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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0046177

Facility Name: Chateau Nrsg & Rehab Center

Address: 7050 Madison Street (Number) Willowbrook (City) 60521 (Zip Code)

County: Dupage

Telephone Number: (630) 323-6380 **Fax #** (630) 323-6416

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steven N. 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 01/01/16 to 12/31/16 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)
** Subject to the attached Accountants Consulting Report*
(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 Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	150	Skilled (SNF)	150	54,900	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	150	TOTALS	150	54,900	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	29,569	7,920	11,956	49,445	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,569	7,920	11,956	49,445	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.06%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 02/01/2003

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 150 and days of care provided 8,960

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: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	335,147	82,296	21,385	438,828		438,828	9,917	448,745			1
2	Food Purchase		313,789		313,789		313,789	(1,044)	312,745			2
3	Housekeeping	202,627	41,763		244,390		244,390	1,142	245,532			3
4	Laundry	173,080	45,743		218,823		218,823	(118,000)	100,823			4
5	Heat and Other Utilities			269,868	269,868		269,868	1,580	271,448			5
6	Maintenance	136,098		308,384	444,482		444,482	12,272	456,754			6
7	Other (specify):*							6,889	6,889			7
8	TOTAL General Services	846,952	483,591	599,637	1,930,180		1,930,180	(87,244)	1,842,936			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	3,338,506	331,515	293,424	3,963,445		3,963,445	37,657	4,001,102			10
10a	Therapy	241,311		241	241,552		241,552		241,552			10a
11	Activities	210,813	68,486		279,299		279,299		279,299			11
12	Social Services	246,565	857		247,422		247,422	23,562	270,984			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	34,965			34,965		34,965	8,848	43,813			15
16	TOTAL Health Care and Programs	4,072,160	400,858	311,665	4,784,683		4,784,683	70,067	4,854,750			16
	C. General Administration											
17	Administrative	136,340			136,340		136,340	98,968	235,308			17
18	Directors Fees											18
19	Professional Services			620,413	620,413	(1,022)	619,391	(520,398)	98,993			19
20	Dues, Fees, Subscriptions & Promotions			87,867	87,867		87,867	(21,906)	65,961			20
21	Clerical & General Office Expenses	106,351	38,470	257,345	402,166		402,166	(36,132)	366,034			21
22	Employee Benefits & Payroll Taxes			778,006	778,006		778,006	(24,623)	753,383			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,031	1,031		1,031	893	1,924			24
25	Other Admin. Staff Transportation			16,545	16,545		16,545	1,040	17,585			25
26	Insurance-Prop.Liab.Malpractice			209,415	209,415		209,415	2,417	211,832			26
27	Other (specify):*							38,746	38,746			27
28	TOTAL General Administration	242,691	38,470	1,970,622	2,251,783	(1,022)	2,250,761	(460,995)	1,789,766			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,161,803	922,919	2,881,924	8,966,646	(1,022)	8,965,624	(478,172)	8,487,452			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 Chateau Nrsg & Rehab Center #0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			114,250	114,250		114,250	82,017	196,267			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16	16		16	241,709	241,725			32
33	Real Estate Taxes			103,175	103,175	1,022	104,197	4,652	108,849			33
34	Rent-Facility & Grounds			684,000	684,000		684,000	(684,000)				34
35	Rent-Equipment & Vehicles			18,303	18,303		18,303	983	19,286			35
36	Other (specify):*			612	612		612	(612)				36
37	**TOTAL Ownership**			920,356	920,356	1,022	921,378	(355,251)	566,127			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		360,546	1,357,496	1,718,042		1,718,042	(21,005)	1,697,037			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			337,725	337,725		337,725		337,725			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		360,546	1,695,221	2,055,767		2,055,767	(21,005)	2,034,762			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,161,803	1,283,465	5,497,501	11,942,769		11,942,769	(854,429)	11,088,340			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 Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(547)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(23,547)	30		9
10	Interest and Other Investment Income	(63,912)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(493)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(156,521)	21		24
25	Fund Raising, Advertising and Promotional	(17,612)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(492)	20		28
29	Other-Attach Schedule	(159,715)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (422,839)		$	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)	(431,590)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (431,590)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (854,429)		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

Chateau Nrsg & Rehab Center

ID# 0046177

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending income	$ (405)	02	1
2	Patient clothing	(3)	10	2
3	Theft Loss	(887)	21	3
4	Collection Expense	(5,718)	21	4
5	Amortization	(612)	36	5
6	Other Income	(8)	21	6
7	PAC Dues	(5,897)	20	7
8	Non-allowable legal	(5,700)	19	8
9	Building Company - Management Fees	(7,500)	17	9
10	Building Company - Bank Service Charge	(299)	21	10
11	Building Company - Filing Fee	(250)	21	11
12	Building Company - Amortization	(12,172)	36	12
13	Laundry Services	(118,000)	04	13
14	Lobbying	(2,264)	21	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**	(159,715)		49

Chateau Nrsg & Rehab Center

ID# 0046177

Report Period Beginning: 01/01/16

Ending: 12/31/16

	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 Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			186		9,731							9,917	1
2	Food Purchase	(1,445)		401									(1,044)	2
3	Housekeeping			1,031		111							1,142	3
4	Laundry	(118,000)											(118,000)	4
5	Heat and Other Utilities			1,438		142							1,580	5
6	Maintenance			3,005	9,004	263							12,272	6
7	Other (specify):*				5,545	1,344							6,889	7
8	**TOTAL General Services**	(119,445)		6,061	14,549	11,591							(87,244)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3)				40,483	(1,447)		(1,090)	(286)			37,657	10
10a	Therapy													10a
11	Activities													11
12	Social Services					23,562							23,562	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					8,848							8,848	15
16	**TOTAL Health Care and Programs**	(3)				72,893	(1,447)		(1,090)	(286)			70,067	16
	C. General Administration													
17	Administrative	(7,500)	7,500	3,008	17,123	78,837							98,968	17
18	Directors Fees													18
19	Professional Services	(5,700)		(385,075)		(129,623)							(520,398)	19
20	Fees, Subscriptions & Promotions	(24,001)		976		1,119							(21,906)	20
21	Clerical & General Office Expenses	(165,947)	549	6,060	103,765	19,441							(36,132)	21
22	Employee Benefits & Payroll Taxes				(24,623)								(24,623)	22
23	Inservice Training & Education													23
24	Travel and Seminar			153		740							893	24
25	Other Admin. Staff Transportation			1,040									1,040	25
26	Insurance-Prop.Liab.Malpractice			1,801		616							2,417	26
27	Other (specify):*				25,571	13,175							38,746	27
28	**TOTAL General Administration**	(203,148)	8,049	(372,037)	121,836	(15,695)							(460,995)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(322,596)	8,049	(365,976)	136,385	68,789	(1,447)		(1,090)	(286)			(478,172)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(23,547)	102,439	2,401		724							82,017	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(63,912)	296,698	8,715		208							241,709	32
33	Real Estate Taxes			4,198		454							4,652	33
34	Rent-Facility & Grounds		(684,000)										(684,000)	34
35	Rent-Equipment & Vehicles			983									983	35
36	Other (specify):*	(12,784)	12,172										(612)	36
37	**TOTAL Ownership**	(100,243)	(272,691)	16,297		1,386							(355,251)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(21,005)						(21,005)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(21,005)						(21,005)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(422,839)	(264,642)	(349,679)	136,385	70,175	(22,452)		(1,090)	(286)			(854,429)	45

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 684,000	Chateau Willowbrook Property	100.00%	$	$ (684,000)	1
2	V	33	Property Taxes	103,175	Chateau Willowbrook Property	100.00%		(103,175)	2
3	V	17	Management Fees		Chateau Willowbrook Property	100.00%	7,500	7,500	3
4	V	21	Bank Service Charge		Chateau Willowbrook Property	100.00%	299	299	4
5	V	21	Filing Fee		Chateau Willowbrook Property	100.00%	250	250	5
6	V	30	Depreciation Expense		Chateau Willowbrook Property	100.00%	102,439	102,439	6
7	V	36	Amortization Expense		Chateau Willowbrook Property	100.00%	12,172	12,172	7
8	V	33	Real Estate Tax Expense		Chateau Willowbrook Property	100.00%	103,175	103,175	8
9	V	32	Interest		Chateau Willowbrook Property	100.00%	296,698	296,698	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 787,175			$ 522,533	$ * (264,642)	14

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 186	$ 186	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	401	401	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,031	1,031	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,438	1,438	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,005	3,005	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,008	3,008	20
21	V	19	Professional Fees	391,080	Extended Care Consulting, LLC	100.00%	6,005	(385,075)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	976	976	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	6,060	6,060	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	153	153	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,040	1,040	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,801	1,801	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,401	2,401	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	8,715	8,715	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	4,198	4,198	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	983	983	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			$ 391,080			$ 41,401	$ * (349,679)	39

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	9,004	$ 9,004	15
16	V	06	Maintenance (Direct)	41,868	Extended Care Consulting, LLC	100.00%	41,868		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	844	844	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	4,701	4,701	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	17,123	17,123	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	103,765	103,765	22
23	V	21	Office and Clerical (Direct)	40,209	Extended Care Consulting, LLC	100.00%	40,209		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	22,110	22,110	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	3,461	3,461	25
26	V	22	Employee Benefits	24,623	Extended Care Consulting, LLC	100.00%		(24,623)	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			$ 106,700			$ 243,085	$ * 136,385	39

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 111	$ 111	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	142	142	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	263	263	17
18	V	19	Professional Fees	130,356	Extended Care Clinical, LLC	100.00%	733	(129,623)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	1,119	1,119	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,909	2,909	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	740	740	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	616	616	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	724	724	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	208	208	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	454	454	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	9,731	9,731	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,344	1,344	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	40,483	40,483	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	23,562	23,562	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	8,848	8,848	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	78,837	78,837	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	16,532	16,532	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	13,175	13,175	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 130,356			$ 200,531	$ * 70,175	39

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 20,095	MAC Rx, LLC	100.00%	$ 18,648	$ (1,447)	15
16	V	21	Clerical & General Office Expenses		MAC Rx, LLC	100.00%			16
17	V	22	Employee Benefits		MAC Rx, LLC	100.00%			17
18	V	39	Ancillary	291,653	MAC Rx, LLC	100.00%	270,648	(21,005)	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			$ 311,748			$ 289,296	$ * (22,452)	39

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 335,749	$ 335,749	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	335,749	CCS Employee Benefits Group	100.00%		(335,749)	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			$ 335,749			$ 335,749	$ *	39

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Various Equipment	18,720	Vent Lease LLC	100.00%	17,630	$ (1,090)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 18,720			$ 17,630	$ * (1,090)	39

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing Equipment Rental	21,453	Reliable Medical of the Midwest, LLC	100.00%	21,167	$ (286)	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			$ 21,453			$ 21,167	$ * (286)	39

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Rothner Health Ventures G II, LLC	100.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	1
2			BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	2
3			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	4
5			GRASMERE PLACE, LLC	CHICAGO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	MAC RX	DES PLAINES	PHARMACY	6
7			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	7
8			MAJOR HOSPITAL DYER	DYER, IN	Chateau Willowbrook Property	Willowbrook	Building Co.	8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			SHEFFIELD MANOR	DYER, IN				18
19			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				19
20			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				20
21			SPRING CREEK NURSING & REHAB CENTER	JOLIET				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			THE PARC AT JOLIET	JOLIET				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				25
26			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				26
27			WHEATON CARE CENTER	WHEATON				27
28								28
29								29
30								30

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Adam Vales	Relative	Clerical	0.00%	See Attached	1.7	4.25%	Alloc. Salary	$ 3,129	22-7	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.85	5.18%	Alloc Sal/Fee	10,339	17-7	2
3	Kimberly Rudolph	Relative	Clerical	0.00%	See Attached	0.27	3.55%	Alloc. Salary	84	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	$ 13,552		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 Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,380,761	34	$ 5,206	$	49,445	$ 186	1
2	02	Food	Patient Days	1,380,761	34	11,203		49,445	401	2
3	03	Housekeeping	Patient Days	1,380,761	34	28,798		49,445	1,031	3
4	05	Utilities	Patient Days	1,380,761	34	40,168		49,445	1,438	4
5	06	Maintenance	Patient Days	1,380,761	34	83,922		49,445	3,005	5
6	17	Administrative	Patient Days	1,380,761	34	84,000		49,445	3,008	6
7	19	Professional Fees	Patient Days	1,380,761	34	167,697		49,445	6,005	7
8	20	Dues and Subscriptions	Patient Days	1,380,761	34	27,266		49,445	976	8
9	21	Office and Clerical	Patient Days	1,380,761	34	169,235		49,445	6,060	9
10	24	Seminar and Travel	Patient Days	1,380,761	34	4,279		49,445	153	10
11	25	Other Staff Admin. Trans.	Patient Days	1,380,761	34	29,053		49,445	1,040	11
12	26	Insurance	Patient Days	1,380,761	34	50,289		49,445	1,801	12
13	30	Depreciation	Patient Days	1,380,761	34	67,038		49,445	2,401	13
14	32	Interest	Patient Days	1,380,761	34	243,379		49,445	8,715	14
15	33	Real Estate Taxes	Patient Days	1,380,761	34	117,233		49,445	4,198	15
16	35	Rent - Equipment & Auto	Patient Days	1,380,761	34	27,451		49,445	983	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,156,218	$		$ 41,401	25

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	1,380,761	34	251,431	251,431	49,445	9,004	1
2	06	Maintenance (Direct)	Direct		20	373,682	373,682		41,868	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,380,761	34	23,565		49,445	844	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		20	46,748			4,701	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,380,761	34	478,172	478,172	49,445	17,123	7
8	21	Office and Clerical (Pooled)	Patient Days	1,380,761	34	2,897,656	2,897,656	49,445	103,765	8
9	21	Office and Clerical (Direct)	Direct		24	460,382	460,382		40,209	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,380,761	34	617,434		49,445	22,110	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		24	73,413			3,461	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					$ 5,222,483	$ 4,461,323		$ 243,085	25

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	818,091	19	$ 1,844	$	49,445	$ 111	1
2	05	Utilities	Patient Days	818,091	19	2,355		49,445	142	2
3	06	Maintenance	Patient Days	818,091	19	4,352		49,445	263	3
4	19	Professional Fees	Patient Days	818,091	19	12,122		49,445	733	4
5	20	Dues and Subscriptions	Patient Days	818,091	19	18,512		49,445	1,119	5
6	21	Office & Clerical	Patient Days	818,091	19	48,124		49,445	2,909	6
7	24	Travel and Seminar	Patient Days	818,091	19	12,239		49,445	740	7
8	26	Insurance	Patient Days	818,091	19	10,196		49,445	616	8
9	30	Depreciation	Patient Days	818,091	19	11,978		49,445	724	9
10	32	Interest	Patient Days	818,091	19	3,446		49,445	208	10
11	33	Real Estate Taxes	Patient Days	818,091	19	7,506		49,445	454	11
12	01	Dietary Salary	Patient Days	818,091	19	160,997	160,997	49,445	9,731	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	818,091	19	22,241		49,445	1,344	13
14	10	Nursing Salary	Patient Days	818,091	19	669,803	669,803	49,445	40,483	14
15	12	Social Service Salary	Patient Days	818,091	19	389,842	389,842	49,445	23,562	15
16	15	Emp. Ben. - Healthcare	Patient Days	818,091	19	146,386		49,445	8,848	16
17	17	Administration Salary	Patient Days	818,091	19	1,304,395	1,304,395	49,445	78,837	17
18	21	Office Salary	Patient Days	818,091	19	273,525	273,525	49,445	16,532	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	818,091	19	217,984		49,445	13,175	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,317,844	$ 2,798,561		$ 200,531	25

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			$	$		$ 18,648	1
2	21	Clerical & General Office Expense	Direct Allocation							2
3	22	Employee Benefits	Direct Allocation							3
4	39	Ancillary	Direct Allocation						270,648	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					$	$		$ 289,296	25

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 335,749	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					$	$		$ 335,749	25

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Various Equipment	Direct Allocation						17,630	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					$	$		$ 17,630	25

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Reliable Medical of the Midwest, LLC
Street Address: 200 Howard Avenue
City / State / Zip Code: Des Plaines, Illinois 60018-5909
Phone Number: (847) 566-0800
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing Equipment Rental	Direct Allocation						21,167	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					$	$		$ 21,167	25

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank Leumi		X				$	$ 5,943,831			$ 296,698	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Advance HFGII		X	Line of Credit				244,215			16	6
7												7
8					-							8
9	TOTAL Facility Related						$	$ 6,188,046			$ 296,714	9
	B. Non-Facility Related*											
10	Interest Income		X								(63,912)	10
11	Allocated - EC Consulting	X									8,715	11
12	Allocated - EC Clinical	X									208	12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (54,989)	14
15	TOTALS (line 9+line14)						$	$ 6,188,046			$ 241,725	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 Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	95,364	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.)	$	101,500	2
3. Under or (over) accrual (line 2 minus line 1).	$	6,136	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	101,691	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.)**	$	1,022	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.	$	108,849	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	53,521	8
	2012	56,110	9
	2013	56,765	10
	2014	90,823	11
	2015	96,848	12

2016 Accrual = $96,848 x 1.05 = $101,691

Allocated from Extended Care Consulting = $4,198

Allocated from Extended Care Clinical = $454

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Chateau Nrsg & Rehab Center COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0046177

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-23-407-043	Long Term Care Property	$ 96,848.26	$ 96,848.26
2.	See Attached	Allocated from 2201 W. Main	$ 167,518.13	$ 4,651.80
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 264,366.39	$ 101,500.06

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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 Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Chateau Nrsg & Rehab Center COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0046177

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,447 B. General Construction Type: Exterior Brick Frame Masonry & Steel Number of Stories 1

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	273,121	2003	$ 295,367	1
2	Allocated from 2201 W. Main, LLC / Clinical			22,771	2
3	TOTALS	273,121		$ 318,138	3

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	150		2003	1987	$ 2,658,301	$ 102,439	39	$ 68,162	$ (34,277)	$ 1,537,072	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	51,953		20	1,641	1,641	37,503	9
10	Various			2004	98,684		20	4,650	4,650	64,346	10
11	Various			2005	69,862		20	3,493	3,493	38,925	11
12	Various			2006	50,399		20	2,958	2,958	33,541	12
13	Various			2007	126,729		20	6,725	6,725	64,472	13
14	Various			2008	30,544		20	1,803	1,803	15,512	14
15	Various			2009	25,582		20	944	944	13,394	15
16	Various			2010	12,771		20	705	705	4,772	16
17	Various			2011	110,418		20	5,830	5,830	31,481	17
18	Various			2012	56,744		20	8,319	8,319	35,989	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 Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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)		238,642			11,932	11,932	130,882	67
68	Related Party Allocations (Pages 12H & 12I)		108,101	1,503		1,452	(51)	72,838	68
69	Financial Statement Depreciation			114,250			(114,250)		69
70	TOTAL (lines 4 thru 69)		$ 3,638,730	$ 218,192		$ 118,614	$ (99,578)	$ 2,080,727	70

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 3,638,730	$ 218,192		$ 118,614	$ (99,578)	$ 2,080,727	1
2	Corridors On All Floors - Paint, Wallpaper	2013	3,921		20	196	196	752	2
3	Rehab Dining Room - Flooring	2013	17,000		20	3,400	3,400	12,750	3
4	New 20 Ampere 208 & 30 Ampere 120 Volt Circuits & Outlets	2013	5,500		20	275	275	963	4
5	Main Entrance Doors - New Vertical Rod Panic Devices	2013	4,435		20	222	222	776	5
6	Rear Entrance Doors - New Panic Device	2013	4,030		20	202	202	688	6
7	Repaired Concrete Staircase Walls, Concrete Curbs, Brick Paver	2013	6,910		20	346	346	1,123	7
8	Ice Cream, Gift Shop - Architectural, Framing, Drywall, Masonry	2013	129,000		20	6,450	6,450	22,575	8
9	Corridors On All Floors - Wallpaper	2013	5,959		20	298	298	1,142	9
10	Nurse Station Rehab-Remove Millwork, Electric, Plumbing. New (	2014	49,000		20	2,450	2,450	6,533	10
11	Cabinetry, Lighting, Plumbing, Electrical, Floor - Beauty Shop &	2014	34,500		20	1,725	1,725	4,600	11
12	Fire Alarm System	2014	4,694		20	235	235	685	12
13	Blinds	2014	7,155		20	1,431	1,431	3,935	13
14	Elevator Door Restrictor	2014	3,635		20	182	182	470	14
15	Doors - Basement, 1St Floor & Kitchen	2014	10,700		20	535	535	1,516	15
16	New Lawler Thermostatic Mixing Valve	2014	2,700		20	135	135	394	16
17	Exhaust Fan	2014	11,788		20	589	589	1,621	17
18	Replace Boiler & Relocate Storage Tank	2014	5,000		20	250	250	646	18
19	Control Panel And Install Remote Annunciator	2015	17,686		20	884	884	1,769	19
20	Water Heater	2015	7,596		20	380	380	570	20
21	Office Phone System	2015	49,620		20	9,924	9,924	14,059	21
22	Dining Room Flooring	2015	26,400		20	5,280	5,280	5,720	22
23	Pump Gasket	2015	3,058		20	153	153	166	23
24	Water Heater	2016	7,596		20	95	95	95	24
25	Security Systems	2016	5,548		20	46	46	46	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,062,162	$ 218,192		$ 154,296	$ (63,896)	$ 2,164,319	34

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 4,062,162	$ 218,192		$ 154,296	$ (63,896)	$ 2,164,319	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)		$ 4,062,162	$ 218,192		$ 154,296	$ (63,896)	$ 2,164,319	34

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 4,062,162	$ 218,192		$ 154,296	$ (63,896)	$ 2,164,319	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
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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)		$ 4,062,162	$ 218,192		$ 154,296	$ (63,896)	$ 2,164,319	34

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 4,062,162	$ 218,192		$ 154,296	$ (63,896)	$ 2,164,319	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
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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)		$ 4,062,162	$ 218,192		$ 154,296	$ (63,896)	$ 2,164,319	34

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Life Safety Code Improvements (Net of Settlement)	2005	231,242		20	11,562	11,562	127,182	9
10	Professional Fees - Architect	2007	7,400		20	370	370	3,700	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)		$ 238,642	$		$ 11,932	$ 11,932	$ 130,882	34

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 238,642	$		$ 11,932	$ 11,932	$ 130,882	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)		$ 238,642	$		$ 11,932	$ 11,932	$ 130,882	34

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting, LLC	2016	8,594	190	39	139	(51)	1,808	3
4									4
5	Allocated from Extended Care Clinical, LLC	2002	3,060	79	39	79		1,121	5
6									6
7	Allocated from 2201 W. Main, LLC	2002	28,319	726	39	726		10,377	7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Clinical, LLC	2002	2,528		20			2,528	9
10	Allocated from Extended Care Clinical, LLC	2003	2,979		20			2,979	10
11	Allocated from Extended Care Clinical, LLC	2005	148		20			148	11
12	Allocated from Extended Care Clinical, LLC	2009	27	1	20	1		11	12
13	Allocated from Extended Care Clinical, LLC	2014	248	12	20	12		37	13
14	Allocated from Extended Care Clinical, LLC	2015	42	2	20	2		4	14
15	Allocated from Extended Care Clinical, LLC	2016	166	8	20	8		8	15
16									16
17	Allocated from 2201 W. Main, LLC	2002	23,393		20			23,393	17
18	Allocated from 2201 W. Main, LLC	2003	27,568		20			27,568	18
19	Allocated from 2201 W. Main, LLC	2005	1,370	2	20	2		1,370	19
20	Allocated from 2201 W. Main, LLC	2009	247	12	20	12		99	20
21	Allocated from 2201 W. Main, LLC	2014	2,299	116	20	116		345	21
22	Allocated from 2201 W. Main, LLC	2015	390	19	20	19		39	22
23	Allocated from 2201 W. Main, LLC	2016	1,539	77	20	77		77	23
24									24
25	Allocated from Extended Care Consulting, LLC	2007	165	8	20	8		82	25
26	Allocated from Extended Care Consulting, LLC	2009	98	5	20	5		40	26
27	Allocated from Extended Care Consulting, LLC	2010	966	48	20	48		338	27
28	Allocated from Extended Care Consulting, LLC	2011	348	17	20	17		104	28
29	Allocated from Extended Care Consulting, LLC	2012	115	6	20	6		29	29
30	Allocated from Extended Care Consulting, LLC	2014	1,588	79	20	79		238	30
31	Allocated from Extended Care Consulting, LLC	2016	1,904	96	20	96		95	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 108,101	$ 1,503		$ 1,452	$ (51)	$ 72,838	34

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 108,101	$ 1,503		$ 1,452	$ (51)	$ 72,838	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 108,101	$ 1,503		$ 1,452	$ (51)	$ 72,838	34

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 215,457	$ 816	$ 39,705	$ 38,889	10	$ 122,926	71
72	Current Year Purchases	6,065		350	350	10	350	72
73	Fully Depreciated Assets	583,408				10	583,408	73
74								74
75	TOTALS	$ 804,930	$ 816	$ 40,055	$ 39,239		$ 706,684	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		2003 FORD ECONO VAN	2003	$ 33,833	$	$	$	5	$ 33,833	76
77		TRUCK REPAIR	2004	1,083				5	1,083	77
78		Truck Repairs	2013	5,548		1,110	1,110	5	4,068	78
79		See Supplemental		9,568	804	804		5	8,878	79
80	TOTALS			$ 50,032	$ 804	$ 1,914	$ 1,110		$ 47,862	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)	$ 5,235,262	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 219,812	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 196,265	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (23,547)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,918,866	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 Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			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.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 13,084 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	Lease	Vehicle Lease	$	$ 6,202	17
18					18
19					19
20					20
21	TOTAL		$ -	$ 6,202	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 Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$		$ 546,205	$		$ 546,205	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			130,384			130,384	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			658,735			658,735	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				294,412		294,412	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					22,172	66,134		88,306	13
14	TOTAL			$		$ 1,357,496	$ 360,546		$ 1,718,042	14

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

Facility Name & ID Number Chateau Nrsg & Rehab Center **#** 0046177 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 3,201	$ 80,089	1
2	Cash-Patient Deposits	49,293	49,293	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,094,542	1,094,542	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	265,044	265,044	6
7	Other Prepaid Expenses	16,795	16,795	7
8	Accounts Receivable (owners or related parties)	140,807	4,192,270	8
9	Other(specify): See Attached Schedule	4,580,038	4,580,038	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,149,720	$ 10,278,071	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		295,367	13
14	Buildings, at Historical Cost		3,805,411	14
15	Leasehold Improvements, at Historical Cost	892,256	892,256	15
16	Equipment, at Historical Cost	465,633	465,633	16
17	Accumulated Depreciation (book methods)	(881,368)	(3,463,025)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	2,538	21,810	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 479,059	$ 2,017,452	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,628,779	$ 12,295,523	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,337,154	$ 1,337,154	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,388	37,388	28
29	Short-Term Notes Payable	244,215	244,215	29
30	Accrued Salaries Payable	203,649	203,649	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,933	7,933	31
32	Accrued Real Estate Taxes(Sch.IX-B)	101,691	101,691	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,932,030	$ 1,932,030	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,943,831	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,943,831	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,932,030	$ 7,875,861	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,696,749	$ 4,419,662	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,628,779	$ 12,295,523	48

***(See instructions.)**

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,808,001	1
2	Restatements (describe):		2
3	Rounding	6	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,808,007	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,888,742	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,888,742	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)**	$ 4,696,749	24 *

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 13,274,034	1
2	Discounts and Allowances for all Levels	(4,912,418)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,361,616	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,792,193	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,792,193	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	3,012	13
14	Non-Patient Meals	547	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	289,933	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	115,632	19
20	Radiology and X-Ray	22,072	20
21	Other Medical Services	64,181	21
22	Laundry	118,000	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 613,377	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	63,912	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 63,912	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	413	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 413	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,831,511	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,930,180	31
32	Health Care	4,784,683	32
33	General Administration	2,251,783	33
	B. Capital Expense		
34	Ownership	920,356	34
	C. Ancillary Expense		
35	Special Cost Centers	1,718,042	35
36	Provider Participation Fee	337,725	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,942,769	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,888,742	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,888,742	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,402,188	44
45	Private Pay - Net Inpatient Revenue	2,161,817	45
46	Medicare - Net Inpatient Revenue	495,215	46
47	Other-(specify) Hospice	280,645	47
48	Other-(specify) Insurance	21,751	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,361,616	49

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

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

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

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

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,950	2,312	$ 111,150	$ 48.08	1
2	Assistant Director of Nursing	1,935	2,136	95,103	44.52	2
3	Registered Nurses	30,281	33,263	1,124,794	33.82	3
4	Licensed Practical Nurses	27,436	29,851	880,768	29.51	4
5	CNAs & Orderlies	71,696	77,328	1,089,778	14.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,273	11,189	241,311	21.57	8
9	Activity Director	1,860	2,089	40,260	19.27	9
10	Activity Assistants	12,114	13,312	154,089	11.58	10
11	Social Service Workers	10,915	12,403	246,565	19.88	11
12	Dietician					12
13	Food Service Supervisor	2,039	2,248	51,044	22.71	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,561	4,978	69,858	14.03	15
16	Dishwashers	18,661	20,387	214,245	10.51	16
17	Maintenance Workers	5,953	6,690	136,098	20.34	17
18	Housekeepers	17,192	19,144	202,627	10.58	18
19	Laundry	14,773	16,458	173,080	10.52	19
20	Administrator	1,958	2,217	101,945	45.98	20
21	Assistant Administrator	1,366	1,558	34,395	22.08	21
22	Other Administrative					22
23	Office Manager	1,201	1,437	22,119	15.39	23
24	Clerical	2,582	2,723	27,113	9.96	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	1,917	2,118	35,722	16.87	31
32	Other Health Care(specify)					32
33	Other(specify)	6,323	7,130	109,739	15.39	33
34	TOTAL (lines 1 - 33)	246,986	270,971	$ 5,161,803 *	$ 19.05	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	416	$ 21,385	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,605	10-03	39
40	Physical Therapy Consultant	3	151	10a-03	40
41	Occupational Therapy Consultant	2	90	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	421	$ 50,231		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	81	3,624	10-03	51
52	Certified Nurse Assistants/Aides	10,957	279,195	10-03	52
53	TOTAL (lines 50 - 52)	11,038	$ 282,819		53

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Stephanie Hunter	Administrator	0	$ 96,778
Domenica Turner	Asst. Administrator	0	34,395
Jamie Kreips	Administrator	0	5,167
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 136,340

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consulting	$ 1,530
Legal	See attached	23,264
Marcum	Accounting Fees	24,826
Pinnacle Quality Insight	Customer Service	4,089
Advanced Discovery	Litigation Support	164
Navex Global Inc	Compliance Software	102
Blymas	Tax Credit Service	1,041
Helmrich Kelleher	Management Consulting	751
Benefit Services Group	Health Benefit Admin	547
ECC	Data Processing	150
See Supplemental Schedule		563,949
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 620,413

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 115,288
Unemployment Compensation Insurance	50,609
FICA Taxes	384,861
Employee Health Insurance	193,913
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	218
Other Employee Benefits	7,073
Holiday Expense	1,421
TOTAL (agree to Schedule V, line 22, col.8)	$ 753,383

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 832
Advertising: Employee Recruitment	29,835
Health Care Worker Background Check	3,163
(Indicate # of checks performed 285)	
Patient Background Checks	
Dues and Subscriptions	25,026
Licenses and Fees	5,011
Allocated from Extended Care Consulting	976
Allocated from Extended Care Clinical	1,119
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 65,961

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,031
Allocated from Extended Care Consulting	153
Allocated from Extended Care Clinical	740
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,924

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Chateau Nrsg & Rehab Center # 0046177 Report Period Beginning: 01/01/16 Ending: 12/31/16

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ILTC $17,870**

(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. $ **79,892** 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. $ **337,725**
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? **Yes** Indicate the amount. $ **547**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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