

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,575	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	155	TOTALS	155	56,575	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	39,929	43	6,898	46,870	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,929	43	6,898	46,870	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.85%

D. How many bed-hold days during this year were paid by the Department?

0 (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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 05/01/87

J. Was the facility purchased or leased after January 1, 1978?

YES Date 05/01/87 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 155 and days of care provided 6,784

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab # 0052712 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				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	219,621	23,695	13,383	256,699		256,699	152	256,851		1
2	Food Purchase		260,786		260,786		260,786	680	261,466		2
3	Housekeeping	116,714	30,816		147,530		147,530	508	148,038		3
4	Laundry	60,066	14,568		74,634		74,634		74,634		4
5	Heat and Other Utilities			137,351	137,351		137,351	1,147	138,498		5
6	Maintenance	102,158		144,656	246,814		246,814	12,891	259,705		6
7	Other (specify):* See Supplemental	42,969			42,969		42,969	774	43,743		7
8	TOTAL General Services	541,528	329,865	295,390	1,166,783		1,166,783	16,152	1,182,935		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	2,130,434	95,499	15,225	2,241,158		2,241,158	(17)	2,241,141		10
10a	Therapy	107,616			107,616		107,616		107,616		10a
11	Activities	94,825	9,948	2,605	107,378		107,378		107,378		11
12	Social Services	248,644	13,045	1,500	263,189		263,189		263,189		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* See Supplemental										15
16	TOTAL Health Care and Programs	2,581,519	118,492	28,330	2,728,341		2,728,341	(17)	2,728,324		16
	C. General Administration										
17	Administrative	275,202			275,202		275,202	20,155	295,357		17
18	Directors Fees										18
19	Professional Services			271,862	271,862		271,862	(140,000)	131,862		19
20	Dues, Fees, Subscriptions & Promotions			35,976	35,976		35,976	(10,001)	25,975		20
21	Clerical & General Office Expenses	201,782	19,490	457,280	678,552		678,552	(342,086)	336,466		21
22	Employee Benefits & Payroll Taxes			703,623	703,623		703,623	(4,168)	699,455		22
23	Inservice Training & Education			116	116		116		116		23
24	Travel and Seminar			4,020	4,020		4,020	262	4,282		24
25	Other Admin. Staff Transportation			15,643	15,643		15,643	1,285	16,928		25
26	Insurance-Prop.Liab.Malpractice			236,481	236,481		236,481	1,381	237,862		26
27	Other (specify):* See Supplemental							25,683	25,683		27
28	TOTAL General Administration	476,984	19,490	1,725,001	2,221,475		2,221,475	(447,489)	1,773,986		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,600,031	467,847	2,048,721	6,116,599		6,116,599	(431,354)	5,685,245		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

**Kensington Place Nursing & Rehab Center, LLC
 Medicaid Cost Report
 01/01/14 - 12/31/14**

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 7 Detailed			
Security	42,969		
Alloc. - Extended Care Consulting, LLC			774
Total	42,969	-	774

Line 15 Detailed

Total	-	-	-
-------	---	---	---

Line 27 Detailed

Alloc. - Extended Care Consulting, LLC			25,683
Total	-	-	25,683

Kensington Place Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/14 - 12/31/14

Page 3 Supplemental Schedule - Other Admin. Staff Transportation

Vendor	Amount	Allowable
Care Consultants of Illinois	2,674	2,674
David Mashiach	521	521
Holly Turner	258	258
Yechiel Mashiach	2,132	2,132
Care Management Facility	1,390	1,390
Zaidi Shoaib	1,127	1,127
Other	7,541	7,541
Alloc. - Extended Care Consulting, LLC	1,285	1,285
Total	<u>16,928</u>	<u>16,928</u>

Facility Name & ID Number Kensington Place Nsg & Rehab

#0052712

Report Period Beginning:

01/01/14

Ending:

12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			5,009	5,009		5,009	97,219	102,228			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,861	5,861		5,861	958	6,819			32
33	Real Estate Taxes			198,918	198,918		198,918	2,481	201,399			33
34	Rent-Facility & Grounds			735,475	735,475		735,475	(735,475)				34
35	Rent-Equipment & Vehicles			31,989	31,989		31,989	755	32,744			35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			977,252	977,252		977,252	(634,062)	343,190			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		157,525	709,155	866,680		866,680		866,680			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			338,448	338,448		338,448		338,448			42
43	Other (specify):* See Supplemental											43
44	TOTAL Special Cost Centers		157,525	1,047,603	1,205,128		1,205,128		1,205,128			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,600,031	625,372	4,073,576	8,298,979		8,298,979	(1,065,416)	7,233,563			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Kensington Place Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/14 - 12/31/14

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other
-------------	----------	----------	-------

Line 36 Detailed

Total	-	-	-
-------	---	---	---

Line 43 Detailed

Total	-	-	-
-------	---	---	---

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(16)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(447,345)	21		24
25	Fund Raising, Advertising and Promotional	(11,672)	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 See Supplemental				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (459,033)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(356,218)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (356,218)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (815,251)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Kensington Place Nsg & RehabID# 0052712Report Period Beginning: 01/01/14Ending: 12/31/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Other Income	\$ (5,549)	21	1
2	Jury Duty Income	(17)	10	2
3	Collections	(1,020)	19	3
4	Bank Charges	(435)	21	4
5	Non-Allowable Interest	(216,000)	32	5
6	Legal	(13,551)	19	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15	Boulevard Property, LLC			15
16	Administration	(7,750)	17	16
17	Professional Services	(5,593)	19	17
18	Office and Clerical	(250)	21	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	(250,165)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Kensington Place Nsg & Rehab# 0052712

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	152	0	0	0	0	0	0	0	0	152	1
2	Food Purchase	0	0	680	0	0	0	0	0	0	0	0	680	2
3	Housekeeping	0	0	508	0	0	0	0	0	0	0	0	508	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,147	0	0	0	0	0	0	0	0	1,147	5
6	Maintenance	0	0	4,734	8,157	0	0	0	0	0	0	0	12,891	6
7	Other (specify):*	0	0	0	774	0	0	0	0	0	0	0	774	7
8	TOTAL General Services	0	0	7,221	8,931	0	0	0	0	0	0	0	16,152	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(17)	0	0	0	0	0	0	0	0	0	0	(17)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(17)	0	0	0	0	0	0	0	0	0	0	(17)	16
	C. General Administration													
17	Administrative	(7,750)	7,750	3,146	17,009	0	0	0	0	0	0	0	20,155	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(20,164)	5,593	(125,429)	0	0	0	0	0	0	0	0	(140,000)	19
20	Fees, Subscriptions & Promotions	(11,672)	0	1,671	0	0	0	0	0	0	0	0	(10,001)	20
21	Clerical & General Office Expenses	(453,579)	250	11,444	99,799	0	0	0	0	0	0	0	(342,086)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(4,168)	0	0	0	0	0	0	0	(4,168)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	262	0	0	0	0	0	0	0	0	262	24
25	Other Admin. Staff Transportation	0	0	1,285	0	0	0	0	0	0	0	0	1,285	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,381	0	0	0	0	0	0	0	0	1,381	26
27	Other (specify):*	0	0	0	25,683	0	0	0	0	0	0	0	25,683	27
28	TOTAL General Administration	(493,165)	13,593	(106,240)	138,323	0	0	0	0	0	0	0	(447,489)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(493,182)	13,593	(99,019)	147,254	0	0	0	0	0	0	0	(431,354)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

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	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	92,963	4,256	0	0	0	0	0	0	0	0	97,219	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(216,016)	216,000	974	0	0	0	0	0	0	0	0	958	32
33	Real Estate Taxes	0	0	2,481	0	0	0	0	0	0	0	0	2,481	33
34	Rent-Facility & Grounds	0	(735,475)	0	0	0	0	0	0	0	0	0	(735,475)	34
35	Rent-Equipment & Vehicles	0	0	755	0	0	0	0	0	0	0	0	755	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(216,016)	(426,512)	8,466	0	0	0	0	0	0	0	0	(634,062)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(709,198)	(412,919)	(90,553)	147,254	0	0	0	0	0	0	0	(1,065,416)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 735,475	Boulevard Property, LLC	100.00%	\$	\$ (735,475)	1
2	V	32 Interest		Boulevard Property, LLC	100.00%			2
3	V	17 Administration		Boulevard Property, LLC	100.00%	7,750	7,750	3
4	V	19 Professional Fees		Boulevard Property, LLC	100.00%	5,593	5,593	4
5	V	21 Office and Clerical		Boulevard Property, LLC	100.00%	250	250	5
6	V	30 Depreciation		Boulevard Property, LLC	100.00%	92,963	92,963	6
7	V	31 Amortization		Boulevard Property, LLC	100.00%			7
8	V	32 Interest		Boulevard Property, LLC	100.00%	216,000	216,000	8
9	V	33 Real Estate Taxes	201,063	Boulevard Property, LLC	100.00%	201,063		9
10	V	36 Mortgage Insurance Premiums		Boulevard Property, LLC	100.00%			10
11	V							11
12	V							12
13	V							13
14	Total		\$ 936,538			\$ 523,619	\$ * (412,919)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Kensington Place Nsg & Rehab

0052712

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	Yechiel Mashiach	15.20%	Avenue Care Nursing and Rehab	Chicago, IL	Ex. Care Consulting	Evanston, IL	Home Office	1
2	Elimelch Ray	7.40%	Beecher Manor Nursing and Rehab	Beecher, IL	Ex. Care Clinical	Evanston, IL	Administrative	2
3	Chaim Ray	7.40%	Briar Place	Indian Head, IL	CC Health Systems	Des Plaines, IL	Dietary & Suppl.	3
4	Devorah Ray-Engel	7.40%	Chateau Village Nursing and Rehab	Willowbrook, IL	CCS VEBA	Evanston, IL	Health Insurance	4
5	Nechama Ray	7.40%	Grasmere Place	Chicago, IL	2201 Main	Evanston, IL	Bldg. Company	5
6	Malkara Ray-Mashiach	15.20%	Lakewood Nursing and Rehab	Plainfield, IL	Rothner Vents	Evanston, IL	Vent. Rental	6
7	Atied	40.00%	Lemont Nursing and Rehab	Lemont, IL	Tricare Rehab	Hillside, IL	Therapy	7
8			Prairie Manor Halth Care	Chicago Heights, IL	Reliable Medical	Des Plaines, IL	Medical Supplies	8
9			Rainbow Beach Nursing Center	Chicago, IL	Harbor Light	Glen Ellyn, IL	Hospice	9
10			Sheridan Shores	Chicago, IL				10
11			South Suburban Rehabilitation Center	Chicago, IL	Boulevard			11
12			Tri-State Nursing and Rehab	Lansing, IL	Property, LLC	Chicago, IL	Bldg. Company	12
13			Wheaton Care Center	Wheaton, IL				13
14			Kensington Place Nursing and Rehab	Chicago, IL				14
15			Countryside Nursing and Rehab	Dolton, IL				15
16			Spring Creek Nursing and Rehab	Joliet, IL				16
17			Park House Nursing and Rehab	Chicago, IL				17
18			Timber Point Healthcare Center	Camp Point, IL				18
19			Prairie Village Healthcare Center	Jacksonville, IL				19
20			Major Hospital - Dyer	Dyer, IN				20
21			Major Hospital - Lake County	East Chicago, IN				21
22			Major Hospital - Sebo	Holbart, IN				22
23			Major Hospital - Lincolnshire	Merrillville, IN				23
24			Major Hospital - Munster	Munster, IN				24
25			McKinley Health Care Center	Canton, OH				25
26			St. James Manor	Crete, IL				26
27			The Parc at Joliet	Joliet, IL				27
28			The Estates of Hyde Park	Chicago, IL				28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 152	\$	152	15
16	V	2 Food		Extended Care Consulting, LLC	100.00%	680		680	16
17	V	3 Housekeeping		Extended Care Consulting, LLC	100.00%	508		508	17
18	V	5 Utilities		Extended Care Consulting, LLC	100.00%	1,147		1,147	18
19	V	6 Maintenance		Extended Care Consulting, LLC	100.00%	4,734		4,734	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	3,146		3,146	20
21	V	19 Professional Fees	134,400	Extended Care Consulting, LLC	100.00%	8,971		(125,429)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,671		1,671	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	11,444		11,444	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	262		262	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,285		1,285	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	1,381		1,381	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	4,256		4,256	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	974		974	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,481		2,481	29
30	V	35 Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	755		755	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		\$ 134,400			\$ 43,847	\$ *	(90,553)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 Maintenance (Pooled)	\$	Extended Care Consulting, LLC	100.00%	\$ 8,157	\$ 8,157	15
16	V	6 Maintenance (Direct)		Extended Care Consulting, LLC	100.00%			16
17	V	7 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	774	774	17
18	V	7 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%			18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	17,009	17,009	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	99,799	99,799	20
21	V	21 Office and Clerical (Direct)	18,243	Extended Care Consulting, LLC	100.00%	18,243		21
22	V	27 Emp. Gen. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	21,515	21,515	22
23	V	27 Emp. Gen. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,168	4,168	23
24	V	22 Employee Benefits	4,168				(4,168)	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		\$ 22,411			\$ 169,665	\$ * 147,254	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$	\$
16	V	10 Nursing		Care Centers Health Systems, Inc.	100.00%		
17	V	39 Ancillary		Care Centers Health Systems, Inc.	100.00%		
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 0	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Ancillary	\$	Tricare Rehab	100.00%	\$	\$	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		\$			\$	0	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Reliable Medical of the Midwest, LLC	100.00%	\$	\$
16	V	10 Nursing Supplies		Reliable Medical of the Midwest, LLC	100.00%		
17	V	39 Ancillary		Reliable Medical of the Midwest, LLC	100.00%		
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 0	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Benefits	\$ 164,923	CCS VEBA	100.00%	\$ 164,923	\$	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		\$ 164,923			\$ 164,923	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Ancillary	\$	Vent Lease, LLC	100.00%	\$	\$
16	V	32 Interest		Vent Lease, LLC	100.00%		
17	V	30 Depreciation		Vent Lease, LLC	100.00%		
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 0	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab # 0052712 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Adam Vales	Relative	Clerical	0.00%	See Attached	1.42	3.55%	Salary	\$ 1,713	22 - 7	1
2	Sherwin Ray	Relative	Administration	0.00%	See Attached	7.50	18.75%	Salary	28,392	17 - 1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 30,105		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

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 Extended Care Consulting, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905 - 3000
 Fax Number (847) 491 - 9565

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	1,251,572	31	\$ 4,057	\$ 46,870	\$ 152	1
2	2	Food	Patient Days	1,251,572	31	18,150	46,870	680	2
3	3	Housekeeping	Patient Days	1,251,572	31	13,578	46,870	508	3
4	5	Utilities	Patient Days	1,251,572	31	30,626	46,870	1,147	4
5	6	Maintenance	Patient Days	1,251,572	31	126,400	46,870	4,734	5
6	17	Administrative	Patient Days	1,251,572	31	84,000	46,870	3,146	6
7	19	Professional Fees	Patient Days	1,251,572	31	239,560	46,870	8,971	7
8	20	Dues and Subscriptions	Patient Days	1,251,572	31	44,626	46,870	1,671	8
9	21	Office and Clerical	Patient Days	1,251,572	31	305,586	46,870	11,444	9
10	24	Travel and Seminar	Patient Days	1,251,572	31	6,989	46,870	262	10
11	25	Other Staff Admin. Trans.	Patient Days	1,251,572	31	34,307	46,870	1,285	11
12	26	Insurance	Patient Days	1,251,572	31	36,877	46,870	1,381	12
13	30	Depreciation	Patient Days	1,251,572	31	113,642	46,870	4,256	13
14	32	Interest	Patient Days	1,251,572	31	26,010	46,870	974	14
15	33	Real Estate Taxes	Patient Days	1,251,572	31	66,240	46,870	2,481	15
16	35	Rent - Equipment and Auto	Patient Days	1,251,572	31	20,168	46,870	755	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,170,816	\$	\$ 43,847	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

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 Extended Care Consulting, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905 - 3000
 Fax Number (847) 491 - 9565

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	Maintenance	Patient Days	1,251,572	31	\$ 217,811	\$ 217,811	46,870	\$ 8,157	1
2	6	Maintenance	Direct	1	1			1		2
3	7	Emp. Ben. - Gen. Serv.	Patient Days	1,251,572	31	20,665		46,870	774	3
4	7	Emp. Ben. - Gen. Serv.	Direct	1	1			1		4
5	17	Administrative	Patient Days	1,251,572	31	454,189	454,189	46,870	17,009	5
6	21	Office and Clerical	Patient Days	1,251,572	31	2,664,950	2,664,951	46,870	99,799	6
7	21	Office and Clerical	Direct	1	1	18,243	18,243	1	18,243	7
8	27	Emp. Gen. - Gen. Admin.	Patient Days	1,251,572	31	574,509	574,509	46,870	21,515	8
9	27	Emp. Gen. - Gen. Admin.	Direct	1	1	4,168		1	4,168	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					\$ 3,954,535	\$ 3,929,703		\$ 169,665	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

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 Care Centers Health Systems, Inc.
 Street Address 200 Howard Avenue #246
 City / State / Zip Code Des Plaines, Illinois 60018
 Phone Number (224) 612 - 5662
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Profit Margin %	77,896	21	\$ 77,896		\$	1
2	10	Nursing	Profit Margin %	234	21	234			2
3	39	Ancillary	Profit Margin %	97,004	21	97,004			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					\$ 175,134		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

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 Tricare Rehab
 Street Address 150 Fencil Lane
 City / State / Zip Code Hillside, Illinois 60162
 Phone Number (708) 449 - 9400
 Fax Number (708) 449 - 9700

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary	Profit Margin %	12	\$ 8,898,201	\$		\$	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				\$ 8,898,201	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

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 Reliable Medical of the Midwest, LLC
 Street Address 200 Howard Avenue, Suite 246
 City / State / Zip Code Des Plaines, Illinois 60018
 Phone Number (847) 566 - 0800
 Fax Number (

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Profit Margin %	70	12	\$ 50	\$	\$	1
2	10	Nursing	Profit Margin %	32,887	12	23,627			2
3	39	Ancillary	Profit Margin %	85,782	12	61,627			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					\$ 85,304	\$	\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

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 CCS VEBA
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905 - 3000
 Fax Number (847) 491 - 9565

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Benefits	Direct Allocations	1	1	\$ 164,923	\$ 1	\$ 164,923	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					\$ 164,923	\$	\$ 164,923	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

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 Vent Lease, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905 - 3000
 Fax Number (847) 491 - 9565

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary	Profit Margin %	110,244	18	\$ 110,244		\$	1
2	32	Depreciation	Direct	2,695	1	2,695			2
3	30	Interest	Direct	2,944	1	2,944			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					\$ 115,883		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab # 0052712 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	Hunter Management	X		Mortgage			\$	\$		\$ 216,000	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	Private Bank		X	Line of Credit						5,861	6									
7	Alloc. - Extended Care Con.	X		Line of Credit						974	7									
8											8									
9	TOTAL Facility Related						\$	\$		\$ 222,835	9									
B. Non-Facility Related*																				
10											10									
11											11									
12	Interest Income		X							(16)	12									
13	Non-Allowable Interest		X							(216,000)	13									
14	TOTAL Non-Facility Related						\$	\$		\$ (216,016)	14									
15	TOTALS (line 9+line14)						\$	\$		\$ 6,819	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # 36

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Kensington Place Nsg & Rehab COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0052712
 CONTACT PERSON REGARDING THIS REPORT Edward N. Slack, CPA
 TELEPHONE (847) 628 - 8796 FAX #: (248) - 327 - 8417

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>17-34-119-001-0000</u>	<u>Long Term Care Facility</u>	\$ <u>56,048.29</u>	\$ <u>56,048.29</u>
2. <u>17-34-119-002-0000</u>	<u>Long Term Care Facility</u>	\$ <u>9,472.02</u>	\$ <u>9,472.02</u>
3. <u>17-34-119-003-0000</u>	<u>Long Term Care Facility</u>	\$ <u>93,545.45</u>	\$ <u>93,545.45</u>
4. <u>17-34-119-004-0000</u>	<u>Long Term Care Facility</u>	\$ <u>9,079.18</u>	\$ <u>9,079.18</u>
5. <u>17-34-119-005-0000</u>	<u>Long Term Care Facility</u>	\$ <u>10,650.61</u>	\$ <u>10,650.61</u>
6. <u>17-34-119-006-0000</u>	<u>Long Term Care Facility</u>	\$ <u>10,650.61</u>	\$ <u>10,650.61</u>
7. <u>Alloc. - Ext. Care Consulting</u>	<u>Long Term Care Facility</u>	\$ <u>162,082.08</u>	\$ <u>2,362.52</u>
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>351,528.24</u></u>	\$ <u><u>191,808.68</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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 providecopies of their original second installment tax bill.

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,293 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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

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

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

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

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

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

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Rows include Facility, Alloc. - Ext. Care, and TOTALS.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Bed*s	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	155		1995	1971	\$ 4,046,250	\$ 92,963		\$ 92,963	\$	\$ 3,189,705	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	8,296						9
10	Various			1988	11,646						10
11	Various			1989	5,250						11
12	Various			1990	7,780						12
13	Various			1991	16,578						13
14	Various			1992	17,269						14
15	Various			1993	21,968						15
16	Various			1994	13,356						16
17	Various			1995	12,270						17
18	Various			1996	15,797						18
19	Various			1997	7,187						19
20	Various			1998	17,815						20
21	Various			1999	6,043						21
22	Various			2000	235,020						22
23	Various			2001	61,023						23
24	Various			2002	236,588						24
25	Various			2003	110,588						25
26	Various			2004	98,820						26
27	Various			2005	1,500						27
28	Various			2006	18,167						28
29	Various			2007	7,963						29
30	Various			2008	12,185						30
31	Various			2009	10,849						31
32	Various			2010	78,439						32
33	Fire Damper and Installation - Year Change from 2010			2011	34,950						33
34	Remove Old and Install New Iron Fence			2011	3,000						34
35	Boiler Repair			2011	10,158						35
36	Electric Switch Panel for Sump Pumps			2011	3,660						36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kensington Place Nsg & Rehab# 0052712

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Bathrooms Tile and Installation - ***** ADJ Per 06/30/13 CP	2010	\$ 9,257	\$		\$	\$	37
38	Exhaust Fan	2011	3,730					38
39	Iron Fence Repair	2011	2,700					39
40	Hot Water Heater	2011	8,000					40
41	Building - Carpentry, Drywall, HVAC, Electrical	2012	64,000					41
42	Architectural Work - Basement	2012	5,695					42
43	Install Fire Alarm Systems and Photo Detectors	2012	9,760					43
44	Call System	2012	10,703					44
45	Tile - Kitchen	2012	8,202					45
46	Tile - Basement Hallway	2012	2,640					46
47	Elevator - Furnish and Install New Door, Rollers, Hatch Door	2012	15,818					47
48	Architectural Work - Basement	2012	7,385					48
49	Install Wiring From Generator for new E-Stop	2012	7,500					49
50	Install New Sprinkler Heads	2012	4,861					50
51	Emergency Panel Replacement	2012	14,121					51
52	Nurse Call System	2012	10,703					52
53	Elevator - GAL Door Restrictors	2013	5,665					53
54	Elevator - GAL Door Restrictors	2013	4,216					54
55	Hot Water Heater - 80 Gallon 199,000 BTU	2013	8,400					55
56	New 30 Circuit Panelboard	2013	6,500					56
57	Fire Alarm System Devises	2013	3,161					57
58	Elevator - 3D Infrared Detector Edge	2013	3,200					58
59	Elevator - Valve Replacement	2013	5,308					59
60	Parking Lot - Ashphalt and Striping	2013	13,863					60
61	Roof Drain	2013	5,635					61
62	Hallway Doors - Egress Locks	2014	14,894	451		451		451
63	Canopy - Main Entrance	2014	9,620	204		204		204
64	Hot Water / Cold Water Riser	2014	10,370	251		251		251
65	Electrical Outlets - Nurses Station	2014	2,893	44		44		44
66	Elevator - Valve Replacement	2014	8,910	255		255		255
67	Sprinkler System - Grounds	2014	3,800	54		54		54
68				81		81		81
69								69
70	TOTAL (lines 4 thru 69)		\$ 5,421,925	\$ 94,303		\$ 94,303	\$	3,191,045

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward		\$ 5,421,925	\$ 94,303		\$ 94,303	\$	\$ 3,191,045	1
2	Related Party Allocations - See Supplemental Schedules								2
3									3
4	Allocations - Extended Care Consulting, LLC	2007	172	9	9		69	4	
5	Allocations - Extended Care Consulting, LLC	2009	103	5	5		31	5	
6	Allocations - Extended Care Consulting, LLC	2010	1,010	51	51		253	6	
7	Allocations - Extended Care Consulting, LLC	2011	364	18	18		73	7	
8	Allocations - Extended Care Consulting, LLC	2013	120	6	6		18	8	
9	Allocations - Extended Care Consulting, LLC	2014	1,661	83	83		83	9	
10								10	
11								11	
12	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	16,471	422	422		5,191	12	
13	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	13,606	1,160	1,160		13,606	13	
14	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2003	16,034	1,367	1,367		16,034	14	
15	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2005	797	85	85		711	15	
16	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2009	144	7	7		43	16	
17	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2014	2,296	115	115		115	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)		\$ 5,474,703	\$ 97,631		\$ 97,631	\$	\$ 3,227,272	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$	5 - 7	\$	71
72	Current Year Purchases	53,032	3,668	3,668		5	3,668	72
73	Fully Depreciated Assets							73
74	See Supplemental	273,090	738	738			268,388	74
75	TOTALS	\$ 326,122	\$ 4,406	\$ 4,406	\$		\$ 272,056	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	Alloc. - Ext. Care Consult.			\$ 6,758	\$ 191	\$ 191	\$		\$ 5,995	76
77										77
78										78
79										79
80	TOTALS			\$ 6,758	\$ 191	\$ 191	\$		\$ 5,995	80

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,919,535	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 102,228	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 102,228	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,505,323	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	Deposit - Interior Project	\$ 42,049	92
93			93
94			94
95		\$ 42,049	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Kensington Place Nursing & Rehab, LLC
Medicaid Cost Report
01/01/14 - 12/31/14

Page 13 Supplemental Schedule

Description	Cost	Depreciation	Accumulated Depreciation
Related Party 1 - Boulevard Property, LLC			
Prior	155,000		155,000
Current			
Total	155,000	-	155,000
Related Party 2 - Extended Care Consulting, LLC			
Prior	110,759	461	108,550
Current	2,770	277	277
Total	113,529	738	108,827
Related Party 3 - Extended Care Consulting, LLC / 2201 Main, LLC			
Prior	4,561		4,561
Current			
Total	4,561	-	4,561
Related Party 4 - Extended Care Clinical, LLC / 2201 Main, LLC			
Prior			
Current			
Total	-	-	-
Total	273,090	738	268,388

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

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 - Related Party

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. [X] YES [] NO

Table with 8 columns: Line, Description, 1 Year Constructed, 2 Number of Beds, 3 Original Lease Date, 4 Rental Amount, 5 Total Years of Lease, 6 Total Years Renewal Option*, 7. Rows include Original Building, Additions, See, Supplement, and TOTAL.

10. Effective dates of current rental agreement: Beginning Ending

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

Table with 2 columns: Fiscal Year Ending, Annual Rent. Rows for years 2015, 2016, and 2017.

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease

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

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

15. Is Movable equipment rental included in building rental? [] YES [X] NO

16. Rental Amount for movable equipment: \$ 22,815 Description: See Supplemental Schedule (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

Table with 5 columns: Line, 1 Use, 2 Model Year and Make, 3 Monthly Lease Payment, 4 Rental Expense for this Period, 5. Row 17 includes Facility, Lexus, and 9,929.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Kensington Place Nursing & Rehab, LLC
Medicaid Cost Report
01/01/14 - 12/31/14

Page 14 Supplemental Schedule - Building and Fixed Equipment

Vendor	Amount
Total	-

Page 14 Supplemental Schedule - Equipment Rental

Vendor	Amount
Hughes Enterprises, Inc.	8,000
Pitney Bowes, Inc.	1,222
US Bank	5,177
Lenovo Financial Services	4,275
Countryside N&R	986
Capital One	2,400
Alloc. - Extended Care Consulting, LLC	755
Total	22,815

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$				\$ 297,948			\$ 297,948	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					67,942			67,942	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs					340,844			340,844	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts						154,189		154,189	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>See Supplemental</u>	39 - 02							3,336		3,336	12
13	Other (specify): <u>See Supplemental</u>	39 - 03						2,421			2,421	13
14	TOTAL			\$				\$ 709,155	\$ 157,525		\$ 866,680	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Kensington Place Nsg & Rehab
Medicaid Cost Report
01/01/14 - 12/31/14**

Page 16 Supplemental Schedule

Description	Supplies	Other
Oxygen	1,876	
Therapy and Rehab Supplies	1,460	
Wheelchairs and Walkers		496
Laboratory		73
Radiology		1,670
Other		182
Total	3,336	2,421

Facility Name & ID Number Kensington Place Nsg & Rehab# 0052712Report Period Beginning: 01/01/14Ending: 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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 395,448	\$ 628,474	1
2	Cash-Patient Deposits	58,568	58,568	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>322,195</u>)	2,003,654	2,003,654	3
4	Supply Inventory (priced at <u>Cost - FIFO</u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	300,655	300,655	6
7	Other Prepaid Expenses	56,330	56,330	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>	843	843	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,815,498	\$ 3,048,524	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		3,624,354	14
15	Leasehold Improvements, at Historical Cost	92,536	92,536	15
16	Equipment, at Historical Cost	53,032	208,032	16
17	Accumulated Depreciation (book methods)	(5,009)	(3,349,714)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Supplemental Schedule</u>	8,000	8,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 148,559	\$ 683,208	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,964,057	\$ 3,731,732	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,107,976	\$ 1,107,976	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	49,293	49,293	28
29	Short-Term Notes Payable	750,000	750,000	29
30	Accrued Salaries Payable	167,350	167,350	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,155	8,155	31
32	Accrued Real Estate Taxes(Sch.IX-B)		198,918	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Supplemental Schedule</u>	88,626	3,200,042	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,171,400	\$ 5,481,734	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	<u>See Supplemental Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,171,400	\$ 5,481,734	46
47	TOTAL EQUITY(page 18, line 24)	\$ 792,657	\$ (1,750,002)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,964,057	\$ 3,731,732	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Kensington Place Nsg & Rehab
Medicaid Cost Report
01/01/14 - 12/31/14

Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Due from Employees	843	843
Total	843	843
Line 23 - Other Long Term Assets		
Organization Costs	8,000	8,000
Total	8,000	8,000
Line 36 - Other Current Liabilities		
Due to Related Parties	88,626	3,200,042
Total	88,626	3,200,042
Line 43 - Other Long Term Liabilities		
Total	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	792,657	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 792,657	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)	\$ 792,657	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,963,237	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,963,237	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	122,817	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 122,817	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	16	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	5,566	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,566	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,091,636	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,166,783	31
32	Health Care	2,728,341	32
33	General Administration	2,221,475	33
B. Capital Expense			
34	Ownership	977,252	34
C. Ancillary Expense			
35	Special Cost Centers	866,680	35
36	Provider Participation Fee	338,448	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,298,979	40
41	Income before Income Taxes (line 30 minus line 40)**	792,657	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 792,657	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 5,475,202	44
45	Private Pay - Net Inpatient Revenue	5,544	45
46	Medicare - Net Inpatient Revenue	3,355,421	46
47	Other-(specify) <u>Hospice - Net Inpatient Revenue</u>	83,265	47
48	Other-(specify) <u>Insurance - Net Inpatient Revenue</u>	43,805	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,963,237	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Kensington Place Nsg & Rehab
Medicaid Cost Report
01/01/14 - 12/31/14**

Page 19 Supplemental Schedule

Description	Total	Adjustment
Line 28 - Other Revenue		
Other Income	5,549	5,549
Jury Duty	17	17
Total	<u>5,566</u>	<u>5,566</u>

Facility Name & ID Number Kensington Place Nsg & Rehab

0052712

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,037	2,214	\$ 104,131	\$ 47.03	1
2	Assistant Director of Nursing	2,021	2,201	79,813	36.26	2
3	Registered Nurses	15,431	16,529	482,504	29.19	3
4	Licensed Practical Nurses	25,226	27,076	668,521	24.69	4
5	CNAs & Orderlies	67,710	73,970	767,445	10.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,542	6,207	107,616	17.34	8
9	Activity Director	1,995	2,148	31,671	14.74	9
10	Activity Assistants	6,181	6,782	63,154	9.31	10
11	Social Service Workers	12,932	14,148	248,644	17.57	11
12	Dietician					12
13	Food Service Supervisor	1,872	2,131	43,206	20.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,440	18,280	176,415	9.65	15
16	Dishwashers					16
17	Maintenance Workers	5,876	6,452	102,158	15.83	17
18	Housekeepers	12,146	13,116	116,714	8.90	18
19	Laundry	4,645	5,407	60,066	11.11	19
20	Administrator	1,930	2,005	145,941	72.79	20
21	Assistant Administrator	2,037	2,201	100,869	45.83	21
22	Other Administrative	390	394	28,392	72.06	22
23	Office Manager					23
24	Clerical	7,326	8,030	201,782	25.13	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	1,869	2,027	28,020	13.82	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Security</u>	4,203	4,636	42,969	9.27	33
34	TOTAL (lines 1 - 33)	197,809	215,954	\$ 3,600,031 *	\$ 16.67	34

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 13,383	01 - 03	35
36	Medical Director	9,000	09 - 03	36
37	Medical Records Consultant	1,548	10 - 03	37
38	Nurse Consultant			38
39	Pharmacist Consultant	13,677	10 - 03	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	2,605	11 - 03	44
45	Social Service Consultant	1,500	12 - 03	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 41,713		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

**Kensington Place Nursing & Rehab, LLC
Medicaid Cost Report
01/01/14 - 12/31/14**

Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Type	Amount
Care Consultants of Illinois	Data Processing / IT	1,194
Relias Learning, LLC	Data Processing / IT	3,719
Care Management Facility	Data Processing / IT	3,612
Emdeon	Data Processing / IT	876
Out of Period	Data Processing / IT	4,800
Other	Data Processing / IT	3,051
Jesse Outlaw Attorney	Legal	750
Williams, Montgomery & John, Ltd.	Legal	94
Law Offices of Michael Z	Legal	4,503
Ashman & Stein	Legal	1,013
Seyfarth	Legal	7,598
Holly Turner	Legal	(250)
Other	Legal	(158)
Grabowski Law Services, LLC	Legal / Collections	1,020
Prospect Resources	Other	2,438
Terrill Consulting Services	Other	12,784
Resource Utilization Xperts	Other	12,784

Total

59,829

**Kensington Place Nsg & Rehab
Medicaid Cost Report
01/01/14 - 12/31/14**

Page 21 Supplemental Schedule - Legal Invoice Detail

Firm Name	Invoice Date	Description of Services	Allowable Amount	Non-Allowable Amount
Jesse Outlaw Attorney	03/13/14	Non-Allowable		750
Williams, Montgomery & John, Ltd.	04/30/14	Non-Allowable		94
Law Offices of Michael Z	07/23/14	Non-Allowable		2,850
Law Offices of Michael Z	08/04/14	Non-Allowable		1,575
Law Offices of Michael Z	08/29/14	Non-Allowable		79
Cash Receipt	08/31/14	Non-Allowable		(157)
Ashman & Stein	08/26/14	Non-Allowable		1,013
Holly Turner	11/30/14	Non-Allowable		(250)
Seyfarth	12/31/14	Non-Allowable		7,598

Total

-	13,551
---	--------

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A											
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? 5 - 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10 - 02
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 338,448
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 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? Yes
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees