$ 225,590		$ 228,005	$ 2,415	$ 232,626	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,885,355	$ 225,590		$ 228,005	$ 2,415	$ 232,626	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)		$ 7,885,355	$ 225,590		$ 228,005	$ 2,415	$ 232,626	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 7,885,355	$ 225,590		$ 228,005	$ 2,415	$ 232,626	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)		$ 7,885,355	$ 225,590		$ 228,005	$ 2,415	$ 232,626	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	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 (12F & 12G lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 4600 Touhy	2012	60,813	1,559	20	2,027	468	4,054	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Managcare	2012	12,697	1,361	20	635	(726)	1,270	9
10	Allocated from Managcare	2013	1,021	582	20	51	(531)	51	10
11									11
12	Allocated from 4600 Touhy	2012	39,163	1,024	20	1,958	934	3,916	12
13	Allocated from 4600 Touhy	2013	9,529	744	20	476	(268)	476	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued		$	$		$	$	$	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 (12H & 12I lines 1 thru 33)		$ 123,223	$ 5,270		$ 5,147	$ (123)	$ 9,767	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 24,536	$ 2,761	$ 2,454	$ (307)	10	$ 5,497	71
72	Current Year Purchases	2,351,961	448,209	232,586	(215,623)	10	232,586	72
73	Fully Depreciated Assets	29,171		12	12	10	29,171	73
74								74
75	TOTALS	$ 2,405,668	$ 450,970	$ 235,052	$ (215,918)		$ 267,254	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Managcare	2013	$ 14,314	$ 890	$ 1,625	$ 735	5	$ 11,464	76
77										77
78										78
79										79
80	TOTALS			$ 14,314	$ 890	$ 1,625	$ 735		$ 11,464	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)	$ 11,200,796	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 677,450	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 464,682	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (212,768)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 511,344	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	PMSI Construction	$ 234,393	92
93	Direct Supply	266,803	93
94			94
95		$ 501,196	95

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

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.	/2014	$
13.	/2015	$
14.	/2016	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 6,113 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	Allocated from Tetrad		$	$ 3,879	17
18					18
19					19
20					20
21	TOTAL		$	$ 3,879	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 858,466	$		$ 858,466	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			202,800			202,800	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			752,699			752,699	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				429,386		429,386	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					111,446	39,130		150,576	13
14	TOTAL			$		$ 1,925,411	$ 468,516		$ 2,393,927	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/13 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 74,557	$ 157,639	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,071,855	3,071,855	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	257,861	257,861	6
7	Other Prepaid Expenses	62,463	62,463	7
8	Accounts Receivable (owners or related parties)	120,724	120,724	8
9	Other(specify): See Attached Schedule	405,078	405,078	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,992,538	$ 4,075,620	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		895,459	13
14	Buildings, at Historical Cost		7,724,626	14
15	Leasehold Improvements, at Historical Cost	40,002	40,002	15
16	Equipment, at Historical Cost	149,961	2,361,680	16
17	Accumulated Depreciation (book methods)	(15,359)	(662,664)	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): See Attached Schedule	501,196	8,066,487	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 675,800	$ 18,425,590	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,668,338	$ 22,501,210	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,105,334	$ 2,105,332	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,652	19,652	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	235,027	235,027	30
31	Accrued Taxes Payable (excluding real estate taxes)	145,095	145,095	31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,619	75,619	32
33	Accrued Interest Payable	1,327	3,358	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,146,782	4,006,100	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,728,836	$ 6,590,183	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	625,000	625,000	39
40	Mortgage Payable		14,955,090	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)**	$ 625,000	$ 15,580,090	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,353,836	$ 22,170,273	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 314,502	$ 330,937	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,668,338	$ 22,501,210	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr **#** 0052183 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	314,502	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 314,502	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 314,502	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,981,311	1
2	Discounts and Allowances for all Levels	(1,536,821)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,444,490	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,465,643	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,465,643	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	522,209	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,641	19
20	Radiology and X-Ray	6,806	20
21	Other Medical Services	32,394	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 574,050	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,837	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,837	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,126	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,126	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,488,146	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,165,812	31
32	Health Care	4,019,571	32
33	General Administration	2,611,266	33
	B. Capital Expense		
34	Ownership	1,526,317	34
	C. Ancillary Expense		
35	Special Cost Centers	2,425,853	35
36	Provider Participation Fee	424,825	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,173,644	40
41	**Income before Income Taxes (line 30 minus line 40)****	314,502	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 314,502	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,027,418	44
45	Private Pay - Net Inpatient Revenue	604,424	45
46	Medicare - Net Inpatient Revenue	2,667,849	46
47	Other-(specify) Hospice	144,799	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,444,490	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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,321	2,426	$ 102,952	$ 42.44	1
2	Assistant Director of Nursing	1,936	1,936	51,245	26.47	2
3	Registered Nurses	10,755	11,246	285,530	25.39	3
4	Licensed Practical Nurses	51,888	54,469	1,189,777	21.84	4
5	CNAs & Orderlies	120,220	124,101	1,435,964	11.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,559	8,031	146,684	18.26	8
9	Activity Director	1,901	2,068	24,450	11.82	9
10	Activity Assistants	8,624	9,112	99,253	10.89	10
11	Social Service Workers	10,127	10,127	184,203	18.19	11
12	Dietician					12
13	Food Service Supervisor	3,674	3,907	67,085	17.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	35,976	37,254	394,154	10.58	15
16	Dishwashers					16
17	Maintenance Workers	12,199	12,991	177,603	13.67	17
18	Housekeepers	29,455	30,604	308,682	10.09	18
19	Laundry	11,677	12,495	139,873	11.19	19
20	Administrator	1,789	1,875	113,199	60.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,145	19,144	281,382	14.70	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	1,876	1,983	38,300	19.31	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	936	960	25,017	26.06	33
34	TOTAL (lines 1 - 33)	331,058	344,729	$ 5,065,353 *	$ 14.69	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	265	$ 18,446	01-03	35
36	Medical Director	Monthly	47,500	09-03	36
37	Medical Records Consultant	Quarterly	2,350	10-03	37
38	Nurse Consultant	Monthly	150,600	10-03	38
39	Pharmacist Consultant	Monthly	10,657	10-03	39
40	Physical Therapy Consultant	Visit	17	10a-03	40
41	Occupational Therapy Consultant	Monthly	9,593	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	253	15,942	12-03	45
46	Other(specify)				46
47	MDS Consultant	Monthly	30,120	10-03	47
48					48
49	TOTAL (lines 35 - 48)	518	$ 285,225		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cynthia Schaaf (Term. 4/19/13)	Administrator	0	$ 42,563
Scott Mow (Start 4/1/13)	Administrator	0	70,636
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 113,199

B. Administrative - Other

Description	Amount
Management Fees - Tetrad Management	$ 166,139
TOTAL (agree to Schedule V, line 17, col. 3)	$ 166,139
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Managcare, Inc	Bookkeeping	$ 240,960
Personnel Planners	Unemployment Consulting	1,642
MTS Consulting	Tax Consulting	3,224
FR&R	Accounting	20,400
Legal	See Attached	8,948
Ability Network	Billing Software	876
eHealth Data Solutions	MDS Software	584
Galaxy Hosted Software	Clinical & Financial Software	13,720
Platinum Healthcare	Computer Services	1,167
Smartlinx Solutions	Workforce Management	12,844
Doris Clink	Operational Consulting	750
See Supplemental Schedule		13,483
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 318,597

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 115,884
Unemployment Compensation Insurance	207,658
FICA Taxes	363,923
Employee Health Insurance	146,047
Employee Meals	270
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	4,698
Vision Insurance	50
Employee Benefits	30,447
Pension	2,006
Holiday Expense	2,987
TOTAL (agree to Schedule V, line 22, col.8)	$ 873,970

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,805
Advertising: Employee Recruitment	16,049
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 824	8,243
Dues and Subscriptions	34,235
Licenses and Permits	3,512
Allocated from Managcare	15,856
Allocated from Tetrad	119
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 79,819

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,403
Allocated from Managcare	679
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,082

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/13 Ending: 12/31/13

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $5,973**

(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. $ **3,517** 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. $ **424,825**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **270** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **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) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.