

		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.

<p>I. IDPH License ID Number: <u>0052167</u></p> <p>Facility Name: <u>Colonial Healthcare And Rehabilitation Centre, Llc</u></p> <p>Address: <u>515 Bureau Valley Parkway</u> <u>Princeton</u> <u>61356</u> Number City Zip Code</p> <p>County: <u>Bureau</u></p> <p>Telephone Number: <u>(815) 875-3347</u> Fax # <u>(815) 875-2012</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1/1/2013</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/15</u> to <u>12/31/15</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="4" style="width: 20%;">Paid Preparer</td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) _____	(Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc

0052167 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>92</u>	Skilled (SNF)	<u>92</u>	<u>33,580</u>	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	<u>92</u>	TOTALS	<u>92</u>	<u>33,580</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	<u>13,029</u>	<u>10,099</u>	<u>3,397</u>	<u>26,525</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,029</u>	<u>10,099</u>	<u>3,397</u>	<u>26,525</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.99%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 92 and days of care provided 2,919

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES 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 Colonial Healthcare And Rehabilitation Cent # 0052167 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	227,337	36,617	7,344	271,298		271,298	31	271,329		1
2	Food Purchase		143,960		143,960		143,960	(2,326)	141,634		2
3	Housekeeping	56,461	11,993	68,071	136,525		136,525	619	137,144		3
4	Laundry	19,735	9,974	45,381	75,090		75,090		75,090		4
5	Heat and Other Utilities			102,103	102,103		102,103	(4,771)	97,332		5
6	Maintenance	58,741	6,584	46,667	111,992		111,992	14,125	126,117		6
7	Other (specify):*										7
8	TOTAL General Services	362,274	209,128	269,566	840,968		840,968	7,679	848,647		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	170	12,170		9
10	Nursing and Medical Records	1,456,828	57,188	33,276	1,547,292		1,547,292	15,264	1,562,556		10
10a	Therapy			531	531		531		531		10a
11	Activities	58,180	6,380	832	65,392		65,392	5	65,397		11
12	Social Services	36,760			36,760		36,760	3,041	39,801		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							4,942	4,942		15
16	TOTAL Health Care and Programs	1,551,768	63,568	46,639	1,661,975		1,661,975	23,422	1,685,397		16
	C. General Administration										
17	Administrative	91,738		100,367	192,105		192,105	(85,300)	106,805		17
18	Directors Fees										18
19	Professional Services			161,064	161,064		161,064	(99,734)	61,330		19
20	Dues, Fees, Subscriptions & Promotions			60,913	60,913		60,913	(36,925)	23,988		20
21	Clerical & General Office Expenses	102,744	22,730	318,141	443,615		443,615	(143,026)	300,589		21
22	Employee Benefits & Payroll Taxes			309,115	309,115		309,115		309,115		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,328	2,328		2,328	(6)	2,322		24
25	Other Admin. Staff Transportation			8,495	8,495		8,495	551	9,046		25
26	Insurance-Prop.Liab.Malpractice			62,540	62,540		62,540	340	62,880		26
27	Other (specify):*							28,036	28,036		27
28	TOTAL General Administration	194,482	22,730	1,022,963	1,240,175		1,240,175	(336,063)	904,112		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,108,524	295,426	1,339,168	3,743,118		3,743,118	(304,962)	3,438,156		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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			24,071	24,071		24,071	211,267	235,338			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			902	902		902	(902)	(0)			32
33	Real Estate Taxes			(38,149)	(38,149)		(38,149)	2,398	(35,751)			33
34	Rent-Facility & Grounds			566,663	566,663		566,663	(566,663)	0			34
35	Rent-Equipment & Vehicles			12,309	12,309		12,309	370	12,679			35
36	Other (specify):*											36
37	TOTAL Ownership			565,796	565,796		565,796	(353,530)	212,266			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		79,937	470,968	550,905		550,905		550,905			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			191,631	191,631		191,631		191,631			42
43	Other (specify):*	39,153		16,560	55,713		55,713	(55,713)				43
44	TOTAL Special Cost Centers	39,153	79,937	679,159	798,249		798,249	(55,713)	742,536			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,147,677	375,363	2,584,123	5,107,163		5,107,163	(714,205)	4,392,958			45

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

Colonial Healthcare And Rehabilitation Centre, Llc

ID# 0052167

Report Period Beginning: 01/01/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Marketing Consultant	\$ (16,560)	43	1
2	Bank Charges	(6,693)	21	2
3	Marketing Salaries	(39,153)	43	3
4	Theft and Loss	(19)	21	4
5	Sequestraton	(25,629)	21	5
6	Marketing Seminar	(36)	24	6
7	Marketing Travel	(1,114)	25	7
8	Prior Period Expense	(379)	21	8
9	Non-allowable Legal	(4,459)	19	9
10	Capitalized R&M	(3,362)	06	10
11	Additional R&M	10,803	06	11
12	Non-Allowable Interest Expense	(902)	32	12
13	Rent for Sale Leaseback Arrangement	(566,663)	34	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(654,167)		49

Colonial Healthcare And Rehabilitation Centre, Llc

Report Period Beginning: ID# 0052167
 Ending: 01/01/15
 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 Colonial Healthcare And Rehabilitation Centre, Llc

0052167

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			31									31	1
2	Food Purchase	(2,326)											(2,326)	2
3	Housekeeping			614	6								619	3
4	Laundry													4
5	Heat and Other Utilities	(6,053)		1,090	193								(4,771)	5
6	Maintenance	7,441		6,404	280								14,125	6
7	Other (specify):*													7
8	TOTAL General Services	(938)		8,139	478								7,679	8
	B. Health Care and Programs													
9	Medical Director			170									170	9
10	Nursing and Medical Records			15,264									15,264	10
10a	Therapy													10a
11	Activities			5									5	11
12	Social Services			3,041									3,041	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			4,942									4,942	15
16	TOTAL Health Care and Programs			23,422									23,422	16
	C. General Administration													
17	Administrative			15,067		(100,367)							(85,300)	17
18	Directors Fees													18
19	Professional Services	(4,459)		(95,595)	67	253							(99,734)	19
20	Fees, Subscriptions & Promotions	(39,553)		2,625	3								(36,925)	20
21	Clerical & General Office Expenses	(225,179)		82,115	38								(143,026)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(36)		30									(6)	24
25	Other Admin. Staff Transportation	(1,114)		232		1,433							551	25
26	Insurance-Prop.Liab.Malpractice			214	126								340	26
27	Other (specify):*			28,036									28,036	27
28	TOTAL General Administration	(270,340)		32,724	234	(98,682)							(336,063)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(271,278)		64,285	713	(98,682)							(304,962)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc

0052167

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	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	206,287		3,698	1,283								211,267	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,459)			2,557								(902)	32
33	Real Estate Taxes				2,398								2,398	33
34	Rent-Facility & Grounds	(566,663)		5,431	(5,431)								(566,663)	34
35	Rent-Equipment & Vehicles			370									370	35
36	Other (specify):*													36
37	TOTAL Ownership	(363,835)		9,499	806								(353,530)	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):*	(55,713)											(55,713)	43
44	TOTAL Special Cost Centers	(55,713)											(55,713)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(690,826)		73,784	1,519	(98,682)							(714,205)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-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 NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 DIETARY	\$	MOSAIC HEALTHCARE	100.00%	\$ 31	\$	31	15
16	V	3 HOUSEKEEPING		MOSAIC HEALTHCARE	100.00%	614		614	16
17	V	5 UTILITIES		MOSAIC HEALTHCARE	100.00%	1,090		1,090	17
18	V	6 REPAIRS AND MAINT.		MOSAIC HEALTHCARE	100.00%	6,404		6,404	18
19	V	9 MEDICAL DIRECTOR		MOSAIC HEALTHCARE	100.00%	170		170	19
20	V	10 NURSING SALARIES	16,560	MOSAIC HEALTHCARE	100.00%	31,824		15,264	20
21	V	11 ACTIVITIES		MOSAIC HEALTHCARE	100.00%	5		5	21
22	V	12 SOCIAL SERVICE SALARIES		MOSAIC HEALTHCARE	100.00%	3,041		3,041	22
23	V	15 NURSING EMP BENS & PR TAXES		MOSAIC HEALTHCARE	100.00%	4,942		4,942	23
24	V	17 ADMINISTRATIVE SALARIES		MOSAIC HEALTHCARE	100.00%	15,067		15,067	24
25	V	19 PROFESSIONAL FEES		MOSAIC HEALTHCARE	100.00%	(1,755)		(1,755)	25
26	V	20 FEES, SUBSCRIPTIONS		MOSAIC HEALTHCARE	100.00%	2,625		2,625	26
27	V	21 CLERICAL AND GENERAL SALARIES		MOSAIC HEALTHCARE	100.00%	99,135		99,135	27
28	V	21 CLERICAL AND GENERAL EXP	27,600	MOSAIC HEALTHCARE	100.00%	10,580		(17,020)	28
29	V	24 SEMINARS		MOSAIC HEALTHCARE	100.00%	30		30	29
30	V	25 ADMIN. STAFF TRANS.		MOSAIC HEALTHCARE	100.00%	232		232	30
31	V	26 INSURANCE		MOSAIC HEALTHCARE	100.00%	214		214	31
32	V	27 GEN. ADMIN. EMP. BEN.		MOSAIC HEALTHCARE	100.00%	28,036		28,036	32
33	V	30 DEPRECIATION		MOSAIC HEALTHCARE	100.00%	3,698		3,698	33
34	V	32 INTEREST EXPENSE		MOSAIC HEALTHCARE	100.00%				34
35	V	34 RENT - BUILDING (RELATED)		MOSAIC HEALTHCARE	100.00%	5,431		5,431	35
36	V	35 EQUIPMENT RENTAL		MOSAIC HEALTHCARE	100.00%	370		370	36
37	V	19 BOOKKEEPING	77,280	MOSAIC HEALTHCARE	100.00%			(77,280)	37
38	V	19 ADMINISTRATIVE CONSULTANT	16,560	MOSAIC HEALTHCARE	100.00%			(16,560)	38
39	Total		\$ 138,000			\$ 211,784	\$ *	73,784	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	3 HOUSKEEPING	\$	4600 TOUHY, LLC	100.00%	\$ 6	\$	6	15
16	V	5 UTILITIES		4600 TOUHY, LLC	100.00%	193		193	16
17	V	6 REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	280		280	17
18	V	19 PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	67		67	18
19	V	20 FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	3		3	19
20	V	21 CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	38		38	20
21	V	26 INSURANCE		4600 TOUHY, LLC	100.00%	126		126	21
22	V	30 DEPRECIATION		4600 TOUHY, LLC	100.00%	1,283		1,283	22
23	V	32 INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	2,557		2,557	23
24	V	33 REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	2,398		2,398	24
25	V								25
26	V	34 RENT	5,431	4600 TOUHY, LLC	100.00%			(5,431)	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		\$ 5,431			\$ 6,950	\$ *	1,519	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	19 PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	253	\$	253	15	
16	V	25 TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	1,433		1,433	16	
17	V								17	
18	V	17 MANAGEMENT FEES	100,367	TETRAD MANAGEMENT, LLC	100.00%			(100,367)	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		\$ 100,367				\$	1,685	\$ * (98,682)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

VII. RELATED PARTIES (continued)

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

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

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

VII. RELATED PARTIES

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

Table with 8 columns: Row Number, Name, Ownership %, Name, City, Name, City, Type of Business. Rows 1-30. Row 1: CENTRAL ILLINOIS OPERATIONS, LLC (99.99%), BRIGHTVIEW CARE CENTER, INC (CHICAGO), 4600 TOUHY, LLC (LINCOLNWOOD), BUILDING CO. Row 2: TETRAD MANAGEMENT, LLC (.01%), LAKE SHORE HEALTHCARE & REHABILITATION CENTRE, LLC (CHICAGO), MANAGCARE, INC. (LINCOLNWOOD), BOOKKEEPING. Row 3: MID AMERICA CARE CENTER, L.L.C. (CHICAGO), TETRAD MANAGEMENT, LLC (LINCOLNWOOD), ADMIN. CONSULTANT.

Facility Name & ID Number Colonial Healthcare And Rehabilitation Cen # 0052167 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	PATIENT DAYS	491,775	10	\$ 583	\$ 26,525	\$ 31	1	
2	3	HOUSEKEEPING	PATIENT DAYS	491,775	10	11,376	26,525	614	2	
3	5	UTILITIES	PATIENT DAYS	491,775	10	20,206	26,525	1,090	3	
4	6	REPAIRS AND MAINT.	PATIENT DAYS	491,775	10	118,728	26,525	6,404	4	
5	9	MEDICAL DIRECTOR	PATIENT DAYS	491,775	10	3,145	26,525	170	5	
6	10	NURSING SALARIES	PATIENT DAYS	491,775	10	590,024	590,024	26,525	31,824	6
7	11	ACTIVITIES	PATIENT DAYS	491,775	10	95	26,525	5	7	
8	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	491,775	10	56,383	56,383	26,525	3,041	8
9	15	NURSING EMP BENS & PR TAX	PATIENT DAYS	491,775	10	91,625	26,525	4,942	9	
10	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	491,775	10	279,351	279,351	26,525	15,067	10
11	19	PROFESSIONAL FEES	PATIENT DAYS	491,775	10	(32,545)	26,525	(1,755)	11	
12	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	491,775	10	48,662	26,525	2,625	12	
13	21	CLERICAL AND GENERAL SA	PATIENT DAYS	491,775	10	1,837,959	1,837,959	26,525	99,135	13
14	21	CLERICAL AND GENERAL EX	PATIENT DAYS	491,775	10	196,155	26,525	10,580	14	
15	24	SEMINARS	PATIENT DAYS	491,775	10	556	26,525	30	15	
16	25	ADMIN. STAFF TRANS.	PATIENT DAYS	491,775	10	4,308	26,525	232	16	
17	26	INSURANCE	PATIENT DAYS	491,775	10	3,971	26,525	214	17	
18	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	491,775	10	519,798	26,525	28,036	18	
19	30	DEPRECIATION	PATIENT DAYS	491,775	10	68,552	26,525	3,698	19	
20	32	INTEREST EXPENSE	PATIENT DAYS	491,775	10		26,525		20	
21	34	RENT - BUILDING (RELATED)	PATIENT DAYS	491,775	10	100,700	26,525	5,431	21	
22	35	EQUIPMENT RENTAL	PATIENT DAYS	491,775	10	6,863	26,525	370	22	
23									23	
24									24	
25	TOTALS					\$ 3,926,495	\$ 2,763,717	\$ 211,784	25	

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSKEEPING	MNGCR. PATIENT DAYS 491,775	10	\$ 107	\$	26,525	\$ 6	1
2	5	UTILITIES	MNGCR. PATIENT DAYS 491,775	10	3,569		26,525	193	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS 491,775	10	5,190		26,525	280	3
4	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS 491,775	10	1,250		26,525	67	4
5	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS 491,775	10	63		26,525	3	5
6	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS 491,775	10	698		26,525	38	6
7	26	INSURANCE	MNGCR. PATIENT DAYS 491,775	10	2,336		26,525	126	7
8	30	DEPRECIATION	MNGCR. PATIENT DAYS 491,775	10	23,779		26,525	1,283	8
9	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS 491,775	10	47,406		26,525	2,557	9
10	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS 491,775	10	44,453		26,525	2,398	10
11								(1,755)	11
12								2,625	12
13								99,135	13
14								10,580	14
15								30	15
16								232	16
17								214	17
18								28,036	18
19								3,698	19
20									20
21								5,431	21
22								370	22
23									23
24									24
25	TOTALS				\$ 128,850	\$		\$ 155,546	25

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	491,775	10	4,682	26,525	253	1
2	25	TRAVEL	PATIENT DAYS	491,775	10	26,559	26,525	1,433	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	\$	\$ 1,685	25

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centri # 0052167 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	Allocated from 4600 Touhy, LLC	X								2,557	6									
7											7									
8											8									
9	TOTAL Facility Related									2,557	9									
B. Non-Facility Related*																				
10	Interest Income									(2,557)	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related									(2,557)	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.)

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2014 report.		\$	<u>98,752</u>	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.)		\$	<u>35,728</u>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(63,024)</u>	3	
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>27,273</u>	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.		\$	<u>(35,751)</u>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>63,256</u>	8	FOR BHF USE ONLY	
	2011	<u>60,975</u>	9		
	2012	<u>63,679</u>	10		
	2013	<u>32,454</u>	11		
	2014	<u>33,331</u>	12		
Credit on line 7 is due to overaccrual of prior years R/E taxes					
Allocated from 4600 Touhy, LLC \$2,398					
				13	FROM R. E. TAX STATEMENT FOR 2014 \$
				14	PLUS APPEAL COST FROM LINE 5 \$
				15	LESS REFUND FROM LINE 6 \$
				16	AMOUNT TO USE FOR RATE CALCULATION \$

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 Colonial Healthcare And Rehabilitation Centre, Llc COUNTY Bureau

FACILITY IDPH LICENSE NUMBER 0052167

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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>16-15-301-008</u>	<u>Long Term Care Property</u>	\$ <u>543.24</u>	\$ <u>543.24</u>
2. <u>16-15-301-009</u>	<u>Long Term Care Property</u>	\$ <u>543.24</u>	\$ <u>543.24</u>
3. <u>16-15-303-020</u>	<u>Long Term Care Property</u>	\$ <u>32,244.02</u>	\$ <u>32,244.02</u>
4. <u>See Attached</u>	<u>Alloc. From 4600 Touhy</u>	\$ <u>86,316.15</u>	\$ <u>2,327.83</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>119,646.65</u>	\$ <u>35,658.33</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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 Colonial Healthcare And Rehabilitation Centre, Llc COUNTY Bureau

FACILITY IDPH LICENSE NUMBER 0052167

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,295 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

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

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

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

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

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

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

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2013	\$ 372,705	1
2	Allocated from 4600 Touhy			4,854	2
3	TOTALS			\$ 377,559	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	92		2013	1973	\$ 2,866,814	\$	35	\$ 81,909	\$ 81,909	\$ 238,486	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	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								67
68		56,547	1,626		2,366	740	9,180	68
69			24,071			(24,071)		69
70		\$ 2,923,361	\$ 25,697		\$ 84,275	\$ 58,578	\$ 247,666	70

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 2,923,361	\$ 25,697		\$ 84,275	\$ 58,578	\$ 247,666	1
2	Installed New 5 Ton Condensing Unit For North A/C	2013	2,734		20	273	273	683	2
3	Installed New Building Signage	2013	6,896		20	690	690	1,667	3
4	Install New Window Treatments & Floor In Therapy Gym	2014	6,268		20	313	313	366	4
5	New Receptacles	2015	7,897		20	263	263	263	5
6	Installation Of Lighting And 23 Bulb Flood Fixtures	2015	8,184		20	273	273	273	6
7	Sealing Of The Blacktop In The Parking Lot	2015	6,957		20	7	7	7	7
8	Installation Of Wiremold/Electric Boxes In Office Area	2015	3,362		20	168	168	168	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)		\$ 2,965,658	\$ 25,697		\$ 86,262	\$ 60,566	\$ 251,093	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,965,658	\$ 25,697		\$ 86,262	\$ 60,566	\$ 251,093	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)	\$ 2,965,658	\$ 25,697		\$ 86,262	\$ 60,566	\$ 251,093	34

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc

0052167

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,965,658	\$ 25,697		\$ 86,262	\$ 60,566	\$ 251,093	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)	\$ 2,965,658	\$ 25,697		\$ 86,262	\$ 60,566	\$ 251,093	34

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc

0052167

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,965,658	\$ 25,697		\$ 86,262	\$ 60,566	\$ 251,093	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)	\$ 2,965,658	\$ 25,697		\$ 86,262	\$ 60,566	\$ 251,093	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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.

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	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	Allocated from 4600 Touhy, LLC	2012	27,694	710	20	923	213	3,693	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Mosaic Healthcare	2013	465	89	20	23	(66)	70	9
10	Allocated from Mosaic Healthcare	2012	5,782	255	20	289	34	1,156	10
11									11
12									12
13	Allocated from 4600 Touhy, LLC	2012	17,835	459	20	892	433	3,567	13
14	Allocated from 4600 Touhy, LLC	2013	4,340	102	20	217	115	651	14
15	Allocated from 4600 Touhy, LLC	2014	431	11	20	22	11	43	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)		\$ 56,547	\$ 1,626		\$ 2,366	\$ 740	\$ 9,180	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 56,547	\$ 1,626		\$ 2,366	\$ 740	\$ 9,180	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)	\$ 56,547	\$ 1,626		\$ 2,366	\$ 740	\$ 9,180	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,364,561	\$ 3,172	\$ 147,919	\$ 144,747	10	\$ 421,450	71
72	Current Year Purchases	14,679		1,157	1,157	10	1,157	72
73	Fully Depreciated Assets	13,480				10	13,480	73
74								74
75	TOTALS	\$ 1,392,720	\$ 3,172	\$ 149,075	\$ 145,903		\$ 436,086	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	2015	\$ 5,124	\$ 182	\$	\$ (182)	5	\$ 5,124	76
77										77
78										78
79										79
80	TOTALS			\$ 5,124	\$ 182	\$	\$ (182)		\$ 5,124	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)	\$ 4,741,061	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 29,051	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 235,338	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 206,287	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 692,303	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.

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. 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:		92		\$ 566,663			3
4	Additions							4
5					(566,663)			5
6								6
7	TOTAL		92		\$			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: _____ *

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: \$ 2,360 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	2014 Ford	\$ 938.09	\$ 10,319	17
18					18
19					19
20					20
21	TOTAL		\$ 938.09	\$ 10,319	21

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 \$ _____

* 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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.

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

	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 170,663	\$		\$ 170,663	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			43,583			43,583	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			223,148			223,148	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				66,705		66,705	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					33,574	13,232		46,806	13
14	TOTAL			\$		\$ 470,968	\$ 79,937		\$ 550,905	14

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc

0052167

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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 187,071	\$	1
2	Cash-Patient Deposits	8,832		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,067,346		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,486		6
7	Other Prepaid Expenses	17,176		7
8	Accounts Receivable (owners or related parties)	902,787		8
9	Other(specify):	103,810		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,293,508	\$	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	39,234		15
16	Equipment, at Historical Cost	104,340		16
17	Accumulated Depreciation (book methods)	(43,551)		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):	307,846		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 407,869	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,701,377	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 730,664	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,832		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	165,975		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,940		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,273		32
33	Accrued Interest Payable	1,034		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	1,056,343		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,008,061	\$	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,008,061	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 693,316	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,701,377	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 314,596	1
2	Restatements (describe):		2
3	Depreciation	(8,757)	3
4	Loss on Intercompany Loan	(7,132)	4
5	Rounding	12	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 298,719	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	387,597	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Additional Paid In Capital	7,000	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 394,597	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)	\$ 693,316	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,535,304	1
2	Discounts and Allowances for all Levels	(173,114)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,362,190	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	941,046	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 941,046	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	1,780	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	75,388	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,441	19
20	Radiology and X-Ray	2,632	20
21	Other Medical Services	77,834	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 165,075	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	26,059	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 26,059	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	390	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 390	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,494,760	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	840,968	31
32	Health Care	1,661,975	32
33	General Administration	1,240,175	33
B. Capital Expense			
34	Ownership	565,796	34
C. Ancillary Expense			
35	Special Cost Centers	606,618	35
36	Provider Participation Fee	191,631	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,107,163	40
41	Income before Income Taxes (line 30 minus line 40)**	387,597	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 387,597	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,740,471	44
45	Private Pay - Net Inpatient Revenue	1,875,168	45
46	Medicare - Net Inpatient Revenue	705,440	46
47	Other-(specify) <u>Hospice</u>	22,486	47
48	Other-(specify) <u>Insurance</u>	18,625	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,362,190	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 Colonial Healthcare And Rehabilitation Centre, Llc

0052167

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,855	2,080	\$ 76,595	\$ 36.82	1
2	Assistant Director of Nursing	1,848	2,080	54,902	26.40	2
3	Registered Nurses	14,900	16,524	497,832	30.13	3
4	Licensed Practical Nurses	9,446	10,292	218,781	21.26	4
5	CNAs & Orderlies	43,124	46,497	578,884	12.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,876	2,096	30,429	14.52	9
10	Activity Assistants	2,767	3,008	26,764	8.90	10
11	Social Service Workers	1,968	2,064	36,760	17.81	11
12	Dietician					12
13	Food Service Supervisor	1,980	2,080	40,328	19.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,869	19,341	187,009	9.67	15
16	Dishwashers					16
17	Maintenance Workers	1,816	2,080	58,741	28.24	17
18	Housekeepers	5,958	6,372	56,461	8.86	18
19	Laundry	2,316	2,587	19,735	7.63	19
20	Administrator	1,896	2,080	91,738	44.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,494	6,818	102,744	15.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,858	2,108	29,834	14.15	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,633	1,714	40,139	23.42	33
34	TOTAL (lines 1 - 33)	119,604	129,821	\$ 2,147,676 *	\$ 16.54	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 7,344	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	11,040	10-03	38
39	Pharmacist Consultant	Monthly	5,676	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Quarterly	531	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Quarterly	832	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	MDS Consultant	Monthly	16,560	10-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 53,983		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
LouAnne Kenwick	Administrator	0	\$ 91,738	Workers' Compensation Insurance	\$ 23,015	IDPH License Fee	\$	
				Unemployment Compensation Insurance	18,839	Advertising: Employee Recruitment	6,144	
				FICA Taxes	158,892	Health Care Worker Background Check (Indicate # of checks performed)	1,643	
				Employee Health Insurance	68,569	Patient Background Checks		
				Employee Meals		Dues and Subscriptions	10,533	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	3,041	
				Other Employee Benefits	23,215	Allocated from Mosaic	2,625	
				Safe Harbor Match Expense	16,586	Allocated from 4600 Touhy, LLC	3	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 91,738	TOTAL (agree to Schedule V, line 22, col.8)		\$ 23,989		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising ()	
Management Fees - Tetrad			\$ 100,367				Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 100,367	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services							Description	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Amount	
FR&R/Marcum LLP	Accounting		\$ 18,780			\$	Out-of-State Travel \$	
Legal	See Attached		15,132					
Personnel Planners	Unemployment Consulting		2,143					
Managcare/Mosaic	Bookkeeping		77,280				In-State Travel	
Smartlinx Solutions	Workforce Management		2,469					
Ability Network	Billing Software		4,741					
HealthMEDX	EMR Software		13,522				Seminar Expense 2,292	
Galaxy Hosted Software	Clinical & Financial Software		1,672				Allocated from Mosaic 30	
eHealth Data Solutions	MDS Software		2,450					
Mosaic Healthcare	Administrative Consultant		16,560					
Madison Specs	Cost Segregation Services		2,250				Entertainment Expense ()	
See Supplemental Schedule			4,065				(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 161,064	TOTAL		\$	TOTAL 2,322	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc

0052167

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 \$8,490
- (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? No
- (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. \$ 18,077 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.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 191,631
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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,780
- (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? N/A
- 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.