FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0050807

Facility Name: Courtyard Healthcare

Address: 3601 S. Harlem Ave . (Number) Berwyn (City) 60402 (Zip Code)

County: Cook

Telephone Number: (708)749-4160 **Fax #** (708)749-7696

HFS ID Number:

Date of Initial License for Current Owners: 2009

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	52,925	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	145	TOTALS	145	52,925	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			5,015	5,015	8
9	SNF/PED					9
10	ICF	36,136	704		36,840	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,136	704	5,015	41,855	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.08%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 2009

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2009 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 145 and days of care provided 4,658

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	329,017	3,137	13,536	345,690		345,690		345,690			1
2	Food Purchase		425,770		425,770		425,770	(72)	425,698			2
3	Housekeeping		5,940	271,615	277,555		277,555		277,555			3
4	Laundry		3,648	153,180	156,828		156,828		156,828			4
5	Heat and Other Utilities			106,215	106,215		106,215	305	106,520			5
6	Maintenance	51,748		116,855	168,603		168,603	88,747	257,350			6
7	Other (specify):*											7
8	**TOTAL General Services**	380,765	438,495	661,401	1,480,661		1,480,661	88,980	1,569,641			8
	B. Health Care and Programs											
9	Medical Director			22,086	22,086		22,086		22,086			9
10	Nursing and Medical Records	3,698,731	229,323	29,240	3,957,294		3,957,294	36,559	3,993,853			10
10a	Therapy		(1,106)	24,000	22,894		22,894		22,894			10a
11	Activities	125,788	1,733		127,521		127,521		127,521			11
12	Social Services	70,632		1,143	71,775		71,775		71,775			12
13	CNA Training											13
14	Program Transportation			1,478	1,478		1,478		1,478			14
15	Other (specify):*							8,136	8,136			15
16	**TOTAL Health Care and Programs**	3,895,151	229,950	77,947	4,203,048		4,203,048	44,695	4,247,743			16
	C. General Administration											
17	Administrative	83,095		465,013	548,108		548,108	(326,162)	221,946			17
18	Directors Fees											18
19	Professional Services			177,129	177,129	(3,028)	174,101	(17,208)	156,894			19
20	Dues, Fees, Subscriptions & Promotions			73,874	73,874		73,874	(47,336)	26,538			20
21	Clerical & General Office Expenses	213,234	38,295	324,591	576,120		576,120	(72,135)	503,985			21
22	Employee Benefits & Payroll Taxes			779,457	779,457		779,457		779,457			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,937	7,937		7,937	68	8,005			24
25	Other Admin. Staff Transportation			21,450	21,450		21,450		21,450			25
26	Insurance-Prop.Liab.Malpractice			358,685	358,685		358,685	637	359,322			26
27	Other (specify):*							35,714	35,714			27
28	**TOTAL General Administration**	296,329	38,295	2,208,136	2,542,760	(3,028)	2,539,732	(426,421)	2,113,311			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,572,245	706,740	2,947,484	8,226,469	(3,028)	8,223,441	(292,746)	7,930,695			29

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

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

Facility Name & ID Number Courtyard Healthcare #0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			27,797	27,797		27,797	446,720	474,517			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			55,245	55,245		55,245	729,581	784,826			32
33	Real Estate Taxes			(47,412)	(47,412)	3,028	(44,384)	420,464	376,080			33
34	Rent-Facility & Grounds			1,096,600	1,096,600		1,096,600	(1,080,105)	16,495			34
35	Rent-Equipment & Vehicles			9,152	9,152		9,152		9,152			35
36	Other (specify):*											36
37	TOTAL Ownership			1,141,382	1,141,382	3,028	1,144,410	516,660	1,661,070			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	17,227	279,887	786,764	1,083,878		1,083,878		1,083,878			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			305,078	305,078		305,078		305,078			42
43	Other (specify):*	50,551	8,320	38,731	97,602		97,602	(97,602)	(0)			43
44	TOTAL Special Cost Centers	67,778	288,207	1,130,573	1,486,558		1,486,558	(97,602)	1,388,956			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,640,023	994,947	5,219,439	10,854,409		10,854,409	126,312	10,980,721			45

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(387)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	446,062	30		9
10	Interest and Other Investment Income	(419)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(72)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(41,426)	21		18
19	Entertainment				19
20	Contributions	(25,600)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,677)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(136,688)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 236,793		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(110,481)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (110,481)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 126,312		37

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

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

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

Courtyard Healthcare

ID# 0050807

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (1,537)	21	1
2	Bank Charges	(43,171)	21	2
3	Marketing Salaries	(50,551)	43	3
4	Marketing Expense	(47,051)	43	4
5	Additional R&M	96,670	06	5
6	Capitalized R&M	(8,394)	06	6
7	PAC Dues	(6,005)	20	7
8	Non Allowable Legal	(533)	19	8
9	Real Estate Tax Penalty	(47,412)	21	9
10	Non Allowable Expense	(16,512)	21	10
11	Dues Refund	(12,193)	20	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
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**	(136,688)		49

Courtyard Healthcare

ID# 0050807

Report Period Beginning: 01/01/15

Ending: 12/31/15

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Courtyard Healthcare # 0050807 **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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(72)											(72)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(387)		692									305	5
6	Maintenance	88,276		471									88,747	6
7	Other (specify):*													7
8	**TOTAL General Services**	87,817		1,163									88,980	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			47,037	(10,478)								36,559	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			8,136									8,136	15
16	**TOTAL Health Care and Programs**			55,173	(10,478)								44,695	16
	C. General Administration													
17	Administrative			(326,162)									(326,162)	17
18	Directors Fees													18
19	Professional Services	(533)		(16,675)									(17,208)	19
20	Fees, Subscriptions & Promotions	(48,475)		1,139									(47,336)	20
21	Clerical & General Office Expenses	(150,058)		77,923									(72,135)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			68									68	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			637									637	26
27	Other (specify):*			35,714									35,714	27
28	**TOTAL General Administration**	(199,065)		(227,356)									(426,421)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(111,248)		(171,020)	(10,478)								(292,746)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Courtyard Healthcare # 0050807 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	446,062		658									446,720	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(419)	730,000										729,581	32
33	Real Estate Taxes		420,464										420,464	33
34	Rent-Facility & Grounds		(1,096,600)	16,495									(1,080,105)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	445,643	53,864	17,153									516,660	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):*	(97,602)											(97,602)	43
44	**TOTAL Special Cost Centers**	(97,602)											(97,602)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	236,793	53,864	(153,867)	(10,478)								126,312	45

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,096,600	Courtyard Realty at Berwyn	100.00%	$	$ (1,096,600)	1
2	V	32	Interest		Courtyard Realty at Berwyn	100.00%	730,000	730,000	2
3	V	33	Real Estate Tax		Courtyard Realty at Berwyn	100.00%	420,464	420,464	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			$ 1,096,600			$ 1,150,464	$ * 53,864	14

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	$ 692	$ 692	15
16	V	6	REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	471	471	16
17	V	10	NURSING SALARY		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	47,037	47,037	17
18	V	15	EMPLOYEE BEN. HEALTH CARE.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	8,136	8,136	18
19	V	17	NON-OWNER ADMIN. COMP.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	94,287	94,287	19
20	V	17	SALARY - DAVID CHEPLOWITZ		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	22,282	22,282	20
21	V	17	SALARY - BARAK BAVER		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	22,282	22,282	21
22	V	19	PROFESSIONAL FEES		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	3,325	3,325	22
23	V	20	LICENSES		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	1,139	1,139	23
24	V	21	OFFICE EXPENSE		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	71,725	71,725	24
25	V	24	SEMINARS		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	68	68	25
26	V	26	AUTO EXPENSE		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	637	637	26
27	V	27	EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	34,636	34,636	27
28	V	30	DEPRECIATION		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	658	658	28
29	V	34	RENT		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	16,495	16,495	29
30	V								30
31	V								31
32	V	21	CLERICAL SALARY		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	6,198	6,198	32
33	V	27	EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	1,078	1,078	33
34	V								34
35	V								35
36	V	17	MANAGEMENT FEES	465,013	PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%		(465,013)	36
37	V	19	CONSULTING SERVICES	20,000	PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%		(20,000)	37
38	V								38
39	Total			$ 485,013			$ 331,146	$ * (153,867)	39

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	$ 19,870	PREMIER HEALTHCARE SUPPLIES, LLC	100.00%	$ 9,392	$ (10,478)	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			$ 19,870			$ 9,392	$ * (10,478)	39

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	AYELET KNOPF	3.00%	GILMAN HEALTHCARE CENTER,LLC	Gilman	PREMIER HEALTHCARE MANA	CHICAGO	MANAGEMENT CO.	1
2	BARAK BAVER	33.53%	PERSHING GARDENS HEALTHCARE CENTER	STICKNEY	PREMIER HEALTHCARE SUPPI	CHICAGO	MEDICAL SUPPLY	2
3	DAVID CHEPLOWITZ	33.53%	WINFIELD WOODS HEALTHCARE CENTER, LLC	WINFIELD	COURTYARD REALTY	BERWYN	BUILDING CO	3
4	HARRY SCHAYER	3.00%	CHAMPAIGN URBANA NURSING & REHAB	SAVOY				4
5	JOSEPH KNOPF	3.00%	GARDENVIEW MANOR	DANVILLE				5
6	NAOMI LOPIN	3.00%	NORRIDGE GARDENS	NORRIDGE				6
7	YISROEL LOPIN	3.00%						7
8	JOSEPH KNOPF-CLASS B	1.72%						8
9	AYELET KNOPF- CLASS B	1.72%						9
10	YISROEL LOPIN- CLASS B	1.72%						10
11	NAOMI LOPIN- CLASS B	1.72%						11
12	JERRY AND DEENA CHEPLOWITZ- CLASS B	0.69%						12
13	ORSHEVE ENTERPRISES, LLC -CLASS B	4.83%						13
14	MICHAEL AND CAROL KNOPF- CLASS B	3.45%						14
15	ISAAC AND RACHEL KNOPF- CLASS B	2.07%						15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	David Cheplowitz	Shareholder	Administrative	33.53%	See Attached	5.00	12.50%	Mgmt Fee	$ 22,282	17-7	1
2	Barak Baver	Shareholder	Administrative	33.53%	See Attached	5.00	12.50%	Mgmt Fee	22,282	17-7	2
3	Sarah Baver	Relative	Clerical	0.00%	See Attached	6.00	15.00%	Alloc. Salary	6,198	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 50,762		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 Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: PREMIER HEALTHCARE MANAGEMENT, L
Street Address: 8170 N. MCCORMICK BLVD. SUITE 137
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	307,887	7	$ 5,092	$	41,855	$ 692	1
2	6	REPAIRS AND MAINTENANC	PATIENT DAYS	307,887	7	3,468		41,855	471	2
3	10	NURSING SALARY	PATIENT DAYS	307,887	7	346,005	346,005	41,855	47,037	3
4	15	EMPLOYEE BEN. HEALTH CA	PATIENT DAYS	307,887	7	59,847		41,855	8,136	4
5	17	NON-OWNER ADMIN. COMI	PATIENT DAYS	307,887	7	693,582	693,582	41,855	94,287	5
6	17	SALARY - DAVID CHEPLOWI	PATIENT DAYS	307,887	7	163,907	163,907	41,855	22,282	6
7	17	SALARY - BARAK BAVER	PATIENT DAYS	307,887	7	163,907	163,907	41,855	22,282	7
8	19	PROFESSIONAL FEES	PATIENT DAYS	307,887	7	24,461		41,855	3,325	8
9	20	LICENSES	PATIENT DAYS	307,887	7	8,375		41,855	1,139	9
10	21	OFFICE EXPENSE	PATIENT DAYS	307,887	7	527,609	459,690	41,855	71,725	10
11	24	SEMINARS	PATIENT DAYS	307,887	7	501		41,855	68	11
12	26	AUTO EXPENSE	PATIENT DAYS	307,887	7	4,685		41,855	637	12
13	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	307,887	7	254,783		41,855	34,636	13
14	30	DEPRECIATION	PATIENT DAYS	307,887	7	4,840		41,855	658	14
15	34	RENT	PATIENT DAYS	307,887	7	121,336		41,855	16,495	15
16										16
17										17
18										18
19	21	CLERICAL SALARY	PATIENT DAYS	40	6	41,318	41,318	6	6,198	19
20	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	40	6	7,190		6	1,078	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,430,906	$ 1,868,409		$ 331,146	25

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: PREMIER HEALTHCARE SUPPLIES, LLC
Street Address: 8170 N. MCCORMICK BLVD. SUITE 137
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	REVENUE	113,303	7	$ 53,554	$	19,870	$ 9,392	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					$ 53,554	$		$ 9,392	25

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Private Bank		X	Mortgage			$	$ 9,566,447			$ 730,000	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Note Payable				3,944,623			55,245	6
7	Private Bank		X	Line of Credit				100,000				7
8												8
9	TOTAL Facility Related						$	$ 13,611,069			$ 785,245	9
	B. Non-Facility Related*											
10	Interest Income		X								(419)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (419)	14
15	TOTALS (line 9+line14)						$	$ 13,611,069			$ 784,826	15

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

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Courtyard Healthcare # 0050807 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 837,346	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.)		$ 456,618	2
3. Under or (over) accrual (line 2 minus line 1).		$ (380,728)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 753,780	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.**		$ 3,028	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.		$ 376,080	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	243,761	8
	2011	281,461	9
	2012	303,015	10
	2013	319,164	11
	2014	456,618	12

*Beginning Accrual Adjusted

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Courtyard Healthcare COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050807

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-31-308-001-0000	Long Term Care Property	$ 108,673.47	$ 98,493.67
2.	16-31-308-002-0000	Long Term Care Property	$ 102,255.60	$ 92,689.85
3.	16-31-308-003-0000	Long Term Care Property	$ 31,743.60	$ 28,739.00
4.	16-31-308-004-0000	Long Term Care Property	$ 106,403.25	$ 96,451.60
5.	16-31-308-005-0000	Long Term Care Property	$ 102,255.60	$ 92,689.85
6.	16-31-308-006-0000	Long Term Care Property	$ 30,624.83	$ 27,688.93
7.	16-31-308-007-0000	Long Term Care Property	$ 7,419.19	$ 6,681.19
8.	16-31-308-008-0000	Long Term Care Property	$ 7,162.71	$ 6,447.11
9.	16-31-308-009-0000	Long Term Care Property	$ 7,492.05	$ 6,737.00
10.			$	$
		TOTALS	$ 504,030.30	$ 456,618.20

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 X 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 Courtyard Healthcare COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050807

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,431 B. General Construction Type: Exterior Brick Frame Concrete Steel Number of Stories 3

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2012	$ 690,291	1
2					2
3	TOTALS			$ 690,291	3

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	145		2012	1964	$ 6,826,214	$	35	$ 195,035	$ 195,035	$ 450,645	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	6,852		20	571	571	3,507	9
10	Various			2010	37,295		20	2,474	2,474	18,882	10
11	Various			2011	47,920		20	8,996	8,996	40,466	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		334,170			16,709	16,709	50,127	67
68	Related Party Allocations (Pages 12H & 12I)		3,384	30		169	139	372	68
69	Financial Statement Depreciation			27,797			(27,797)		69
70	TOTAL (lines 4 thru 69)		$ 7,255,835	$ 27,827		$ 223,953	$ 196,126	$ 563,998	70

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,255,835	$ 27,827		$ 223,953	$ 196,126	$ 563,998	1
2	Cast Iron For Stair Railing	2012	3,750		20	188	188	688	2
3	75' Retaining Wall	2012	4,200		20	280	280	1,003	3
4	New Wall Sign With Flood Lights; New Monument Style Sign	2012	9,695		20	646	646	2,262	4
5	Cable Wiring	2013	14,828		20	2,966	2,966	6,920	5
6	Condenser & Air Handler	2013	5,566		20	1,113	1,113	2,969	6
7	New A/C Unit	2013	16,200		20	810	810	2,025	7
8	New Railings	2013	3,590		20	718	718	1,915	8
9	Permit Fees	2013	11,034		20	552	552	1,379	9
10	1St Floor Corridor & Dining Rm:Remove Cove Base, Install New	2013	25,047		20	1,252	1,252	2,505	10
11	1St Floor Corridor: Remove & Replace Light Fixtures, New Hand	2013	40,699		20	2,035	2,035	4,070	11
12	1St Floor Dining Room: Remove & Replace Light Fixtures, New W	2013	5,198		20	260	260	520	12
13	1St Floor Family Lounge: Remove Cove Base, New Carpeting, Wa	2013	3,741		20	187	187	374	13
14	1St Floor Resident Rooms: Remove & Replace Case Base, New Vi	2013	47,749		20	2,387	2,387	4,775	14
15	1St Floor Resident Bathrooms: New Vinyl Flooring,New Wall Tile	2013	34,649		20	1,732	1,732	3,465	15
16	1St Floor Guest Bathrooms: Remove & Replace Flooring, New Wa	2013	4,464		20	223	223	446	16
17	Shower Rm 2: Floor Tile, Shower Fixture,Sink,Faucet,Grab Bars,	2013	36,320		20	1,816	1,816	3,632	17
18	Shower Rm 1: Floor Tile, Shower Fixture,Sink,Faucet,Grab Bars,	2013	38,117		20	1,906	1,906	3,812	18
19	2Nd Floor Corridor & Dining Room: Remove Cove Base, New Vin	2013	41,528		20	2,076	2,076	4,153	19
20	2Nd Floor Corridor & Dining Room: New Handrails, Wallcoverin	2013	27,159		20	1,358	1,358	2,716	20
21	2Nd Floor Resident Room:Remove Cove Base, New Vinyl Flooring	2013	30,277		20	1,514	1,514	3,028	21
22	2Nd Floor Resident Bathroom: Remove And Replace Flooring, Ne	2013	25,681		20	1,284	1,284	2,568	22
23	Basement Corridor:New Flooring	2013	8,166		20	408	408	817	23
24	Basement Therapy Room: Remove & Replace Light Fixtures, New	2013	21,125		20	1,056	1,056	2,113	24
25	Various Areas: Structural Engineering Service	2013	7,958		20	398	398	796	25
26	Lobby: New Flooring, Dividing Wall,Wallcovering,Wall Panels, Li	2013	48,735		20	2,437	2,437	4,874	26
27	Design And Build New Smoking Patio- Demo Current Area	2013	48,428		20	2,421	2,421	4,843	27
28	Admissions Office: New Flooring, New Panels	2013	4,072		20	204	204	407	28
29	1St Floor Corridor:One Side Door Lamination, Lighting,Roller Sh	2013	8,732		20	437	437	873	29
30	Administrators Office: New Flooring, Wallcovering, Stationary Pa	2013	5,359		20	268	268	536	30
31	1St Floor Nurses Station: Remove Current Nurses Station, Install	2013	30,124		20	1,506	1,506	3,012	31
32	1St Floor Family Lounge & Resident Rooms: Loundge-New Floori	2013	20,527		20	1,026	1,026	2,053	32
33	1St Floor-Various-Remove Existing Wallcovering, Prep Walls, Ins	2013	42,621		20	2,131	2,131	4,262	33
34	TOTAL (lines 1 thru 33)		$ 7,931,176	$ 27,827		$ 261,550	$ 233,723	$ 643,806	34

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,931,176	$ 27,827		$ 261,550	$ 233,723	$ 643,806	1
2	2Nd Floor Corridor: Remove & Replace Light Fixtures, New Nurs	2013	31,320		20	1,566	1,566	3,132	2
3	2Nd Floor Nurses Station: Installation Of Pure Vinyl Tile And Mil	2013	4,263		20	213	213	426	3
4	2Nd Floor Dining Room: New Lighting, Chair Rail, Stationary Pa	2013	7,749		20	387	387	775	4
5	2Nd Floor Family Lounge: New Lighting, New Carpet Flooring, St	2013	15,802		20	790	790	1,580	5
6	2Nd Floor Resident Room: Upholstered Cornice, Roller Shades, C	2013	32,580		20	1,629	1,629	3,258	6
7	2Nd Floor Shower Room:Labor To Remove Old Bathroom And R	2013	34,568		20	1,728	1,728	3,457	7
8	3Rd Floor Corridor & Dining Room: Remove Cove Base, Install N	2013	16,234		20	812	812	1,623	8
9	3Rd Floor Corridor:Handrails, Lighting,Refinish Nurses Station,F	2013	46,607		20	2,330	2,330	4,661	9
10	3Rd Floor Dining Room & Nurses Station: New Flooring, Dining F	2013	9,580		20	479	479	958	10
11	3Rd Floor Family Room:Carpeting,Panels,Acrylic Panels	2013	13,892		20	695	695	1,389	11
12	3Rd Floor Activity Room:New Flooring, Decorative Panels	2013	4,580		20	229	229	458	12
13	3Rd Floor Resident Rooms:Remove &Replace Cove Base,Roller S	2013	78,085		20	3,904	3,904	7,809	13
14	3Rd Floor Resident Bathrooms;Flooring,Fixtures,Toilet,Sinks,Fau	2013	46,307		20	2,315	2,315	4,631	14
15	Basement Corridor:Sinage,Handrails,Corner Guards	2013	2,928		20	146	146	293	15
16	Basement Therapy Room:Demo Wall Between Room & Staff Lour	2013	3,423		20	171	171	342	16
17	Beauty Salon:Flooring, Roller Shades	2013	3,308		20	165	165	331	17
18	Locker Room:Plumbing, Flooring-Bathroom:Flooring & Wall Tile	2013	8,386		20	419	419	839	18
19	Basement Office:Flooring; Elevator:Replace Interior	2013	9,634		20	482	482	963	19
20	Vestibule: Remove Existing Structure, New Doors, Walls,Flooring	2013	56,868		20	2,843	2,843	5,687	20
21	1St Floor Dining Room:Fireplace Panels And Drywall	2013	9,289		20	464	464	929	21
22	1St Floor Guest &2Nd Floor Resident Bathrooms: Flooring, Finish	2013	10,687		20	534	534	1,069	22
23	Various Areas: Remove Existing Wallcovering,Prep Walls & Insta	2013	68,516		20	3,426	3,426	6,852	23
24	Various Bathroom Change Orders:Flooring, Toilets, Drain	2013	3,412		20	171	171	341	24
25	3Rd Floor Office:Change Order-Flooring, New Wall, Door	2013	6,791		20	340	340	679	25
26	Vestibule, Lobby & Admissions Office Change Order:Structural F	2013	14,963		20	748	748	1,496	26
27	1St Floor Corridor Change Order:Outside Edge Protectors	2013	6,532		20	327	327	653	27
28	1St Floor Dining Room Change Order: Crown Molding, Cornice	2013	3,668		20	183	183	367	28
29	1St Floor Nurses Station & Various Areas Chang Order: Roller Sh	2013	5,982		20	299	299	598	29
30	1St Floor Resident Rooms Chang Order: Demo Closet & Relocate	2013	7,478		20	374	374	748	30
31	2Nd Floor Dining Room Change Order: Malamine Panels Around	2013	10,076		20	504	504	1,008	31
32	2Nd Floor Family Lounge & Beauty Salon Change Order: Remove	2013	3,881		20	194	194	388	32
33	2Nd Floor Resident Room Change Order: Demo Closet	2013	7,478		20	374	374	748	33
34	TOTAL (lines 1 thru 33)		$ 8,516,043	$ 27,827		$ 290,793	$ 262,966	$ 702,293	34

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,516,043	$ 27,827		$ 290,793	$ 262,966	$ 702,293	1
2	New Backflow Preventer For Existing Sewers	2013	7,700		20	385	385	770	2
3	Hardscaping, Lighting, Install Irrigation	2014	50,000		20	2,500	2,500	5,000	3
4	4 New Led Light Fixtures	2014	3,135		20	157	157	314	4
5	Shunt Trip Breakers For Both North And South Elevators	2014	15,500		20	775	775	1,550	5
6	Mixing Valve Replacement For Domestic In Boiler Room	2014	3,722		20	186	186	372	6
7	Sump Pump	2014	15,500		20	775	775	1,550	7
8	New Electricals For Controls For New Service To Fire Pump	2014	17,170		20	859	859	1,717	8
9	New Fire Alarm System	2014	32,617		20	1,631	1,631	3,262	9
10	New Security System	2014	15,510		20	776	776	1,582	10
11	Change Order:Concrete Sidewalk, Custom Baseboard Heater Cov	2014	24,991		20	1,250	1,250	2,499	11
12	Service To Install Lighting	2014	4,000		20	200	200	400	12
13	Service To Restore Power And Lighting	2014	3,000		20	150	150	300	13
14	Plumbing Work For The Bathroom	2014	5,350		20	268	268	535	14
15	Install 63 Fire Dampers In Bathrooms	2014	11,500		20	575	575	1,150	15
16	Remove 23 Dilapidated Fluorescent Fixtures	2014	8,750		20	438	438	875	16
17	Bathroom Exhaust System Correction	2014	7,700		20	385	385	770	17
18	Install Water Filtration System & New Steamer/Hoses/Pvc Drain &	2015	2,630		20	131	131	131	18
19	Install New Floor Tile/Painting/Piping In Kitchen/Halls/Conf. Roo	2015	6,335		20	317	317	317	19
20	Install Conduit Sleeve Basement To 3Rd Floor/Junction Box Each	2015	3,000		20	150	150	150	20
21	Damper Test/Replace 68X Fire Damper Links Throughout Facilit	2015	6,122		20	306	306	306	21
22	Rose Planting/Fix Retaining Walls/Ground Covers/Weed Killer	2015	2,710		20	136	136	136	22
23	Install Code Compliant Toe Guards On Front/Back Of North Elev	2015	3,599		20	180	180	180	23
24	Install Tv Outlets First/Second Floor Day/Dining/Dialysis Rooms	2015	3,685		20	184	184	184	24
25	Remodel Toilet/Shower/Tub Room/Flooring/Masonry/Painting/Ele	2015	35,891		20	1,795	1,795	1,795	25
26	Upgrade Fire Recall/Pressure Test/Door Restrictors/Pit Ladder Ne	2015	45,549		20	2,277	2,277	2,277	26
27	Install New Transfer Switch/Wiring And Panel For Life Safety Fo	2015	36,500		20	1,825	1,825	1,825	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,888,208	$ 27,827		$ 309,401	$ 281,574	$ 732,240	34

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 8,888,208	$ 27,827		$ 309,401	$ 281,574	$ 732,240	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,888,208	$ 27,827		$ 309,401	$ 281,574	$ 732,240	34

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	New 6' Water Main	2013	334,170		20	16,709	16,709	50,127	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)		$ 334,170	$		$ 16,709	$ 16,709	$ 50,127	34

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 334,170	$		$ 16,709	$ 16,709	$ 50,127	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)		$ 334,170	$		$ 16,709	$ 16,709	$ 50,127	34

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Premier Healthcare Management, LLC	2013	3,384	30	20	169	139	372	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)		$ 3,384	$ 30		$ 169	$ 139	$ 372	34

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,384	$ 30		$ 169	$ 139	$ 372	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 3,384	$ 30		$ 169	$ 139	$ 372	34

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,288,921	$ 253	$ 151,023	$ 150,770	10	$ 377,131	71
72	Current Year Purchases	155,484	375	14,093	13,718	10	14,093	72
73	Fully Depreciated Assets	7,677				10	7,677	73
74								74
75	TOTALS	$ 1,452,082	$ 628	$ 165,116	$ 164,488		$ 398,901	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 11,030,581	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 28,455	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 474,517	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 446,062	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,131,140	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Premier HC Mgmt, LLC				16,495			5
6								6
7	TOTAL				$ 16,495 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 688 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Lexus	$	$ 8,464	17
18					18
19					19
20					20
21	TOTAL		$	$ 8,464	21

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$			$ 271,982	$		$ 271,982	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				78,863			78,863	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs				332,033			332,033	4
5	Physician Care		visits								5
6	Dental Care	39 - 03	visits				1,099			1,099	6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 02	# of prescrpts					252,178		252,178	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify): See Supplemental				17,227		102,787	27,709		147,723	13
14	TOTAL			$	17,227		$ 786,764	$ 279,887		$ 1,083,878	14

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

STATE OF ILLINOIS

Facility Name & ID Number Courtyard Healthcare # 0050807 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,729,020	$ 3,209,923	1
2	Cash-Patient Deposits	226,536	226,536	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,569,672	7,569,672	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,306	2,306	6
7	Other Prepaid Expenses	1,866	1,866	7
8	Accounts Receivable (owners or related parties)	40,000	241,180	8
9	Other(specify):	140,084	163,434	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 9,709,484	$ 11,414,917	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		450,000	13
14	Buildings, at Historical Cost		4,473,171	14
15	Leasehold Improvements, at Historical Cost	1,886,903	1,886,903	15
16	Equipment, at Historical Cost	1,080,350	1,709,543	16
17	Accumulated Depreciation (book methods)	(358,669)	(590,928)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		711	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	686,727	3,159,898	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,295,311	$ 11,089,298	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 13,004,795	$ 22,504,215	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,142,782	$ 2,184,783	26
27	Officer's Accounts Payable	454,896	454,896	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,944,623	3,944,623	29
30	Accrued Salaries Payable	275,171	275,171	30
31	Accrued Taxes Payable (excluding real estate taxes)	378,442	378,442	31
32	Accrued Real Estate Taxes(Sch.IX-B)		753,780	32
33	Accrued Interest Payable	5,607	5,607	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	585,371	585,371	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,786,892	$ 8,582,673	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,733,337	39
40	Mortgage Payable		7,933,110	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	5,418,999	4,632,133	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,418,999	$ 14,298,580	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 12,205,891	$ 22,881,253	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 798,904	$ (377,038)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 13,004,795	$ 22,504,215	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 436,307	1
2	Restatements (describe):		2
3	**Late Adjusting Entries**	791,891	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,228,198	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(329,314)	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	(99,980)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (429,294)	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)**	$ 798,904	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,643,234	1
2	Discounts and Allowances for all Levels	499,055	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,142,289	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	246,116	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 246,116	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,070	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,070	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	419	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 419	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,135,201	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,135,201	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,525,095	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,480,661	31
32	Health Care	4,203,048	32
33	General Administration	2,542,760	33
	B. Capital Expense		
34	Ownership	1,141,382	34
	C. Ancillary Expense		
35	Special Cost Centers	1,181,480	35
36	Provider Participation Fee	305,078	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,854,409	40
41	**Income before Income Taxes (line 30 minus line 40)****	(329,314)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (329,314)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,093,544	44
45	Private Pay - Net Inpatient Revenue	231,310	45
46	Medicare - Net Inpatient Revenue	2,624,097	46
47	Other-(specify) Insurance	183,581	47
48	Other-(specify) Veterans	9,757	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,142,289	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,525	2,576	$ 105,937	$ 41.12	1
2	Assistant Director of Nursing	1,202	1,214	55,683	45.87	2
3	Registered Nurses	19,164	20,173	580,394	28.77	3
4	Licensed Practical Nurses	71,640	74,625	1,863,477	24.97	4
5	CNAs & Orderlies	86,535	91,089	1,057,040	11.60	5
6	CNA Trainees					6
7	Licensed Therapist	651	708	17,227	24.33	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,828	11,175	125,272	11.21	10
11	Social Service Workers	3,732	3,888	70,632	18.17	11
12	Dietician					12
13	Food Service Supervisor	2,199	2,290	51,017	22.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,518	25,289	278,000	10.99	15
16	Dishwashers					16
17	Maintenance Workers	2,975	3,067	51,748	16.87	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,831	2,154	83,095	38.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,390	17,435	213,234	12.23	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	1,939	2,179	36,200	16.61	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,500	1,517	51,068	33.67	33
34	TOTAL (lines 1 - 33)	244,629	259,379	$ 4,640,024 *	$ 17.89	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	279	$ 13,536	01-03	35
36	Medical Director	Monthly	22,086	09-03	36
37	Medical Records Consultant	Monthly	800	10-03	37
38	Nurse Consultant	Monthly	10,858	10-03	38
39	Pharmacist Consultant	Monthly	12,787	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	1,143	12-03	45
46	Other(specify)				46
47	Rehab Management Consultant	Monthly	24,000	10a-03	47
48	MDS Consultant	Monthly	4,795	10-03	48
49	TOTAL (lines 35 - 48)	279	$ 90,005		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tanya Krabbe	Administrator	0	$ 83,095
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,095

B. Administrative - Other

Description	Amount
Premier Healthcare Management, LLC - Management Fees	$ 465,013
TOTAL (agree to Schedule V, line 17, col. 3)	$ 465,013
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Richard Peelo & Associates	Accounting Services	$ 500
FR&R/Marcum LLP	Accounting Fees	36,652
See Attached	Legal Fees	17,874
LTC	Consulting Fees	45,584
Singer Networks, LLC	Data Processing	2,206
Ability Network Inc.	Data Processing	1,830
MatrixCare	Data Processing	17,173
ADP	Data Processing	10,805
HDSI	Data Processing	6,048
Nebo Systems Inc	Data Processing	1,509
E-Health Data Solutions	Data Processing	4,200
See Supplemental Schedule		32,749
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 177,129

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 121,506
Unemployment Compensation Insurance	109,762
FICA Taxes	291,048
Employee Health Insurance	222,452
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Contribution	20,333
Other Employee Benfits	12,883
Employee Physical Exam	474
Employee Meals	999
TOTAL (agree to Schedule V, line 22, col.8)	$ 779,456

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	12,517
Health Care Worker Background Check	
(Indicate # of checks performed 89)	890
Patient Background Checks 272.5	2,725
Licenses & Permits	2,990
Dues & Subscriptions	6,277
Allocated from Premier HC Mgmt, LLC	1,139
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,539

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,937
Allocated from Premier HC Mgmt, LLC	68
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,005

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
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11													
12													
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14													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC: $6,277**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,575** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **305,078**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

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

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

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

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