FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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

I. IDPH License ID Number: 0052183

Facility Name: Capitol Healthcare And Rehabilitation Centre, Llc

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

County: Sangamon

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	251	Skilled (SNF)	251	91,615	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	251	TOTALS	251	91,615	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	45,023	4,377	11,943	61,343	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,023	4,377	11,943	61,343	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.96%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 251 and days of care provided 6,543

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centr # 0052183 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	431,662	117,139	22,417	571,218		571,218	73	571,291			1
2	Food Purchase		336,626		336,626		336,626	(240)	336,386			2
3	Housekeeping	148,628	45,900	186,132	380,660		380,660	1,432	382,092			3
4	Laundry	68,375	30,816	124,230	223,421		223,421		223,421			4
5	Heat and Other Utilities			370,266	370,266		370,266	(52,835)	317,431			5
6	Maintenance	96,321	14,794	128,525	239,640		239,640	25,689	265,329			6
7	Other (specify):*											7
8	**TOTAL General Services**	744,986	545,275	831,570	2,121,831		2,121,831	(25,881)	2,095,950			8
	B. Health Care and Programs											
9	Medical Director			73,105	73,105		73,105	392	73,497			9
10	Nursing and Medical Records	3,432,972	380,492	147,405	3,960,869		3,960,869	28,043	3,988,912			10
10a	Therapy	65,195		684	65,879		65,879		65,879			10a
11	Activities	163,875	7,623		171,498		171,498	12	171,510			11
12	Social Services	264,874			264,874		264,874	7,033	271,907			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							11,429	11,429			15
16	**TOTAL Health Care and Programs**	3,926,916	388,115	221,194	4,536,225		4,536,225	46,909	4,583,134			16
	C. General Administration											
17	Administrative	142,868		162,445	305,313		305,313	(127,599)	177,714			17
18	Directors Fees											18
19	Professional Services			420,686	420,686		420,686	(263,070)	157,616			19
20	Dues, Fees, Subscriptions & Promotions			166,602	166,602		166,602	(75,495)	91,107			20
21	Clerical & General Office Expenses	245,061	42,212	758,588	1,045,861		1,045,861	(394,405)	651,456			21
22	Employee Benefits & Payroll Taxes			817,973	817,973		817,973	(90,159)	727,814			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,240	6,240		6,240	69	6,309			24
25	Other Admin. Staff Transportation			42,911	42,911		42,911	3,850	46,761			25
26	Insurance-Prop.Liab.Malpractice			134,463	134,463		134,463	787	135,250			26
27	Other (specify):*							64,839	64,839			27
28	**TOTAL General Administration**	387,929	42,212	2,509,908	2,940,049		2,940,049	(881,183)	2,058,866			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,059,831	975,602	3,562,672	9,598,105		9,598,105	(860,155)	8,737,950			29

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

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc #0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			153,201	153,201		153,201	418,850	572,051			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,797	33,797		33,797	(33,797)	0			32
33	Real Estate Taxes			98,068	98,068		98,068	5,545	103,613			33
34	Rent-Facility & Grounds			1,400,000	1,400,000		1,400,000	(1,400,000)	0			34
35	Rent-Equipment & Vehicles			27,684	27,684		27,684	(12,850)	14,834			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,712,750	1,712,750		1,712,750	(1,022,251)	690,499			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		423,048	2,031,906	2,454,954		2,454,954		2,454,954			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			456,110	456,110		456,110		456,110			42
43	Other (specify):*	46,320		45,180	91,500		91,500	(91,500)				43
44	**TOTAL Special Cost Centers**	46,320	423,048	2,533,196	3,002,564		3,002,564	(91,500)	2,911,064			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,106,151	1,398,650	7,808,618	14,313,419		14,313,419	(1,973,906)	12,339,513			45

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Reference	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	(45,030)	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	407,333	30		9
10	Interest and Other Investment Income	(5,913)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(240)	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	(31,388)	21		18
19	Entertainment				19
20	Contributions	(7,250)	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	(444,315)	21		24
25	Fund Raising, Advertising and Promotional	(71,435)	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	(1,733,915)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,932,152)		$	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)	(41,754)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (41,754)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,973,906)		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

STATE OF ILLINOIS

Capitol Healthcare And Rehabilitation Centre, Llc

ID# **0052183**

Report Period Beginning: **01/01/15**

Ending: **12/31/15**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Income	$ (3,651)	21	1
2	Marketing Consultant	(45,180)	43	2
3	Bank Charges	(12,478)	21	3
4	Marketing Salaries	(46,320)	43	4
5	Theft and Loss	(4,698)	21	5
6	Medicare Sequestration	(74,008)	21	6
7	Non-allowable Interest	(33,797)	32	7
8	Non-Allowable Auto Lease	(13,706)	35	8
9	Non-Allowable Legal	(3,731)	19	9
10	Additional R&M	14,232	06	10
11	Capitalized R&M	(4,000)	06	11
12	Medical Records	(375)	10	12
13	Unemployment Security Tax Refund	(90,159)	22	13
14	PPA- Sewer Surcharge	(10,771)	05	14
15	PPA Expense	(2,385)	21	15
16	PAC Dues	(2,888)	20	16
17	Rent for Sale Leaseback Arrangement	(1,400,000)	34	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**	(1,733,915)		49

Capitol Healthcare And Rehabilitation Centre, Llc

ID# 0052183

Report Period Beginning: 01/01/15

Ending: 12/31/15

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary			73									73	1
2	Food Purchase	(240)											(240)	2
3	Housekeeping			1,419	13								1,432	3
4	Laundry													4
5	Heat and Other Utilities	(55,801)		2,520	445								(52,835)	5
6	Maintenance	10,232		14,810	647								25,689	6
7	Other (specify):*													7
8	**TOTAL General Services**	(45,809)		18,822	1,106								(25,881)	8
	B. Health Care and Programs													
9	Medical Director			392									392	9
10	Nursing and Medical Records	(375)		28,418									28,043	10
10a	Therapy													10a
11	Activities			12									12	11
12	Social Services			7,033									7,033	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			11,429									11,429	15
16	**TOTAL Health Care and Programs**	(375)		47,285									46,909	16
	C. General Administration													
17	Administrative			34,846		(162,445)							(127,599)	17
18	Directors Fees													18
19	Professional Services	(3,731)		(260,080)	156	584							(263,070)	19
20	Fees, Subscriptions & Promotions	(81,573)		6,070	8								(75,495)	20
21	Clerical & General Office Expenses	(572,923)		178,431	87								(394,405)	21
22	Employee Benefits & Payroll Taxes	(90,159)											(90,159)	22
23	Inservice Training & Education													23
24	Travel and Seminar			69									69	24
25	Other Admin. Staff Transportation			537		3,313							3,850	25
26	Insurance-Prop.Liab.Malpractice			495	291								787	26
27	Other (specify):*			64,839									64,839	27
28	**TOTAL General Administration**	(748,386)		25,208	542	(158,548)							(881,183)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(794,570)		91,315	1,648	(158,548)							(860,155)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc **#** 0052183 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	407,333		8,551	2,966								418,850	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(39,710)			5,913								(33,797)	32
33	Real Estate Taxes				5,545								5,545	33
34	Rent-Facility & Grounds	(1,400,000)		12,561	(12,561)								(1,400,000)	34
35	Rent-Equipment & Vehicles	(13,706)		856									(12,850)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(1,046,083)		21,968	1,863								(1,022,251)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(91,500)											(91,500)	43
44	**TOTAL Special Cost Centers**	(91,500)											(91,500)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,932,152)		113,283	3,511	(158,548)							(1,973,906)	45

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] 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			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$	MOSAIC HEALTHCARE	100.00%	$ 73	$ 73	15
16	V	3	HOUSEKEEPING		MOSAIC HEALTHCARE	100.00%	1,419	1,419	16
17	V	5	UTILITIES		MOSAIC HEALTHCARE	100.00%	2,520	2,520	17
18	V	6	REPAIRS AND MAINT.		MOSAIC HEALTHCARE	100.00%	14,810	14,810	18
19	V	9	MEDICAL DIRECTOR		MOSAIC HEALTHCARE	100.00%	392	392	19
20	V	10	NURSING SALARIES	45,180	MOSAIC HEALTHCARE	100.00%	73,598	28,418	20
21	V	11	ACTIVITIES		MOSAIC HEALTHCARE	100.00%	12	12	21
22	V	12	SOCIAL SERVICE SALARIES		MOSAIC HEALTHCARE	100.00%	7,033	7,033	22
23	V	15	NURSING EMP BENS & PR TAXES		MOSAIC HEALTHCARE	100.00%	11,429	11,429	23
24	V	17	ADMINISTRATIVE SALARIES		MOSAIC HEALTHCARE	100.00%	34,846	34,846	24
25	V	19	PROFESSIONAL FEES		MOSAIC HEALTHCARE	100.00%	(4,060)	(4,060)	25
26	V	20	FEES, SUBSCRIPTIONS		MOSAIC HEALTHCARE	100.00%	6,070	6,070	26
27	V	21	CLERICAL AND GENERAL SALARIES		MOSAIC HEALTHCARE	100.00%	229,263	229,263	27
28	V	21	CLERICAL AND GENERAL EXP	75,300	MOSAIC HEALTHCARE	100.00%	24,468	(50,832)	28
29	V	24	SEMINARS		MOSAIC HEALTHCARE	100.00%	69	69	29
30	V	25	ADMIN. STAFF TRANS.		MOSAIC HEALTHCARE	100.00%	537	537	30
31	V	26	INSURANCE		MOSAIC HEALTHCARE	100.00%	495	495	31
32	V	27	GEN. ADMIN. EMP. BEN.		MOSAIC HEALTHCARE	100.00%	64,839	64,839	32
33	V	30	DEPRECIATION		MOSAIC HEALTHCARE	100.00%	8,551	8,551	33
34	V	32	INTEREST EXPENSE		MOSAIC HEALTHCARE	100.00%			34
35	V	34	RENT - BUILDING (RELATED)		MOSAIC HEALTHCARE	100.00%	12,561	12,561	35
36	V	35	EQUIPMENT RENTAL		MOSAIC HEALTHCARE	100.00%	856	856	36
37	V	19	BOOKKEEPING	210,840	MOSAIC HEALTHCARE	100.00%		(210,840)	37
38	V	19	ADMINISTRATIVE CONSULTANT	45,180	MOSAIC HEALTHCARE	100.00%		(45,180)	38
39	Total			$ 376,500			$ 489,783	$ * 113,283	39

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	3	HOUSEKEEPING	$	4600 TOUHY, LLC	100.00%	$ 13	$ 13	15
16	V	5	UTILITIES		4600 TOUHY, LLC	100.00%	445	445	16
17	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	647	647	17
18	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	156	156	18
19	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	8	8	19
20	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	87	87	20
21	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	291	291	21
22	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	2,966	2,966	22
23	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	5,913	5,913	23
24	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	5,545	5,545	24
25	V								25
26	V	34	RENT	12,561	4600 TOUHY, LLC	100.00%		(12,561)	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			$ 12,561			$ 16,072	$ * 3,511	39

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	19	PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	584	$ 584	15
16	V	25	TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	3,313	3,313	16
17	V								17
18	V	17	MANAGEMENT FEES	162,445	TETRAD MANAGEMENT, LLC	100.00%		(162,445)	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			$ 162,445			$ 3,897	$ * (158,548)	39

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Cent # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											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 Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	491,775	10	$ 583	$	61,343	$ 73	1
2	3	HOUSEKEEPING	PATIENT DAYS	491,775	10	11,376		61,343	1,419	2
3	5	UTILITIES	PATIENT DAYS	491,775	10	20,206		61,343	2,520	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	491,775	10	118,728		61,343	14,810	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	491,775	10	3,145		61,343	392	5
6	10	NURSING SALARIES	PATIENT DAYS	491,775	10	590,024	590,024	61,343	73,598	6
7	11	ACTIVITIES	PATIENT DAYS	491,775	10	95		61,343	12	7
8	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	491,775	10	56,383	56,383	61,343	7,033	8
9	15	NURSING EMP BENS & PR TAX	PATIENT DAYS	491,775	10	91,625		61,343	11,429	9
10	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	491,775	10	279,351	279,351	61,343	34,846	10
11	19	PROFESSIONAL FEES	PATIENT DAYS	491,775	10	(32,545)		61,343	(4,060)	11
12	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	491,775	10	48,662		61,343	6,070	12
13	21	CLERICAL AND GENERAL SAI	PATIENT DAYS	491,775	10	1,837,959	1,837,959	61,343	229,263	13
14	21	CLERICAL AND GENERAL EX	PATIENT DAYS	491,775	10	196,155		61,343	24,468	14
15	24	SEMINARS	PATIENT DAYS	491,775	10	556		61,343	69	15
16	25	ADMIN. STAFF TRANS.	PATIENT DAYS	491,775	10	4,308		61,343	537	16
17	26	INSURANCE	PATIENT DAYS	491,775	10	3,971		61,343	495	17
18	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	491,775	10	519,798		61,343	64,839	18
19	30	DEPRECIATION	PATIENT DAYS	491,775	10	68,552		61,343	8,551	19
20	32	INTEREST EXPENSE	PATIENT DAYS	491,775	10			61,343		20
21	34	RENT - BUILDING (RELATED)	PATIENT DAYS	491,775	10	100,700		61,343	12,561	21
22	35	EQUIPMENT RENTAL	PATIENT DAYS	491,775	10	6,863		61,343	856	22
23										23
24										24
25	TOTALS					$ 3,926,495	$ 2,763,717		$ 489,783	25

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSKEEPING	MNGCR. PATIENT DAYS	491,775	10	$ 107	$	61,343	$ 13	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	491,775	10	3,569		61,343	445	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	491,775	10	5,190		61,343	647	3
4	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	491,775	10	1,250		61,343	156	4
5	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	491,775	10	63		61,343	8	5
6	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	491,775	10	698		61,343	87	6
7	26	INSURANCE	MNGCR. PATIENT DAYS	491,775	10	2,336		61,343	291	7
8	30	DEPRECIATION	MNGCR. PATIENT DAYS	491,775	10	23,779		61,343	2,966	8
9	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	491,775	10	47,406		61,343	5,913	9
10	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	491,775	10	44,453		61,343	5,545	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 128,850	$		$ 16,072	25

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	491,775	10	4,682		61,343	584	1
2	25	TRAVEL	PATIENT DAYS	491,775	10	26,559		61,343	3,313	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					$ 31,241	$		$ 3,897	25

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Allocated from Mosaic Healthcare		X								5,913	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 5,913	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,913)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,913)	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

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** 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							$	$			$	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							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc **#** 0052183 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 77,542	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.)		$ 103,884	2
3. Under or (over) accrual (line 2 minus line 1).		$ 26,342	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 77,271	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 103,613	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010		8
2011		9
2012	74,136	10
2013	96,145	11
2014	98,339	12

Allocated from 4600 Touhy, LLC - $5,545

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Capitol Healthcare And Rehabilitation Centre, Llc COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0052183

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-28.0-401-018	Long Term Care Property	$ 94,209.44	$ 94,209.44
2.	14-28.0-401-006	Long Term Care Property	$ 4,129.74	$ 4,129.74
3.	See Attached	Allocated From 4600 Touhy, LLC	$ 86,316.15	$ 5,383.45
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 184,655.33	$ 103,722.63

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

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

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Capitol Healthcare And Rehabilitation Centre, Llc COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0052183

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2013	$ 895,459	1
2	Allocated from 4600 Touhy LLC			11,226	2
3	TOTALS			$ 906,685	3

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	251		2013	1975	$ 7,724,626	$	35	$ 220,704	$ 220,704	$ 662,112	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

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)		130,774	3,761		5,472	1,711	21,229	68
69	Financial Statement Depreciation			153,201			(153,201)		69
70	TOTAL (lines 4 thru 69)		$ 7,855,400	$ 156,962		$ 226,176	$ 69,214	$ 683,341	70

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,855,400	$ 156,962		$ 226,176	$ 69,214	$ 683,341	1
2	Painting Of South Elevation	2013	7,940		20	794	794	2,051	2
3	Installed 10 New 2 Inch Copper Clad Boiler Tubes	2013	9,375		20	938	938	2,500	3
4	Rebranding Of Signage	2013	4,407		20	220	220	569	4
5	Installed Dome Camera At Dock Door, Installed Delayed Egress S	2013	2,795		20	559	559	1,351	5
6	Water Heater	2013	12,989		20	649	649	1,380	6
7	Fixed Wiring For Nurse Call System	2014	5,286		20	264	264	463	7
8	Installed 17 Emergency Pull Cords & 14 Bed Visual Stations	2014	8,495		20	1,699	1,699	2,832	8
9	Installed 2 Hydraulic Jacks In Elevator	2014	17,425		20	871	871	1,307	9
10	Installed 4 Accutech Door Packs	2014	5,705		20	285	285	380	10
11	Installed Soft Started In #1 Passenger Elevator	2014	2,850		20	143	143	166	11
12	Installed New Water Heater For Entire Building	2014	12,560		20	628	628	1,256	12
13	Installed New Generator For Entire Facility	2014	28,017		20	1,401	1,401	1,985	13
14	Installed New Hvac	2014	2,742		20	137	137	251	14
15	Painted Parking Lot Stripes & Exterior Handrails In Upper & Lo	2014	3,500		20	175	175	277	15
16	Installed New Signage For Exits And Resident Room Numbers	2014	6,614		20	331	331	634	16
17	Installed 1 Traditional Slope Style Awning	2014	3,571		20	179	179	298	17
18	Installed New Fence Around Building	2014	11,390		20	570	570	902	18
19	3Rd Floor Resident Room-Paint Walls & Ceiling, Install Cabinets	2014	217,149		20	10,857	10,857	17,191	19
20	3Rd Floor Corridor-Paint Door Frames, Installed Door Guards, F	2014	60,479		20	3,024	3,024	4,788	20
21	Therapy / Dining Rm-Install Sink, Faucet, Countertops, Fixtures,	2014	32,028		20	1,601	1,601	2,536	21
22	3Rd Floor Bathrooms-Installed Vanity Tops, Toilet Doors, Floorin	2014	168,834		20	8,442	8,442	13,366	22
23	Supervision & Moblization Storage For 3Rd Floor Renovation	2014	55,750		20	2,788	2,788	4,414	23
24	Install Handles On Corridor Doors, Vanity Lights, Light Fixtures	2014	67,437		20	3,372	3,372	5,339	24
25	Resident Rms 320, 322, 327, 329 - Install New Bath Tubs	2014	15,600		20	780	780	1,235	25
26	Installed New Cabinets, Countertops, Sink, Faucet, Stove, Therapi	2014	6,955		20	348	348	551	26
27	Replaced 4 Shut Off Valves	2014	2,590		20	130	130	205	27
28	3Rd Floor Restrooms-Paint, Install New Sink, Faucet, Toliet, Mirr	2014	3,708		20	185	185	294	28
29	3Rd Floor Showers - Replace Floor, Plumbing, Fixtures, Shower V	2014	77,510		20	3,876	3,876	6,136	29
30	Paint Doors In 3Rd Floor Corridor	2014	17,873		20	894	894	1,415	30
31	Install Carpet In Main Entrance, Dining, Conference Rm, Admini	2014	51,480		20	2,574	2,574	4,076	31
32	Replace Pressure Backflow Preventer Assembly	2015	7,544		20	314	314	314	32
33	Installation Of Telephone System	2015	17,088		20	1,424	1,424	1,424	33
34	TOTAL (lines 1 thru 33)		$ 8,803,087	$ 156,962		$ 276,626	$ 119,664	$ 765,224	34

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,803,087	$ 156,962		$ 276,626	$ 119,664	$ 765,224	1
2	Installed Fire Doors	2015	10,796		20	360	360	360	2
3	Installation Of New Windows For 3Rd Floor Lounge	2015	3,300		20	110	110	110	3
4	Install Commercial Carpet Tiles	2015	4,136		20	207	207	207	4
5	2 Ton Condensing Unit For The Nurses Station	2015	3,181		20	265	265	265	5
6	4 Ptac Air Conditioner	2015	2,925		20	341	341	341	6
7	Painting 3Rd Floor Wing Hallway Walls	2015	4,000		20	200	200	200	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,831,425	$ 156,962		$ 278,108	$ 121,146	$ 766,706	34

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,831,425	$ 156,962		$ 278,108	$ 121,146	$ 766,706	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,831,425	$ 156,962		$ 278,108	$ 121,146	$ 766,706	34

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 8,831,425	$ 156,962		$ 278,108	$ 121,146	$ 766,706	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
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17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,831,425	$ 156,962		$ 278,108	$ 121,146	$ 766,706	34

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3									3
4	Allocated from 4600 Touhy, LLC	2012	64,048	1,642	35	2,135	493	8,540	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from Mosaic Healthcare	2013	1,075	206	20	54	(152)	161	10
11	Allocated from Mosaic Healthcare	2012	13,372	589	20	669	80	2,674	11
12									12
13									13
14	Allocated from 4600 Touhy, LLC	2012	41,246	1,062	20	2,062	1,000	8,249	14
15	Allocated from 4600 Touhy, LLC	2013	10,036	236	20	502	266	1,505	15
16	Allocated from 4600 Touhy, LLC	2014	997	26	20	50	24	100	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)		$ 130,774	$ 3,761		$ 5,472	$ 1,711	$ 21,229	34

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 130,774	$ 3,761		$ 5,472	$ 1,711	$ 21,229	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 130,774	$ 3,761		$ 5,472	$ 1,711	$ 21,229	34

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,757,467	$ 7,335	$ 286,828	$ 279,493	10	$ 781,542	71
72	Current Year Purchases	59,226		7,114	7,114	10	7,114	72
73	Fully Depreciated Assets	31,174				10	31,174	73
74								74
75	TOTALS	$ 2,847,868	$ 7,335	$ 293,943	$ 286,608		$ 819,830	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 Mosaic Healthcar	2015	$ 11,850	$ 421	$	$ (421)	5	$ 11,850	76
77										77
78										78
79										79
80	TOTALS			$ 11,850	$ 421	$	$ (421)		$ 11,850	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,597,828	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 164,718	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 572,051	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 407,333	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,598,387	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ARC Healthcare II Operating Partnership (Sale Leaseback Arrangement)
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		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:		251		$ 1,400,000			3
4	Additions							4
5					(1,400,000)			5
6								6
7	TOTAL		251		$ **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 6,500 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2012 Dodge	$ 694.52	$ 8,334	17
18					18
19					19
20					20
21	TOTAL		$ 694.52	$ 8,334	21

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

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$		$ 787,326	$		$ 787,326	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			228,057			228,057	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			778,220			778,220	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				398,397		398,397	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					238,303	24,651		262,954	13
14	TOTAL			$		$ 2,031,906	$ 423,048		$ 2,454,954	14

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

STATE OF ILLINOIS

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (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	$ 6,755	$	1
2	Cash-Patient Deposits	34,473		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,114,939		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	176,994		6
7	Other Prepaid Expenses	37,964		7
8	Accounts Receivable (owners or related parties)	22,549		8
9	Other(specify):	13,075		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,406,749	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,244,759		15
16	Equipment, at Historical Cost	378,685		16
17	Accumulated Depreciation (book methods)	(264,654)		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):	755,616		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,114,406	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,521,155	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,185,738	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,473		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	242,359		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,592		31
32	Accrued Real Estate Taxes(Sch.IX-B)	77,271		32
33	Accrued Interest Payable	1,189		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	4,157,860		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,729,482	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	8,532		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 8,532	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,738,014	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (216,859)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,521,155	$	48

*(See instructions.)

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc **#** 0052183 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,493,955	1
2	Restatements (describe):		2
3	**Late Journal Entries**	(732,131)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 761,824	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,690,172)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	711,489	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (978,683)	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)**	$ (216,859)	24 *

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

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,856,096	1
2	Discounts and Allowances for all Levels	(3,535,446)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,320,650	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,824,738	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,824,738	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	341,493	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,041	19
20	Radiology and X-Ray	7,341	20
21	Other Medical Services	7,394	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 372,269	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,053	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,053	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	99,537	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 99,537	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,623,247	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,121,831	31
32	Health Care	4,536,225	32
33	General Administration	2,940,049	33
	B. Capital Expense		
34	Ownership	1,712,750	34
	C. Ancillary Expense		
35	Special Cost Centers	2,546,454	35
36	Provider Participation Fee	456,110	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,313,419	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,690,172)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,690,172)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,313,559	44
45	Private Pay - Net Inpatient Revenue	1,401,533	45
46	Medicare - Net Inpatient Revenue	967,373	46
47	Other-(specify) Hospice	339,993	47
48	Other-(specify) Insurance	298,192	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,320,650	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 Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	2,080	$ 96,889	$ 46.58	1
2	Assistant Director of Nursing	1,728	1,768	60,833	34.41	2
3	Registered Nurses	17,252	18,242	592,466	32.48	3
4	Licensed Practical Nurses	51,167	55,173	1,284,398	23.28	4
5	CNAs & Orderlies	110,054	115,879	1,357,404	11.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,008	2,088	65,195	31.22	8
9	Activity Director	2,642	2,805	47,809	17.04	9
10	Activity Assistants	9,839	10,470	116,066	11.09	10
11	Social Service Workers	8,932	9,506	174,049	18.31	11
12	Dietician					12
13	Food Service Supervisor	4,626	4,761	82,461	17.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,265	32,135	349,201	10.87	15
16	Dishwashers					16
17	Maintenance Workers	5,856	6,293	96,321	15.31	17
18	Housekeepers	15,565	16,379	148,628	9.07	18
19	Laundry	6,172	6,728	68,375	10.16	19
20	Administrator	1,728	1,782	102,099	57.29	20
21	Assistant Administrator	1,563	1,745	40,769	23.36	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,679	16,769	245,061	14.61	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	2,844	3,033	40,982	13.51	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	7,845	8,450	137,145	16.23	33
34	TOTAL (lines 1 - 33)	297,725	316,086	$ 5,106,151 *	$ 16.15	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		$ 22,417	01-03	35
36	Medical Director	Monthly	73,105	09-03	36
37	Medical Records Consultant	Quarterly	1,020	10-03	37
38	Nurse Consultant	Monthly	75,300	10-03	38
39	Pharmacist Consultant	Monthly	20,302	10-03	39
40	Physical Therapy Consultant	3	176	10a-03	40
41	Occupational Therapy Consultant	0.5	20	10a-03	41
42	Respiratory Therapy Consultant	8	488	10a-03	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)	11	$ 192,828		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	185	$ 9,254	10-03	50
51	Licensed Practical Nurses	1,038	41,529	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,223	$ 50,783		53

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rachel Cassella	Administrator	0	$ 46,725
Jason Young	Administrator	0	55,374
Kim Willis	Asst. Administrator	0	37,164
Apple Glover	Asst. Administrator	0	3,605
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 142,868

B. Administrative - Other

Description	Amount
Management Fees - Tetrad Management	$ 162,445
TOTAL (agree to Schedule V, line 17, col. 3)	$ 162,445
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 59,198
FR&R/Marcum LLP	Accounting	18,780
Personnel Planners	Unemployment Consulting	11,250
Mosaic Healthcare	Bookkeeping	210,840
Achieve Accreditation	Accrediation Assistance	16,406
Ability Network, Inc	Billing Software	4,742
Smartlinx Solutions	Workforce Management	4,894
Galaxy Hosted Software	Clinical & Financial Software	1,672
eHealth Data Solutions	MDS Software	218
HealthMEDX	EMR Software	39,607
Creative Technology Solutions	Computer Services	1,195
See Supplemental Schedule		51,886
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 420,686

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,617
Unemployment Compensation Insurance	97,487
FICA Taxes	380,714
Employee Health Insurance	132,457
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	52,079
Safe Harbor Match Expense	6,460
TOTAL (agree to Schedule V, line 22, col.8)	$ 727,814

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	$
Advertising: Employee Recruitment	44,273
Health Care Worker Background Check	
(Indicate # of checks performed 754)	7,548
Patient Background Checks	
Dues and Subscriptions	26,270
Licenses and Permits	6,938
Allocated from Mosaic Healthcare	6,070
Allocated from 4600 Touhy, LLC	8
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 91,106

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,240
Allocated from Mosaic Healthcare	69
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,309

**See instructions.

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 Report Period Beginning: 01/01/15 Ending: 12/31/15

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													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Capitol Healthcare And Rehabilitation Centre, Llc # 0052183 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $26,933**

(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. $ **29,195** 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? **Yes**
If YES, give effective date of lease. **12/31/2014**

(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. $ **456,110**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.