FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0046201

Facility Name: Lemont Nrsg & Rehab Center

Address: 12450 Walker Road (Number) Lemont (City) 60539 (Zip Code)

County: Cook

Telephone Number: (630) 243-0400 **Fax #** (630) 243-5063

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2003

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) Lisa M. Hanlon, 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 Lemont Nrsg & Rehab Center # 0046201 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	158	Skilled (SNF)	158	57,670	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	158	TOTALS	158	57,670	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	21,887	10,426	19,009	51,322	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,887	10,426	19,009	51,322	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.99%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 02/01/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 158 and days of care provided 17,942

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 Lemont Nrsg & Rehab Center # 0046201 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	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	327,062	93,470	21,274	441,806		441,806	5,291	447,097			1
2	Food Purchase		399,107		399,107		399,107	(53)	399,054			2
3	Housekeeping	190,460	54,365		244,825		244,825	662	245,487			3
4	Laundry	71,092	31,905		102,997		102,997		102,997			4
5	Heat and Other Utilities			214,718	214,718		214,718	(7,850)	206,868			5
6	Maintenance	94,864		436,712	531,576		531,576	(142,489)	389,087			6
7	Other (specify):*							6,892	6,892			7
8	TOTAL General Services	683,478	578,847	672,704	1,935,029		1,935,029	(137,547)	1,797,482			8
	B. Health Care and Programs											
9	Medical Director			45,000	45,000		45,000		45,000			9
10	Nursing and Medical Records	3,339,038	175,208	126,764	3,641,010		3,641,010	46,590	3,687,600			10
10a	Therapy	246,655			246,655		246,655		246,655			10a
11	Activities	201,883	27,940		229,823		229,823		229,823			11
12	Social Services	228,966			228,966		228,966	21,389	250,355			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							7,832	7,832			15
16	TOTAL Health Care and Programs	4,016,542	203,148	171,764	4,391,454		4,391,454	75,811	4,467,265			16
	C. General Administration											
17	Administrative	161,758			161,758		161,758	96,784	258,542			17
18	Directors Fees											18
19	Professional Services			823,634	823,634	(16,604)	807,030	(679,470)	127,560			19
20	Dues, Fees, Subscriptions & Promotions			98,698	98,698		98,698	(31,971)	66,727			20
21	Clerical & General Office Expenses	168,605	40,686	183,138	392,429		392,429	54,484	446,913			21
22	Employee Benefits & Payroll Taxes			836,372	836,372		836,372	(11,161)	825,211			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,543	4,543		4,543	1,569	6,112			24
25	Other Admin. Staff Transportation			3,362	3,362		3,362	1,407	4,769			25
26	Insurance-Prop.Liab.Malpractice			207,675	207,675		207,675	2,083	209,758			26
27	Other (specify):*							35,386	35,386			27
28	TOTAL General Administration	330,363	40,686	2,157,422	2,528,471	(16,604)	2,511,867	(530,889)	1,980,978			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,030,383	822,681	3,001,890	8,854,954	(16,604)	8,838,350	(592,625)	8,245,725			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 Lemont Nrsg & Rehab Center #0046201 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			129,978	129,978		129,978	229,738	359,716			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							576,350	576,350			32
33	Real Estate Taxes			314,727	314,727	16,604	331,331	52,541	383,872			33
34	Rent-Facility & Grounds			1,860,605	1,860,605		1,860,605	(1,860,000)	605			34
35	Rent-Equipment & Vehicles			8,839	8,839		8,839	827	9,666			35
36	Other (specify):*											36
37	TOTAL Ownership			2,314,149	2,314,149	16,604	2,330,753	(1,000,544)	1,330,209			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,314,261	2,045,514	3,359,775		3,359,775	(152,080)	3,207,695			39
40	Barber and Beauty Shops			326	326		326	(326)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			237,456	237,456		237,456		237,456			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,314,261	2,283,296	3,597,557		3,597,557	(152,406)	3,445,151			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,030,383	2,136,942	7,599,335	14,766,660		14,766,660	(1,745,574)	13,021,086			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 Lemont Nrsg & Rehab Center # 0046201 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	(9,299)	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	85,534	30		9
10	Interest and Other Investment Income	(168,611)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(797)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(899)	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	(92,287)	21		24
25	Fund Raising, Advertising and Promotional	(28,300)	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	(209,880)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (424,539)		$	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)	(1,321,035)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,321,035)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,745,574)		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

Lemont Nrsg & Rehab Center

ID# 0046201

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber and Beauty Shop	$ (326)	40	1
2	State Replacement Tax	(206)	21	2
3	Theft Loss	(494)	21	3
4	Collections Expense	(6,357)	21	4
5	PAC Dues	(4,875)	20	5
6	Building Company - Filing Fees	(250)	20	6
7	Building Company -Amortization	(30,877)	36	7
8	Capitalized R&M	(156,192)	06	8
9	Building Co Legal	(120)	19	9
10	Misc Income	(263)	21	10
11	Jury Duty Income	(168)	21	11
12	Patient Clothing	(312)	10	12
13	Non Allowable Legal	(7,315)	19	13
14	Building Co Bookkeeping	(1,975)	19	14
15	Non Allowable Seminar	(150)	24	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**	(209,880)		49

Lemont Nrsg & Rehab Center

ID# 0046201

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 Lemont Nrsg & Rehab Center # 0046201 **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			166		5,125							5,291	1
2	Food Purchase	(797)		744									(53)	2
3	Housekeeping			557		105							662	3
4	Laundry													4
5	Heat and Other Utilities	(9,299)		1,256		193							(7,850)	5
6	Maintenance	(156,192)		5,183	8,361	159							(142,489)	6
7	Other (specify):*				6,307	585							6,892	7
8	**TOTAL General Services**	(166,288)		7,906	14,668	6,167							(137,547)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(312)				47,217					(315)		46,590	10
10a	Therapy													10a
11	Activities													11
12	Social Services					21,389							21,389	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,832							7,832	15
16	**TOTAL Health Care and Programs**	(312)				76,438					(315)		75,811	16
	C. General Administration													
17	Administrative			3,445	18,624	74,715							96,784	17
18	Directors Fees													18
19	Professional Services	(9,410)	120	(500,945)		(169,235)							(679,470)	19
20	Fees, Subscriptions & Promotions	(34,324)	250	1,830		273							(31,971)	20
21	Clerical & General Office Expenses	(99,775)	1,975	12,531	109,279	30,474							54,484	21
22	Employee Benefits & Payroll Taxes				(11,161)				(0)				(11,161)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(150)		287		1,432							1,569	24
25	Other Admin. Staff Transportation			1,407									1,407	25
26	Insurance-Prop.Liab.Malpractice			1,512		571							2,083	26
27	Other (specify):*				23,558	11,828							35,386	27
28	**TOTAL General Administration**	(143,659)	2,345	(479,933)	140,300	(49,942)			(0)				(530,889)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(310,259)	2,345	(472,027)	154,968	32,663			(0)		(315)		(592,625)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 **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	85,534	138,198	4,660		1,346							229,738	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(168,611)	705,750	1,067		38,144							576,350	32
33	Real Estate Taxes		49,314	2,716		511							52,541	33
34	Rent-Facility & Grounds		(1,860,000)										(1,860,000)	34
35	Rent-Equipment & Vehicles			827									827	35
36	Other (specify):*	(30,877)	30,877											36
37	**TOTAL Ownership**	(113,954)	(935,861)	9,270		40,001							(1,000,544)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(1,603)	(143,881)			(6,595)		(152,080)	39
40	Barber and Beauty Shops	(326)											(326)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(326)					(1,603)	(143,881)			(6,595)		(152,406)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(424,539)	(933,516)	(462,757)	154,968	72,664	(1,603)	(143,881)	(0)		(6,910)		(1,745,574)	45

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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 6-Supplemental		See 6-Supplemental		See 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	Rent	$ 1,860,000	Lemont Property, LLC	100.00%	$	$ (1,860,000)	1
2	V	33	Rent - RE Taxes	314,727	Lemont Property, LLC	100.00%		(314,727)	2
3	V	32	Interest	136,064	Lemont Property, LLC	100.00%	841,814	705,750	3
4	V	21	Bank Service Charge		Lemont Property, LLC	100.00%			4
5	V	20	Filing Fees		Lemont Property, LLC	100.00%	250	250	5
6	V	30	Depreciation		Lemont Property, LLC	100.00%	138,198	138,198	6
7	V	36	Amortization		Lemont Property, LLC	100.00%	30,877	30,877	7
8	V	33	Real Estate Tax		Lemont Property, LLC	100.00%	364,041	364,041	8
9	V	21	Bookkeeping Fees		Lemont Property, LLC	100.00%	1,975	1,975	9
10	V	19	Legal Fees		Lemont Property, LLC	100.00%	120	120	10
11	V		Real Estate Tax	49,315	Lemont Property, LLC	100.00%		(49,315)	11
12	V								12
13	V								13
14	Total			$ 2,360,106			$ 1,377,275	$ * (982,831)	14

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 166	$ 166	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	744	744	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	557	557	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,256	1,256	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	5,183	5,183	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,445	3,445	20
21	V	19	Professional Fees	510,768	Extended Care Consulting, LLC	100.00%	9,823	(500,945)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,830	1,830	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	12,531	12,531	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	287	287	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,407	1,407	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,512	1,512	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	4,660	4,660	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	1,067	1,067	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,716	2,716	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	827	827	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			$ 510,768			$ 48,011	$ * (462,757)	39

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	8,932	$ 8,932	15
16	V	06	Maintenance (Direct)	37,870	Extended Care Consulting, LLC	100.00%	37,299	(571)	16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	847	847	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	5,460	5,460	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	18,624	18,624	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	109,279	109,279	22
23	V	21	Office and Clerical (Direct)		Extended Care Consulting, LLC	100.00%			23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	23,558	23,558	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%			25
26	V	22	Employee Benefits	11,161	Extended Care Consulting, LLC	100.00%		(11,161)	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			$ 49,031			$ 203,999	$ * 154,968	39

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 105	$ 105	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	193	193	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	159	159	17
18	V	19	Professional Fees	170,256	Extended Care Clinical, LLC	100.00%	1,021	(169,235)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	273	273	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,576	1,576	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,432	1,432	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	571	571	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,346	1,346	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	38,144	38,144	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	511	511	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	5,125	5,125	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	585	585	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	47,217	47,217	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	21,389	21,389	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	7,832	7,832	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	74,715	74,715	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	28,898	28,898	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	11,828	11,828	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 170,256			$ 242,920	$ * 72,664	39

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	39	Various Equipment	18,015	Vent Lease LLC	100.00%	16,412	$ (1,603)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 18,015			$ 16,412	$ * (1,603)	39

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	39	Therapy	$ 2,019,215	Tri Care Rehab	100.00%	$ 1,875,333	$ (143,881)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,019,215			$ 1,875,333	$ * (143,881)	39

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 246,273	$ 246,273	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	246,273	CCS Employee Benefits Group	100.00%		(246,273)	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			$ 246,273			$ 246,273	$ * (0)	39

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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 Supplies, Supplements	$ 18,560	Care Centers Health Systems, Inc.	100.00%	$ 18,560	$	15
16	V	39	Ancillary Expense	4,090	Care Centers Health Systems, Inc.	100.00%	4,090		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			$ 22,650			$ 22,650	$ *	39

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	10	Nursing Supplies / Nursing Equip. Rental	1,118	Reliable Medical of the Midwest, LLC	100.00%	803	$ (315)	15
16	V	39	Ancillary Expense	23,422	Reliable Medical of the Midwest, LLC	100.00%	16,827	(6,595)	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			$ 24,540			$ 17,630	$ * (6,910)	39

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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 Lemont Nrsg & Rehab Center # 0046201 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	ROTHNER HEALTH VENTURES G II, LLC	100.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	LEMONT PROPERTY, LLC		BLDG COMPANY	1
2			BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTIN	EVANSTON	MANAGEMENT/BOOKKEEP	2
3			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPLEM	4
5			GRASMERE PLACE, LLC	CHICAGO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	ROTHNER VENTS LLC	EVANSTON	VENTALATOR RENTAL	6
7			MAJOR HOSPITAL DYER	DYER, IN	TRICARE REHAB	HILLSIDE	THERAPY	7
8			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLY	8
9			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN	CARE CENTER BULDING LLC	EVANSTON	BLDG COMPANY	9
10			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				10
11			MAJOR HOSPITAL SEBOS	HOBART, IN				11
12			MCKINLEY HEALTH CARE CENTER	CANTON, OH				12
13			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				13
14			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				14
15			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				15
16			RAINBOW BEACH QOC, L.L.C.	CHICAGO				16
17			SHEFFIELD MANOR	DYER, IN				17
18			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				18
19			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				19
20			ST. JAMES WELLNESS REHAB VILLAS	CRETE				20
21			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				21
22			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				22
23			WHEATON CARE CENTER	WHEATON				23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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 Lemont Nrsg & Rehab Center # 0046201 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	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$		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 Lemont Nrsg & Rehab Center # 0046201 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 Lemont Nrsg & Rehab Center # 0046201 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: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 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	01	Dietary	Patient Days	1,251,572	31	$ 4,057	$	51,322	$ 166	1
2	02	Food	Patient Days	1,251,572	31	18,150		51,322	744	2
3	03	Housekeeping	Patient Days	1,251,572	31	13,578		51,322	557	3
4	05	Utilities	Patient Days	1,251,572	31	30,626		51,322	1,256	4
5	06	Maintenance	Patient Days	1,251,572	31	126,400		51,322	5,183	5
6	17	Administrative	Patient Days	1,251,572	31	84,000		51,322	3,445	6
7	19	Professional Fees	Patient Days	1,251,572	31	239,560		51,322	9,823	7
8	20	Dues and Subscriptions	Patient Days	1,251,572	31	44,626		51,322	1,830	8
9	21	Office and Clerical	Patient Days	1,251,572	31	305,586		51,322	12,531	9
10	24	Seminar and Travel	Patient Days	1,251,572	31	6,989		51,322	287	10
11	25	Other Staff Admin. Trans.	Patient Days	1,251,572	31	34,307		51,322	1,407	11
12	26	Insurance	Patient Days	1,251,572	31	36,877		51,322	1,512	12
13	30	Depreciation	Patient Days	1,251,572	31	113,642		51,322	4,660	13
14	32	Interest	Patient Days	1,251,572	31	26,010		51,322	1,067	14
15	33	Real Estate Taxes	Patient Days	1,251,572	31	66,240		51,322	2,716	15
16	35	Rent - Equipment & Auto	Patient Days	1,251,572	31	20,168		51,322	827	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,170,816	$		$ 48,011	25

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 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	06	Maintenance (Pooled)	Patient Days	1,251,572	31	217,811	217,811	51,322	8,932	1
2	06	Maintenance (Direct)	Direct		31	252,781	252,781		37,299	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,251,572	31	20,665		51,322	847	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	33,212			5,460	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,251,572	31	454,189	454,189	51,322	18,624	7
8	21	Office and Clerical (Pooled)	Patient Days	1,251,572	31	2,664,951	2,664,951	51,322	109,279	8
9	21	Office and Clerical (Direct)	Direct		31	385,321	385,321			9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,251,572	31	574,509		51,322	23,558	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	59,282				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					$ 4,662,721	$ 3,975,053		$ 203,999	25

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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: Extended Care Clinical, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 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	03	Housekeeping	Patient Days	758,409	19	$ 1,549	$	51,322	$ 105	1
2	05	Utilities	Patient Days	758,409	19	2,849		51,322	193	2
3	06	Maintenance	Patient Days	758,409	19	2,348		51,322	159	3
4	19	Professional Fees	Patient Days	758,409	19	15,090		51,322	1,021	4
5	20	Dues and Subscriptions	Patient Days	758,409	19	4,042		51,322	273	5
6	21	Office & Clerical	Patient Days	758,409	19	23,285		51,322	1,576	6
7	24	Travel and Seminar	Patient Days	758,409	19	21,158		51,322	1,432	7
8	26	Insurance	Patient Days	758,409	19	8,431		51,322	571	8
9	30	Depreciation	Patient Days	758,409	19	19,889		51,322	1,346	9
10	32	Interest	Patient Days	758,409	19	563,670		51,322	38,144	10
11	33	Real Estate Taxes	Patient Days	758,409	19	7,558		51,322	511	11
12	01	Dietary Salary	Patient Days	758,409	19	75,731	75,731	51,322	5,125	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	758,409	19	8,645		51,322	585	13
14	10	Nursing Salary	Patient Days	758,409	19	697,742	697,742	51,322	47,217	14
15	12	Social Service Salary	Patient Days	758,409	19	316,078	316,078	51,322	21,389	15
16	15	Emp. Ben. - Healthcare	Patient Days	758,409	19	115,731		51,322	7,832	16
17	17	Administration Salary	Patient Days	758,409	19	1,104,097	1,104,097	51,322	74,715	17
18	21	Office Salary	Patient Days	758,409	19	427,044	427,044	51,322	28,898	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	758,409	19	174,785		51,322	11,828	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,589,719	$ 2,620,691		$ 242,920	25

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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: Vent Lease, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	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	39	Various Equipment	Direct Allocation						16,412	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					$	$		$ 16,412	25

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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: TriCare Rehab
Street Address: 240 Fencl Lane
City / State / Zip Code: Hillside, IL 60162
Phone Number: (773) 449-9400
Fax Number: (773) 449-9700

	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	39	Therapy	Direct Allocation			$	$		$ 1,875,333	1
2	39	Pharmacy	Direct Allocation							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					$	$		$ 1,875,333	25

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	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	22	Employee Health Insurance	Direct Allocation			$	$		$ 246,273	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					$	$		$ 246,273	25

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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: Care Centers Health Systems, Inc.
Street Address: 200 Howard
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: (224) 612-5662
Fax Number: (224) 612-5862

	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 Supplies, Supplements	Direct Allocation			$	$		$ 18,560	1
2	39	Ancillary Expense	Direct Allocation						4,090	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					$	$		$ 22,650	25

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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: Reliable Medical of the Midwest, LLC
Street Address: 200 Howard Avenue
City / State / Zip Code: Des Plaines, Illinois 60018-5909
Phone Number: (847) 566-0800
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	10	Nursing Supplies / Nursing Equip	Direct Allocation						803	1
2	39	Ancillary Expense	Direct Allocation						16,827	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					$	$		$ 17,630	25

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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 Lemont Nrsg & Rehab Center # 0046201 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Cole Taylor		X				$	$ 13,605,000			$ 841,814	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Note Payable - Mattresses		X					94,919				6
7	Note Payable - Computers		X					5,856				7
8												8
9	TOTAL Facility Related						$	$ 13,705,775			$ 841,814	9
	B. Non-Facility Related*											
10	Interest Income		X								(168,611)	10
11	Alloc from Extended Care Consult		X								1,067	11
12	Alloc from Extended Care Clinical		X								38,144	12
13	See Supplemental Schedule										(136,064)	13
14	TOTAL Non-Facility Related						$	$			$ (265,464)	14
15	TOTALS (line 9+line14)						$	$ 13,705,775			$ 576,350	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 Lemont Nrsg & Rehab Center # 0046201 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							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15	Interest Income - Bldg Co.		X				$	$			$ (136,064)	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										(136,064)	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 Lemont Nrsg & Rehab Center # 0046201 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.**	$ 359,164	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.)		$ 356,010	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,154)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 370,422	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.)**		$ 16,604	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 $ 49,315 For 2010 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.		$ 383,872	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	341,908	8
	2010	352,925	9
	2011	326,633	10
	2012	342,061	11
	2013	352,783	12

2014 Accrual: $352,783 x 1.05 = $370,422

Allocated from Extended Care Consulting: $2,716

Allocated from Extended Care Clinical: $511

	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 Lemont Nrsg & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

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.	22-27-300-076-0000	Long Term Care Property	$ 344,564.87	$ 344,564.87
2.	22-27-300-077-0000	Long Term Care Property	$ 8,218.45	$ 8,218.45
3.	See Attached	Alloc from 2201 Main/Care Center	$ 162,082.08	$ 3,074.06
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 514,865.40	$ 355,857.38

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 Lemont Nrsg & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

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 Lemont Nrsg & Rehab Center # 0046201 Report Period Beginning: 01/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,000 B. General Construction Type: Exterior Brick Frame Masonry & Steel Number of Stories 1

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		2003	$ 823,094	1
2	Allocated from 2201 Main/Care Centers Building LLC			15,552	2
3	TOTALS			$ 838,646	3

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	158		2003	1995	$ 5,391,423	$ 138,198	Various	$ 252,705	$ 114,507	$ 3,350,748	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	48,664		20	2,045	2,045	30,974	9
10	Various			2004	35,166		20	1,628	1,628	22,564	10
11	Various			2005	7,375		20	369	369	3,657	11
12	Various			2007	30,675		20	1,809	1,809	13,948	12
13	Various			2008	46,456		20	2,323	2,323	15,182	13
14	Various			2010	120,716		20	6,301	6,301	26,019	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 Lemont Nrsg & Rehab Center # 0046201 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)		67,964	4,293		4,293		47,049	68
69	Financial Statement Depreciation			129,978			(129,978)		69
70	TOTAL (lines 4 thru 69)		$ 5,748,438	$ 272,469		$ 271,473	$ (996)	$ 3,510,141	70

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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		$ 5,748,438	$ 272,469		$ 271,473	$ (996)	$ 3,510,141	1
2	Sprinkler System Repair	2011	2,745		20	137	137	549	2
3	Dry System Repair	2011	5,710		20	286	286	1,118	3
4	Flooring & Trim Renovation	2011	35,000		20	1,750	1,750	5,979	4
5	Blinds	2011	9,834		20	1,967	1,967	7,048	5
6	Flooring & Trim Renovation	2011	35,000		20	1,750	1,750	5,833	6
7	Flooring & Trim Renovations	2011	25,000		20	1,250	1,250	4,167	7
8	Flooring & Trim Renovations	2011	35,000		20	1,750	1,750	5,688	8
9	Flooring & Trim Renovations	2011	80,000		20	4,000	4,000	13,000	9
10	Fuel Injection Pump	2011	5,895		20	295	295	909	10
11	Pipe Repair - Fire Alarm System	2011	3,372		20	169	169	618	11
12	Fire Sprinkler System Repair	2011	6,285		20	314	314	1,152	12
13	Painting	2011	5,547		20	277	277	971	13
14	Painting	2011	6,688		20	334	334	1,143	14
15	Painting	2011	12,721		20	636	636	2,120	15
16	Painting	2011	4,439		20	222	222	721	16
17	Painting	2011	3,660		20	183	183	580	17
18	Painting	2011	3,262		20	163	163	503	18
19	Flooring & Trim	2012	24,700		20	4,940	4,940	13,585	19
20	Landmark Construction - Wood Trim In Hallways, Flooring	2012	25,000		20	5,000	5,000	15,000	20
21	Flooring & Trim Renovation	2012	15,540		20	3,108	3,108	9,324	21
22	Hvac	2012	8,725		20	436	436	945	22
23	Architectual Fees	2012	20,000		20	1,000	1,000	2,667	23
24	Replace 2 Metal Doors	2012	6,185		20	309	309	670	24
25	Painting	2012	2,523		20	126	126	378	25
26	Painting	2012	3,208		20	160	160	468	26
27	Sprinkler System Repair	2012	5,470		20	274	274	707	27
28	New Conduit & Wire For Lighting In North Corridor, Nurse Static	2012	3,900		20	195	195	488	28
29	Installed Wiring, Fire Cable & Transformer	2012	4,558		20	228	228	627	29
30	New Piping In Attic And First Floor	2012	7,534		20	377	377	1,067	30
31	Corridors On All Floors - Painting	2012	35,637		20	1,782	1,782	3,712	31
32	Administration Office Flood Repair Work & Debris Removal	2012	7,000		20	350	350	963	32
33	Nurse Call System	2013	12,239		20	612	612	1,173	33
34	TOTAL (lines 1 thru 33)		$ 6,210,816	$ 272,469		$ 305,853	$ 33,384	$ 3,614,012	34

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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		$ 6,210,816	$ 272,469		$ 305,853	$ 33,384	$ 3,614,012	1
2	Patched Asphalt, Installed Concrete Slabs	2013	5,140		20	257	257	471	2
3	1St & 2Nd Floor Elevators - Piping Skylights & Sprinklers	2013	6,440		20	322	322	590	3
4	Toilet And Sewer Line Repairs; Slab Jacking	2013	3,350		20	168	168	265	4
5	Fire Damper Repairs	2013	2,575		20	515	515	815	5
6	Installed Backflow Preventer For Sprinkler System	2013	7,950		20	398	398	530	6
7	Front Site Lighting And Repair	2013	16,500		20	825	825	1,031	7
8	Sprinklers - Repaired Butterfly Valves From Sprinklers	2013	2,778		20	139	139	162	8
9	Sprinklers - Replaced Dry Valve, Installed New Trim, Accelerator,	2013	5,023		20	251	251	335	9
10	Generator Repair - E-Stop Button And Wiring	2013	2,832		20	142	142	283	10
11	Physical Therapy Rm Remodel: New Carpentry, Framing,	2013	13,350		20	668	668	1,224	11
12	Drywall, New Doors & Frames, Paint Rm & Electrical Work	2013			20				12
13	Remove Concrete Floor In Rom 106, Dig To Find Cause Of	2013	3,400		20	170	170	340	13
14	Sinking Floor Repair And Install New Concrete	2013			20				14
15	Lobby Flooring & Wallcovering, Dining Rm, Skylite & Column	2013	57,717		20	2,886	2,886	5,050	15
16	Crown Molding, Rear Vestibule Flooring, Decorative Floor Logo,	2013			20				16
17	Labor And Materials To Fix Racked Door	2014	3,600		20	105	105	105	17
18	Furnish And Installl A Faux Stucco Monument Sign	2014	13,365		20	223	223	223	18
19	Demetia Shower Rm: Ceiling Replacement, Plumbing Revisions	2014	79,000		20	583	583	583	19
20	Repair Hot Water Tank #3	2014	3,134		20	157	157	157	20
21	Replaced Annunciator On 2Nd Flr Nurses Station	2014	3,539		20	177	177	177	21
22	Repack Fire Pump And Replace Pressure Switch	2014	4,371		20	219	219	219	22
23	Dry System Compressor Repair	2014	3,940		20	197	197	197	23
24	Sprinkler System Repair	2014	3,080		20	154	154	154	24
25	New Compressor For Sprinkler System	2014	4,533		20	227	227	227	25
26	Resident Room Repair:Asbestos Survey, Sawcutting,	2014	21,500		20	448	448	448	26
27	New Flooring, Remove Old Materials	2014			20				27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,477,932	$ 272,469		$ 315,081	$ 42,612	$ 3,627,599	34

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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		$ 6,477,932	$ 272,469		$ 315,081	$ 42,612	$ 3,627,599	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)		$ 6,477,932	$ 272,469		$ 315,081	$ 42,612	$ 3,627,599	34

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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		$ 6,477,932	$ 272,469		$ 315,081	$ 42,612	$ 3,627,599	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)		$ 6,477,932	$ 272,469		$ 315,081	$ 42,612	$ 3,627,599	34

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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 Lemont Nrsg & Rehab Center # 0046201 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
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 Lemont Nrsg & Rehab Center # 0046201 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	Allocated from 2201 Main LLC/Care Centers Building LLC	2002	18,035	462	20	462		5,684	3
4	Allocated from Extended Care Clinical LLC	2002	3,396	87	20	87		1,070	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Extended Care Consulting LLC	2007	189	9	20	9		75	9
10	Allocated from Extended Care Consulting LLC	2009	113	6	20	6		34	10
11	Allocated from Extended Care Consulting LLC	2010	1,106	55	20	55		277	11
12	Allocated from Extended Care Consulting LLC	2011	398	20	20	20		80	12
13	Allocated from Extended Care Consulting LLC	2012	131	7	20	7		20	13
14	Allocated from Extended Care Consulting LLC	2014	1,819	91	20	91		91	14
15									15
16	Allocated from 2201 Main LLC/Care Centers Building LLC	2002	14,899	1,270	20	1,270		14,899	16
17	Allocated from 2201 Main LLC/Care Centers Building LLC	2003	17,557	1,496	20	1,496		17,577	17
18	Allocated from 2201 Main LLC/Care Centers Building LLC	2005	872	93	20	93		778	18
19	Allocated from 2201 Main LLC/Care Centers Building LLC	2009	157	8	20	8		47	19
20	Allocated from 2201 Main LLC/Care Centers Building LLC	2014	2,514	126	20	126		126	20
21									21
22	Allocated from Extended Care Clinical LLC	2002	2,805	239	20	239		2,805	22
23	Allocated from Extended Care Clinical LLC	2003	3,306	282	20	282		3,306	23
24	Allocated from Extended Care Clinical LLC	2005	164	17	20	17		147	24
25	Allocated from Extended Care Clinical LLC	2009	30	1	20	1		9	25
26		2014	473	24	20	24		24	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 67,964	$ 4,293		$ 4,293	$	$ 47,049	34

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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		$ 67,964	$ 4,293		$ 4,293	$	$ 47,049	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)		$ 67,964	$ 4,293		$ 4,293	$	$ 47,049	34

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	$ 220,555	$ 505	$ 37,771	$ 37,266	10	$ 132,992	71
72	Current Year Purchases	151,357	303	5,960	5,657	10	5,960	72
73	Fully Depreciated Assets	466,679				10	466,679	73
74								74
75	TOTALS	$ 838,591	$ 808	$ 43,731	$ 42,923		$ 605,630	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 Extended Care C	2014	$ 7,400	$ 209	$ 209	$	5	$ 6,564	76
77		Allocated from Extended Care Cl	2014	3,477	695	695		5	1,723	77
78										78
79										79
80	TOTALS			$ 10,877	$ 904	$ 904	$		$ 8,287	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)	$ 8,166,046	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 274,181	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 359,715	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 85,534	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,241,517	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	Wing Expansion Architect Fees	$ 85,312	92
93			93
94			94
95		$ 85,312	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 Lemont Nrsg & Rehab Center # 0046201 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 ☐ 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	Conference Room				605			5
6								6
7	TOTAL				$ 605 **			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 ☐ NO
16. Rental Amount for movable equipment: $ 9,666 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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 Lemont Nrsg & Rehab Center # 0046201 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 831,450	$		$ 831,450	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			133,972			133,972	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			1,052,713			1,052,713	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				935,466		935,466	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					27,379	378,795		406,174	13
14	TOTAL			$		$ 2,045,514	$ 1,314,261		$ 3,359,775	14

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	$ 748,379	$ 1,034,346	1
2	Cash-Patient Deposits	27,856	27,856	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,571,101	1,571,101	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	261,262	261,262	6
7	Other Prepaid Expenses	16,515	16,515	7
8	Accounts Receivable (owners or related parties)	4,071,221	12,141,264	8
9	Other(specify):	7,884,745	8,085,890	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 14,581,079	$ 23,138,234	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		823,094	13
14	Buildings, at Historical Cost		5,590,504	14
15	Leasehold Improvements, at Historical Cost	908,249	908,249	15
16	Equipment, at Historical Cost	424,828	424,828	16
17	Accumulated Depreciation (book methods)	(676,412)	(3,467,411)	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):	85,313	154,786	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 741,978	$ 4,434,050	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,323,057	$ 27,572,284	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,093,119	$ 2,093,122	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,679	24,679	28
29	Short-Term Notes Payable	100,775	100,775	29
30	Accrued Salaries Payable	135,896	135,896	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,171	11,171	31
32	Accrued Real Estate Taxes(Sch.IX-B)	370,422	370,422	32
33	Accrued Interest Payable		71,773	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36			76,279	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,736,062	$ 2,884,117	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		13,605,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 13,605,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,736,062	$ 16,489,117	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 12,586,995	$ 11,083,167	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,323,057	$ 27,572,284	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,711,683	1
2	Restatements (describe):		2
3	**Prior Year Bad Debt**	(39,307)	3
4	**Prior Year Dividends**	(126,882)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,545,494	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,042,501	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	(1,001,000)	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)**	$ 1,041,501	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)**	$ 12,586,995	24 *

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	$ 16,639,726	1
2	Discounts and Allowances for all Levels	(10,231,532)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,408,194	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,037,828	6
7	Oxygen	920	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,038,748	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	1,696	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	938,687	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	90,601	19
20	Radiology and X-Ray	75,331	20
21	Other Medical Services	81,173	21
22	Laundry	5,689	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,193,177	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	168,611	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 168,611	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	431	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 431	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,809,161	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,935,029	31
32	Health Care	4,391,454	32
33	General Administration	2,528,471	33
	B. Capital Expense		
34	Ownership	2,314,149	34
	C. Ancillary Expense		
35	Special Cost Centers	3,360,101	35
36	Provider Participation Fee	237,456	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,766,660	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,042,501	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,042,501	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,526,570	44
45	Private Pay - Net Inpatient Revenue	2,275,781	45
46	Medicare - Net Inpatient Revenue	368,668	46
47	Other-(specify) Hospice	239,078	47
48	Other-(specify) Insurance	(1,903)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,408,194	49

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

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

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

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,083	2,345	$ 115,862	$ 49.41	1
2	Assistant Director of Nursing	1,734	1,958	74,129	37.86	2
3	Registered Nurses	28,152	31,099	1,034,516	33.27	3
4	Licensed Practical Nurses	28,409	30,758	878,641	28.57	4
5	CNAs & Orderlies	90,201	97,503	1,185,485	12.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,371	12,681	246,655	19.45	8
9	Activity Director	1,889	2,165	46,643	21.54	9
10	Activity Assistants	15,751	16,852	155,240	9.21	10
11	Social Service Workers	9,355	10,486	228,966	21.84	11
12	Dietician					12
13	Food Service Supervisor	3,605	3,917	91,461	23.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,157	6,908	104,555	15.14	15
16	Dishwashers	13,536	14,463	131,046	9.06	16
17	Maintenance Workers	4,351	4,832	94,864	19.63	17
18	Housekeepers	18,356	20,143	190,460	9.46	18
19	Laundry	6,053	6,764	71,092	10.51	19
20	Administrator	1,905	2,169	129,628	59.76	20
21	Assistant Administrator	1,203	1,296	32,130	24.79	21
22	Other Administrative					22
23	Office Manager	1,928	2,114	30,679	14.51	23
24	Clerical	6,020	6,641	137,926	20.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,091	3,267	50,405	15.43	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	255,150	278,361	$ 5,030,383 *	$ 18.07	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	438	$ 21,274	01-03	35
36	Medical Director	Monthly	45,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,656	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	438	$ 76,930		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	467	$ 28,271	10-03	50
51	Licensed Practical Nurses	753	31,818	10-03	51
52	Certified Nurse Assistants/Aides	2,359	56,019	10-03	52
53	TOTAL (lines 50 - 52)	3,579	$ 116,108		53

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Wendy Janulis	Administrator	0.00%	$ 129,628
Jamie Krieps	Assistant Admin	0.00%	3,917
Leigh Drew	Assistant Admin	0.00%	28,213
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 161,758

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Rothblatt, and Ruttenberg	Accounting	$ 25,698
Personal Planners	Unemployment Consultant	3,588
Pro Payroll Solutions	Payroll Processing	24,756
E-Health Data Solutions	MDS Software Fee	2,385
AIS Assessment & Intelligence	Customer Satisfaction Survey	1,329
Ability Network	Medicare Billing	1,854
National Datacare Corporation	Resident Fund Processing	1,025
Online MSDS	MSDS Management	629
Pinnacle Consulting	Customer Satisf. Survey	3,164
Limitless Technology	Cost Reduction Services	18,078
Legat Architects	Architectural Services	8,361
See Supplemental Schedule		732,766
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 823,633

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 128,436
Unemployment Compensation Insurance	154,372
FICA Taxes	373,704
Employee Health Insurance	134,980
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	11,572
Holiday Expense	9,514
Other Employee Welfare	12,633
TOTAL (agree to Schedule V, line 22, col.8)	$ 825,211

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	21,920
Health Care Worker Background Check	13,491
(Indicate # of checks performed 1266)	
Patient Background Checks	
Dues and Subscriptions	16,224
Licenses and Fees	10,999
Alloc. from Extended Care Consulting	1,830
Alloc. from Extended Care Clinical	273
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 66,727

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,393
Alloc. from Extended Care Consulting	287
Alloc. from Extended Care Clinical	1,432
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,112

**See instructions.

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on Long Term Care $14,773**

(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. $ **66,498** 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. $ **237,456**
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? **N/A** 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? **None**
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.