FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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.

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 01/01/14 to 12/31/14 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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1 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	40,884		12,717	53,601	8
9	SNF/PED					9
10	ICF		3,920		3,920	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,884	3,920	12,717	57,521	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.79%

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 8,945

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: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	385,287	96,473	21,454	503,214		503,214	88	503,302			1
2	Food Purchase		324,584		324,584		324,584	(1,061)	323,523			2
3	Housekeeping	303,671	52,879		356,550		356,550	1,494	358,044			3
4	Laundry	144,952	22,331	1,853	169,136		169,136		169,136			4
5	Heat and Other Utilities			374,469	374,469		374,469	(27,949)	346,520			5
6	Maintenance	163,470	28,337	104,884	296,691		296,691	68,048	364,739			6
7	Other (specify):*											7
8	**TOTAL General Services**	997,380	524,604	502,660	2,024,644		2,024,644	40,620	2,065,264			8
	B. Health Care and Programs											
9	Medical Director			43,700	43,700		43,700	8,632	52,332			9
10	Nursing and Medical Records	2,933,354	292,555	91,736	3,317,645		3,317,645	61,016	3,378,661			10
10a	Therapy	50,810		1,700	52,510		52,510		52,510			10a
11	Activities	141,217	3,463		144,680		144,680	16	144,696			11
12	Social Services	195,277			195,277		195,277	5,861	201,138			12
13	CNA Training											13
14	Program Transportation			3,889	3,889		3,889		3,889			14
15	Other (specify):*							5,797	5,797			15
16	**TOTAL Health Care and Programs**	3,320,658	296,018	141,025	3,757,701		3,757,701	81,322	3,839,023			16
	C. General Administration											
17	Administrative	156,715		163,832	320,547		320,547	40,367	360,914			17
18	Directors Fees											18
19	Professional Services			429,643	429,643	(5,233)	424,410	(251,507)	172,904			19
20	Dues, Fees, Subscriptions & Promotions			135,172	135,172		135,172	(47,513)	87,659			20
21	Clerical & General Office Expenses	233,938	35,280	781,866	1,051,084		1,051,084	(465,558)	585,526			21
22	Employee Benefits & Payroll Taxes			858,504	858,504		858,504		858,504			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,967	1,967		1,967	174	2,141			24
25	Other Admin. Staff Transportation			34,245	34,245		34,245	4,258	38,503			25
26	Insurance-Prop.Liab.Malpractice			132,384	132,384		132,384	769	133,153			26
27	Other (specify):*							48,156	48,156			27
28	**TOTAL General Administration**	390,653	35,280	2,537,613	2,963,546	(5,233)	2,958,313	(670,853)	2,287,460			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,708,691	855,902	3,181,298	8,745,891	(5,233)	8,740,658	(548,911)	8,191,747			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr #0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			31,366	31,366		31,366	526,383	557,749			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,360	63,360		63,360	1,241,787	1,305,147			32
33	Real Estate Taxes			98,068	98,068	5,233	103,301	4,582	107,883			33
34	Rent-Facility & Grounds			1,385,957	1,385,957		1,385,957	(1,385,957)				34
35	Rent-Equipment & Vehicles			32,412	32,412		32,412	(15,390)	17,022			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,611,163	1,611,163	5,233	1,616,396	371,405	1,987,801			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		399,923	2,084,242	2,484,165		2,484,165		2,484,165			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			421,851	421,851		421,851		421,851			42
43	Other (specify):*	23,715		47,180	70,895		70,895	(70,895)				43
44	**TOTAL Special Cost Centers**	23,715	399,923	2,553,273	2,976,911		2,976,911	(70,895)	2,906,016			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,732,406	1,255,825	7,345,734	13,333,965		13,333,965	(248,401)	13,085,564			45

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

	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	(30,155)	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	(138,407)	30		9
10	Interest and Other Investment Income	(11,174)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(220)	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	(3,250)	21		18
19	Entertainment				19
20	Contributions	(3,449)	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	(1,248,732)	21		24
25	Fund Raising, Advertising and Promotional	(36,778)	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	(402,636)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,874,801)		$	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)	1,626,400		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,626,400		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (248,401)		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

Capitol Hlthcare & Rehab Ctr

ID# 0052183

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Prior Period Expenses	$ (42,309)	21	1
2	Medicare Sequestration	(116,162)	21	2
3	Marketing Consultant	(47,180)	43	3
4	Bank Charges	(18,065)	21	4
5	Marketing Salaries	(23,715)	43	5
6	Theft and Loss	(1,742)	21	6
7	Building Company - Amortization Expense	(169,074)	31	7
8	Non-allowable Legal	(1,803)	19	8
9	Additional R&M	62,206	06	9
10	PAC Dues	(11,827)	20	10
11	Non-allowable Auto Lease	(15,864)	35	11
12	Food Rebate	(841)	02	12
13	Non-allowable Interest	(16,261)	32	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(402,636)		49

Capitol Hlthcare & Rehab Ctr

ID# 0052183

Report Period Beginning: 01/01/14

Ending: 12/31/14

	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:** 01/01/14 **Ending:** 12/31/14

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			88									88	1
2	Food Purchase	(1,061)											(1,061)	2
3	Housekeeping			1,494									1,494	3
4	Laundry													4
5	Heat and Other Utilities	(30,155)		1,583	623								(27,949)	5
6	Maintenance	62,206		5,602	240								68,048	6
7	Other (specify):*													7
8	**TOTAL General Services**	30,990		8,767	863								40,620	8
	B. Health Care and Programs													
9	Medical Director			8,632									8,632	9
10	Nursing and Medical Records			61,016									61,016	10
10a	Therapy													10a
11	Activities			16									16	11
12	Social Services			5,861									5,861	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			5,797									5,797	15
16	**TOTAL Health Care and Programs**			81,322									81,322	16
	C. General Administration													
17	Administrative			127,470		(87,103)							40,367	17
18	Directors Fees													18
19	Professional Services	(1,803)		(250,581)	523	354							(251,507)	19
20	Fees, Subscriptions & Promotions	(52,054)		4,528	13								(47,513)	20
21	Clerical & General Office Expenses	(1,430,260)	836,716	127,896	46	44							(465,558)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			174									174	24
25	Other Admin. Staff Transportation			1,081		3,177							4,258	25
26	Insurance-Prop.Liab.Malpractice			487	282								769	26
27	Other (specify):*			48,156									48,156	27
28	**TOTAL General Administration**	(1,484,116)	836,716	59,211	864	(83,528)							(670,853)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,453,126)	836,716	149,300	1,727	(83,528)							(548,911)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(138,407)	655,177	6,801	2,812								526,383	30
31	Amortization of Pre-Op. & Org.	(169,074)	169,074											31
32	Interest	(27,435)	1,263,427	142	5,653								1,241,787	32
33	Real Estate Taxes				4,582								4,582	33
34	Rent-Facility & Grounds		(1,385,957)	20,186	(20,186)								(1,385,957)	34
35	Rent-Equipment & Vehicles	(15,864)		474									(15,390)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(350,780)	701,721	27,603	(7,139)								371,405	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):*	(70,895)											(70,895)	43
44	**TOTAL Special Cost Centers**	(70,895)											(70,895)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,874,801)	1,538,437	176,903	(5,412)	(83,528)							(248,401)	45

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 1,385,957	CAHRC Realty, LLC	100.00%	$	$ (1,385,957)	1
2	V	31	Amortization Expense		CAHRC Realty, LLC	100.00%	169,074	169,074	2
3	V	30	Depreciation Expense		CAHRC Realty, LLC	100.00%	655,177	655,177	3
4	V	32	Interest Expense - Private Bank		CAHRC Realty, LLC	100.00%	806,282	806,282	4
5	V	32	Interest Expense - Greystone		CAHRC Realty, LLC	100.00%	274,176	274,176	5
6	V	21	Intercompany		CAHRC Realty, LLC	100.00%	836,716	836,716	6
7	V	32	Interest Expense		CAHRC Realty, LLC	100.00%	182,969	182,969	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,385,957			$ 2,924,394	$ * 1,538,437	14

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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%	$ 88	$ 88	15
16	V	3	HOUSEKEEPING		MANAGCARE, INC.	100.00%	1,494	1,494	16
17	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,583	1,583	17
18	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	5,602	5,602	18
19	V	9	MEDICAL DIRECTOR		MANAGCARE, INC.	100.00%	8,632	8,632	19
20	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%	61,016	61,016	20
21	V	11	ACTIVITIES		MANAGCARE, INC.	100.00%	16	16	21
22	V	12	SOCIAL SERVICE SALARIES		MANAGCARE, INC.	100.00%	5,861	5,861	22
23	V	15	NURSING EMP BENS & PR TAXES		MANAGCARE, INC.	100.00%	5,797	5,797	23
24	V	17	ADMINISTRATIVE SALARIES		MANAGCARE, INC.	100.00%	127,470	127,470	24
25	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	5,439	5,439	25
26	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	4,528	4,528	26
27	V	21	CLERICAL AND GENERAL SALARIES		MANAGCARE, INC.	100.00%	119,229	119,229	27
28	V	21	CLERICAL AND GENERAL EXP		MANAGCARE, INC.	100.00%	8,667	8,667	28
29	V	24	SEMINARS		MANAGCARE, INC.	100.00%	174	174	29
30	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	1,081	1,081	30
31	V	26	INSURANCE		MANAGCARE, INC.	100.00%	487	487	31
32	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	48,156	48,156	32
33	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	6,801	6,801	33
34	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	142	142	34
35	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	20,186	20,186	35
36	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	474	474	36
37	V	19	BOOKKEEPING	210,840	MANAGCARE, INC.	100.00%		(210,840)	37
38	V	19	ADMINISTRATIVE CONSULTANT	45,180	MANAGCARE, INC.	100.00%		(45,180)	38
39	Total			$ 256,020			$ 432,923	$ * 176,903	39

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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%	$ 623	$ 623	15
16	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	240	240	16
17	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	523	523	17
18	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	13	13	18
19	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	46	46	19
20	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	282	282	20
21	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	2,812	2,812	21
22	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	5,653	5,653	22
23	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	4,582	4,582	23
24	V								24
25	V	34	RENT	20,186	4600 TOUHY, LLC	100.00%		(20,186)	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			$ 20,186			$ 14,774	$ * (5,412)	39

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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%	$ 23,609	$ 23,609	15
16	V	17	ADMINISTRATIVE SALARY - JOSH DAVIS		TETRAD MANAGEMENT, LLC	100.00%	23,609	23,609	16
17	V	17	ADMINISTRATIVE SALARY - MOSHE DAVIS		TETRAD MANAGEMENT, LLC	100.00%	23,609	23,609	17
18	V	19	PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	354	354	18
19	V	21	OFFICE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	44	44	19
20	V	25	TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	3,177	3,177	20
21	V	17	ADMINISTRATIVE SALARY - ELI DAVIS		TETRAD MANAGEMENT, LLC	100.00%	5,902	5,902	21
22	V								22
23	V	17	MANAGEMENT FEES	163,832	TETRAD MANAGEMENT, LLC	100.00%		(163,832)	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			$ 163,832			$ 80,304	$ * (83,528)	39

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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.

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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.

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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.

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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.

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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.

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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.

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	TETRAD MANAGEMENT, LLC	.01%	BRIGHTVIEW CARE CENTER, INC	CHICAGO	CAHRC REALTY, LLC	LINCOLNWOOD	BUILDING COMPANY	1
2	CENTRAL ILLINOIS OPERATIONS	99.99%	LAKE SHORE HEALTHCARE & REHABILITATION CENTRE,LLC	CHICAGO	4600 TOUHY, LLC	LINCOLNWOOD	BUILDING CO.	2
3			MID AMERICA CARE CENTER, L.L.C.	CHICAGO	MANAGCARE, INC.	LINCOLNWOOD	BOOKKEEPING	3
4			COLONIAL HEALTHCARE & REHABILITATION CTR., LLC	PRINCETON	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	ADMIN. CONSULTANT	4
5			THE HEIGHTS HEALTHCARE & REHABILITATION CTR, LLC	PEORIA HEIGHTS				5
6			MORTON TERRACE HEALTHCARE & REHAB CTR., LLC	MORTON				6
7			MORTON VILLA HEALTHCARE & REHABILITATION CTR., LLC	MORTON				7
8			RIVERSHORES NURSING & REHABILITATION CENTER, LLC	MARSEILLES				8
9			MAYFIELD HEALTHCARE AND REHAB CENTER	CHICAGO				9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1	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	Moshe Davis	Relative	Mgmt / Admin	0%	See Attached	5.19	11.80%	Alloc. Fees	$ 23,609	17-7	1
2	Yehoshua Davis	Relative	Mgmt / Admin	0%	See Attached	5.67	11.81%	Alloc. Fees	23,609	17-7	2
3	Nesanel Davis	Relative	Mgmt / Admin	0%	See Attached	5.67	11.81%	Alloc. Fees	23,609	17-7	3
4	Eli Davis	Relative	Mgmt / Admin	0%	See Attached	4.72	11.80%	Alloc. Fees	5,902	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 76,729		13

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

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	487,280	10	$ 748	$	57,521	$ 88	1
2	3	HOUSEKEEPING	PATIENT DAYS	487,280	10	12,659		57,521	1,494	2
3	5	UTILITIES	PATIENT DAYS	487,280	10	13,409		57,521	1,583	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	487,280	10	47,454		57,521	5,602	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	487,280	10	73,125		57,521	8,632	5
6	10	NURSING SALARIES	PATIENT DAYS	487,280	10	516,890	516,890	57,521	61,016	6
7	11	ACTIVITIES	PATIENT DAYS	487,280	10	136		57,521	16	7
8	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	487,280	10	49,654	49,654	57,521	5,861	8
9	15	NURSING EMP BENS & PR TA	PATIENT DAYS	487,280	10	49,107		57,521	5,797	9
10	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	487,280	10	1,079,846	1,079,846	57,521	127,470	10
11	19	PROFESSIONAL FEES	PATIENT DAYS	487,280	10	46,077		57,521	5,439	11
12	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	487,280	10	38,354		57,521	4,528	12
13	21	CLERICAL AND GENERAL SA	PATIENT DAYS	487,280	10	1,010,032	1,010,032	57,521	119,229	13
14	21	CLERICAL AND GENERAL EX	PATIENT DAYS	487,280	10	73,419		57,521	8,667	14
15	24	SEMINARS	PATIENT DAYS	487,280	10	1,473		57,521	174	15
16	25	ADMIN. STAFF TRANS.	PATIENT DAYS	487,280	10	9,155		57,521	1,081	16
17	26	INSURANCE	PATIENT DAYS	487,280	10	4,123		57,521	487	17
18	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	487,280	10	407,944		57,521	48,156	18
19	30	DEPRECIATION	PATIENT DAYS	487,280	10	57,614		57,521	6,801	19
20	32	INTEREST EXPENSE	PATIENT DAYS	487,280	10	1,200		57,521	142	20
21	34	RENT - BUILDING (RELATED)	PATIENT DAYS	487,280	10	171,000		57,521	20,186	21
22	35	EQUIPMENT RENTAL	PATIENT DAYS	487,280	10	4,015		57,521	474	22
23										23
24										24
25	TOTALS					$ 3,667,434	$ 2,656,422		$ 432,923	25

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	487,280	10	$ 5,277	$	57,521	$ 623	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	487,280	10	2,035		57,521	240	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	487,280	10	4,429		57,521	523	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	487,280	10	148		57,521	13	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	487,280	10	391		57,521	46	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	487,280	10	2,388		57,521	282	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	487,280	10	23,819		57,521	2,812	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	487,280	10	47,891		57,521	5,653	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	487,280	10	38,818		57,521	4,582	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					$ 125,196	$		$ 14,774	25

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	487,280	10	$ 200,000	$ 200,000	57,521	$ 23,609	1
2	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	487,280	10	200,000	200,000	57,521	23,609	2
3	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	487,280	10	200,000	200,000	57,521	23,609	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	487,280	10	3,000		57,521	354	4
5	21	OFFICE EXPENSE	PATIENT DAYS	487,280	10	374		57,521	44	5
6	25	TRAVEL	PATIENT DAYS	487,280	10	26,914		57,521	3,177	6
7	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	487,280	10	50,000	50,000	57,521	5,902	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					$ 680,288	$ 650,000		$ 80,304	25

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Private Bank		X	Mortgage			$	$			$ 806,282	1
2	Greystone		X	Mortgage							274,176	2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Line of Credit							41,323	6
7	Allocated from Managcare		X								142	7
8	See Supplemental Schedule										5,653	8
9	TOTAL Facility Related						$	$			$ 1,127,576	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,397)	10
11	Interest Expense - Bldg Co.		X								182,969	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 177,572	14
15	TOTALS (line 9+line14)						$	$			$ 1,305,148	15

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

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

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

	1	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 4600 Touhy, LLC		X				$	$			$ 5,653	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										5,653	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: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 75,619	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.)		$ 100,727	2
3. Under or (over) accrual (line 2 minus line 1).		$ 25,108	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 77,542	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.)**		$ 5,233	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 $ 2,567 For 2011 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.		$ 107,883	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009		8
2010		9
2011		10
2012	74,136	11
2013	96,145	12

Allocated from 4600 Touhy, LLC - $4,582

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A) 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	$ 92,107.44	$ 92,107.44
2.	14-28.0-401-006	Long Term Care Property	$ 4,037.60	$ 4,037.60
3.	See Attached	Allocated From 4600 Touhy, LLC	$ 84,567.54	$ 4,991.39
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 180,712.58	$ 101,136.43

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

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.

2000 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: 01/01/14 Ending: 12/31/14

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? [X] (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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 655,177	35	$ 220,704	$ (434,473)	$ 441,408	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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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)		123,759	3,987		5,178	1,191	14,913	68
69	Financial Statement Depreciation			31,366			(31,366)		69
70	TOTAL (lines 4 thru 69)		$ 7,848,385	$ 690,530		$ 225,882	$ (464,648)	$ 456,321	70

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 7,848,385	$ 690,530		$ 225,882	$ (464,648)	$ 456,321	1
2	Painting Of South Elevation	2013	7,940		20	794	794	1,257	2
3	Installed 10 New 2 Inch Copper Clad Boiler Tubes	2013	9,375		20	938	938	1,563	3
4	Rebranding Of Signage	2013	4,407		20	220	220	349	4
5	Installed Dome Camera At Dock Door, Installed Delayed Egress Sy	2013	2,795		20	559	559	792	5
6	Water Heater	2013	12,989		20	649	649	731	6
7	Fixed Wiring For Nurse Call Station	2014	5,286		20	198	198	198	7
8	Installed 17 Emergency Pull Cords And 14 Bed Visual Stations	2014	8,495		20	1,133	1,133	1,133	8
9	Installed 2 Hydraulic Jacks In Elevator	2014	17,425		20	436	436	436	9
10	Installed 4 Accutech Door Packs	2014	5,705		20	95	95	95	10
11	Installed Soft Starter In #1 Passenger Elevator	2014	2,850		20	24	24	24	11
12	Installed New Water Heater For Entire Building	2014	12,560		20	628	628	628	12
13	Installed New Generator For Entire Building	2014	28,017		20	584	584	584	13
14	Installed New Hvac	2014	2,742		20	137	137	137	14
15	Painted Parking Lot Stripes And Exterior Handrails In Upper And	2014	3,500		20	175	175	175	15
16	Installed New Signage For Exits And Resident Room Numbers	2014	6,614		20	331	331	331	16
17	Installed 1 Traditional Slope Style Awning	2014	3,571		20	179	179	179	17
18	Installed New Fence Around The Building	2014	11,390		20	570	570	570	18
19	Renovated Entire Facility - Painted, Plumbing, Electrical,	2014							19
20	Flooring, And Fire Protection	2014	778,593		20	38,930	38,930	38,930	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)		$ 8,772,640	$ 690,530		$ 272,460	$ (418,070)	$ 504,430	34

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 8,772,640	$ 690,530		$ 272,460	$ (418,070)	$ 504,430	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 8,772,640	$ 690,530		$ 272,460	$ (418,070)	$ 504,430	34

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 8,772,640	$ 690,530		$ 272,460	$ (418,070)	$ 504,430	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
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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)		$ 8,772,640	$ 690,530		$ 272,460	$ (418,070)	$ 504,430	34

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 8,772,640	$ 690,530		$ 272,460	$ (418,070)	$ 504,430	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)		$ 8,772,640	$ 690,530		$ 272,460	$ (418,070)	$ 504,430	34

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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 12E, Carried Forward		$	$		$	$	$	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	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$	$		$	$	$	34

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4	Allocated from 4600 Touhy, LLC	2012	60,611	1,554	30	2,020	466	6,061	4
5									5
6									6
7									7
8	Leasehold Information								8
9									9
10	Allocated from Managcare, Inc.	2013	1,018	271	20	51	(220)	102	10
11	Allocated from Managcare, Inc.	2012	12,655	905	20	633	(272)	1,898	11
12									12
13									13
14	Allocated from 4600 Touhy, LLC	2012	39,033	1,011	20	1,952	941	5,855	14
15	Allocated from 4600 Touhy, LLC	2013	9,498	223	20	475	252	950	15
16	Allocated from 4600 Touhy, LLC	2014	944	23	20	47	24	47	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)		$ 123,759	$ 3,987		$ 5,178	$ 1,191	$ 14,913	34

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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 12H, Carried Forward		$ 123,759	$ 3,987		$ 5,178	$ 1,191	$ 14,913	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 123,759	$ 3,987		$ 5,178	$ 1,191	$ 14,913	34

**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: 01/01/14 Ending: 12/31/14

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	$ 2,377,464	$ 4,935	$ 246,016	$ 241,081	10	$ 484,077	71
72	Current Year Purchases	368,187		37,654	37,654	10	37,654	72
73	Fully Depreciated Assets	29,075				10	29,075	73
74								74
75	TOTALS	$ 2,774,726	$ 4,935	$ 283,671	$ 278,736		$ 550,806	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	$ 14,267	$ 691	$ 1,619	$ 928	5	$ 13,045	76
77										77
78										78
79										79
80	TOTALS			$ 14,267	$ 691	$ 1,619	$ 928		$ 13,045	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)	$ 12,457,092	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 696,156	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 557,749	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (138,407)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,068,281	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 8,688 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	Facility	2012 Dodge	$ 694.52	$ 8,334	17
18					18
19					19
20					20
21	TOTAL		$ 694.52	$ 8,334	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.

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$		$ 872,885	$		$ 872,885	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			201,559			201,559	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			905,887			905,887	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				374,340		374,340	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					103,911	25,583		129,494	13
14	TOTAL			$		$ 2,084,242	$ 399,923		$ 2,484,165	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.

STATE OF ILLINOIS

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,850	$	1
2	Cash-Patient Deposits	12,991		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,416,811		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	256,654		6
7	Other Prepaid Expenses	212,993		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	260,486		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,162,785	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,222,481		15
16	Equipment, at Historical Cost	284,002		16
17	Accumulated Depreciation (book methods)	(46,725)		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):	601,237		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,060,995	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,223,780	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,176,563	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,991		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	213,277		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,899		31
32	Accrued Real Estate Taxes(Sch.IX-B)	77,542		32
33	Accrued Interest Payable	1,189		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	177,727		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,690,188	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	2,039,637		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,039,637	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,729,825	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,493,955	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,223,780	$	48

*(See instructions.)

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 314,502	1	
2	Restatements (describe):		2	
3			3	
4	**Rounding**	(7)	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 314,495	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	467,971	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants	711,489	11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,179,460	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,493,955	24	*

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

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 11,043,366	1
2	Discounts and Allowances for all Levels	(2,051,443)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,991,923	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,410,706	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,410,706	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	347,122	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,050	19
20	Radiology and X-Ray	7,452	20
21	Other Medical Services	2,631	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 366,255	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,174	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,174	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	21,878	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 21,878	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,801,936	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,024,644	31
32	Health Care	3,757,701	32
33	General Administration	2,963,546	33
	B. Capital Expense		
34	Ownership	1,611,163	34
	C. Ancillary Expense		
35	Special Cost Centers	2,555,060	35
36	Provider Participation Fee	421,851	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,333,965	40
41	**Income before Income Taxes (line 30 minus line 40)****	467,971	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 467,971	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,621,666	44
45	Private Pay - Net Inpatient Revenue	711,289	45
46	Medicare - Net Inpatient Revenue	2,078,372	46
47	Other-(specify) Hospice	107,511	47
48	Other-(specify) Insurance	473,085	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,991,923	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.**

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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	1,919	2,000	$ 95,355	$ 47.68	1
2	Assistant Director of Nursing	1,360	1,493	43,674	29.25	2
3	Registered Nurses	12,035	12,868	354,677	27.56	3
4	Licensed Practical Nurses	52,381	55,942	1,148,900	20.54	4
5	CNAs & Orderlies	106,255	112,487	1,257,489	11.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,294	2,577	50,810	19.72	8
9	Activity Director	1,016	1,040	16,137	15.52	9
10	Activity Assistants	10,831	11,736	125,080	10.66	10
11	Social Service Workers	7,511	8,178	169,638	20.74	11
12	Dietician					12
13	Food Service Supervisor	3,737	4,006	65,261	16.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,626	30,618	320,026	10.45	15
16	Dishwashers					16
17	Maintenance Workers	11,869	13,098	163,470	12.48	17
18	Housekeepers	28,626	30,133	303,671	10.08	18
19	Laundry	11,794	12,929	144,952	11.21	19
20	Administrator	2,272	2,408	102,191	42.44	20
21	Assistant Administrator	1,760	1,884	54,524	28.94	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,082	17,175	233,938	13.62	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	1,620	1,934	33,259	17.20	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,382	2,446	49,353	20.18	33
34	TOTAL (lines 1 - 33)	304,370	324,952	$ 4,732,405 *	$ 14.56	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	308	$ 21,454	01-03	35
36	Medical Director	Monthly	43,700	09-03	36
37	Medical Records Consultant	Quarterly	1,880	10-03	37
38	Nurse Consultant	Monthly	75,300	10-03	38
39	Pharmacist Consultant	Monthly	14,556	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	1,700	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	308	$ 158,590		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rachel Cassella	Administrator	0	$ 39,854
Scott Mow	Administrator	0	56,205
Margaret Nicholson	Administrator	0	6,132
Apple Glover	Asst. Administrator	0	38,167
Erich Marks	Asst. Administrator	0	16,357
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 156,715

B. Administrative - Other

Description	Amount
Management Fees - Tetrad Management	$ 163,832
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 163,832

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 14,625
Achieve Accreditation	Accrediation Assistance	22,202
Legal	See Attached	42,898
Personnel Planners	Unemployment Consulting	9,878
Managcare, Inc	Bookkeeping	210,840
Managcare, Inc	Administrative Consultant	45,180
eHealth Data Solutions	MDS Software	2,100
HealthMEDX	EMR Software	39,168
Ability Network, Inc	Billing Software	3,964
Smartlinx Solutions	Workforce Management	5,053
Galaxy Hosted Software	Clinical & Financial Software	5,142
See Supplemental Schedule		28,593
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 429,642

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 80,717
Unemployment Compensation Insurance	243,025
FICA Taxes	354,711
Employee Health Insurance	156,443
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	924
Vision Insurance	264
Other Employee Benefits	9,500
Safe Harbor Match Expense	7,999
Holiday Expense	4,919
TOTAL (agree to Schedule V, line 22, col.8)	$ 858,502

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	47,595
Health Care Worker Background Check	
(Indicate # of checks performed 385)	3,850
Patient Background Checks	
Dues and Subscriptions	26,034
Licenses and Permits	3,649
Allocated from Managcare, Inc.	4,528
Allocated from 4600 Touhy, LLC	13
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 87,660

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,967
Allocated from Managcare, Inc.	174
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,141

**See instructions.

Facility Name & ID Number Capitol Hlthcare & Rehab Ctr # 0052183 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $35,839**

(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. $ **10,313** 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. $ **421,851**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.