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: 0052167

Facility Name: Colonial Healthcare And Rehabilitation Centre, Llc

Address: 515 Bureau Valley Parkway (Number) Princeton (City) 61356 (Zip Code)

County: Bureau

Telephone Number: (815) 875-3347 **Fax #** (815) 875-2012

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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	92	Skilled (SNF)	92	33,672	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	92	TOTALS	92	33,672	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	12,236	9,794	3,426	25,456	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,236	9,794	3,426	25,456	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.60%

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 01/01/2013

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 92 and days of care provided 2,359

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Cent # 0052167 Report Period Beginning: 01/01/16 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	207,870	28,784	6,936	243,590		243,590	33	243,623			1
2	Food Purchase		127,906		127,906		127,906	(1,605)	126,301			2
3	Housekeeping	886	1,101	136,996	138,983		138,983	434	139,417			3
4	Laundry	106	6,876	92,181	99,163		99,163		99,163			4
5	Heat and Other Utilities			113,292	113,292		113,292	(6,306)	106,986			5
6	Maintenance	57,955	6,880	58,456	123,291		123,291	(2,165)	121,126			6
7	Other (specify):*											7
8	TOTAL General Services	266,817	171,547	407,861	846,225		846,225	(9,609)	836,616			8
	B. Health Care and Programs											
9	Medical Director			13,000	13,000		13,000		13,000			9
10	Nursing and Medical Records	1,516,457	68,208	47,587	1,632,252		1,632,252	14,028	1,646,280			10
10a	Therapy			552	552		552		552			10a
11	Activities	57,242	7,132	1,323	65,697		65,697		65,697			11
12	Social Services	57,693		427	58,120		58,120	2,879	60,999			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,584	6,584			15
16	TOTAL Health Care and Programs	1,631,392	75,340	62,889	1,769,621		1,769,621	23,492	1,793,113			16
	C. General Administration											
17	Administrative	96,229		114,354	210,583		210,583	(84,065)	126,518			17
18	Directors Fees											18
19	Professional Services			214,636	214,636		214,636	(148,766)	65,870			19
20	Dues, Fees, Subscriptions & Promotions			46,919	46,919		46,919	(27,981)	18,938			20
21	Clerical & General Office Expenses	100,253	20,411	252,490	373,154		373,154	(120,327)	252,827			21
22	Employee Benefits & Payroll Taxes			339,177	339,177		339,177		339,177			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,503	2,503		2,503	489	2,992			24
25	Other Admin. Staff Transportation			6,694	6,694		6,694	2,196	8,890			25
26	Insurance-Prop.Liab.Malpractice			69,948	69,948		69,948	474	70,422			26
27	Other (specify):*							22,661	22,661			27
28	TOTAL General Administration	196,482	20,411	1,046,721	1,263,614		1,263,614	(355,319)	908,295			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,094,691	267,298	1,517,471	3,879,460		3,879,460	(341,437)	3,538,023			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 Colonial Healthcare And Rehabilitation Centre, Llc #0052167 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			22,140	22,140		22,140	217,720	239,860			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							2,084	2,084			32
33	Real Estate Taxes			35,892	35,892		35,892	2,450	38,342			33
34	Rent-Facility & Grounds			471,260	471,260		471,260	(470,122)	1,138			34
35	Rent-Equipment & Vehicles			12,053	12,053		12,053	269	12,322			35
36	Other (specify):*											36
37	**TOTAL Ownership**			541,345	541,345		541,345	(247,600)	293,745			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		77,866	437,121	514,987		514,987		514,987			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			176,449	176,449		176,449		176,449			42
43	Other (specify):*	32,510		17,297	49,807		49,807	(49,807)	(0)			43
44	**TOTAL Special Cost Centers**	32,510	77,866	630,867	741,243		741,243	(49,807)	691,436			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,127,201	345,164	2,689,683	5,162,048		5,162,048	(638,844)	4,523,204			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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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	(1,113)	02		4
5	Telephone, TV & Radio in Resident Rooms	(7,226)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	216,467	30		9
10	Interest and Other Investment Income	(204)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(492)	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	(8,852)	21		18
19	Entertainment	(177)	21		19
20	Contributions	(200)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(136,122)	21		24
25	Fund Raising, Advertising and Promotional	(25,191)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(136)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(718,878)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (682,124)		$	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)	43,280		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 43,280		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (638,844)		37

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

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

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

STATE OF ILLINOIS

Colonial Healthcare And Rehabilitation Centre, Llc

ID# 0052167

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Expenses	$ (16,560)	43	1
2	Bank Charges	(5,946)	21	2
3	Marketing Salaries	(32,510)	43	3
4	Theft and Loss	(56)	21	4
5	Sequetration	(28,270)	21	5
6	Capitalized R&M	(5,097)	06	6
7	Non-Allowable Legal	(39,347)	19	7
8	PAC Dues	(2,814)	20	8
9	Professional Fees Refund	(3,326)	21	9
10	Rent for Sale Leaseback Arrangement	(471,260)	34	10
11	Marketing Travel	(737)	43	11
12	Additional R&M	1,399	06	12
13	Non-Allowable Expense	(114,354)	17	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(718,878)		49

Colonial Healthcare And Rehabilitation Centre, Llc

ID# 0052167

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 Colonial Healthcare And Rehabilitation Centre, Llc **#** 0052167 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			33									33	1
2	Food Purchase	(1,605)											(1,605)	2
3	Housekeeping			434									434	3
4	Laundry													4
5	Heat and Other Utilities	(7,226)		762	159								(6,306)	5
6	Maintenance	(3,698)		958	423	152							(2,165)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(12,529)		2,186	582	152							(9,609)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			14,028									14,028	10
10a	Therapy													10a
11	Activities													11
12	Social Services			2,879									2,879	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			6,584									6,584	15
16	**TOTAL Health Care and Programs**			23,492									23,492	16
	C. General Administration													
17	Administrative	(114,354)		30,289									(84,065)	17
18	Directors Fees													18
19	Professional Services	(39,347)		(40,036)	61	(69,443)							(148,766)	19
20	Fees, Subscriptions & Promotions	(28,205)		209	15								(27,981)	20
21	Clerical & General Office Expenses	(182,885)		27,789	11	34,757							(120,327)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			99		390							489	24
25	Other Admin. Staff Transportation			295		1,901							2,196	25
26	Insurance-Prop.Liab.Malpractice			239	102	132							474	26
27	Other (specify):*			16,825		5,837							22,661	27
28	**TOTAL General Administration**	(364,791)		35,709	189	(26,426)							(355,319)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(377,320)		61,386	771	(26,274)							(341,437)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 **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	216,467			1,253								217,720	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(204)			2,288								2,084	32
33	Real Estate Taxes				2,450								2,450	33
34	Rent-Facility & Grounds	(471,260)		8,258	(8,258)	1,138							(470,122)	34
35	Rent-Equipment & Vehicles			269									269	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(254,997)		8,527	(2,268)	1,138							(247,600)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(49,807)											(49,807)	43
44	**TOTAL Special Cost Centers**	(49,807)											(49,807)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(682,124)		69,913	(1,497)	(25,136)							(638,844)	45

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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. [ ] YES [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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	1	DIETARY	$	MOSAIC HEALTHCARE	100.00%	$ 33	$ 33	15
16	V	3	HOUSEKEEPING		MOSAIC HEALTHCARE	100.00%	434	434	16
17	V	5	UTILITIES		MOSAIC HEALTHCARE	100.00%	762	762	17
18	V	6	REPAIRS AND MAINT.		MOSAIC HEALTHCARE	100.00%	958	958	18
19	V	10	NURSING SALARIES		MOSAIC HEALTHCARE	100.00%	30,588	30,588	19
20	V	12	SOCIAL SERVICE SALARIES		MOSAIC HEALTHCARE	100.00%	2,879	2,879	20
21	V	15	NURSING EMP BENS & PR TAXES		MOSAIC HEALTHCARE	100.00%	6,584	6,584	21
22	V	17	ADMINISTRATIVE SALARIES		MOSAIC HEALTHCARE	100.00%	30,289	30,289	22
23	V	19	PROFESSIONAL FEES		MOSAIC HEALTHCARE	100.00%	938	938	23
24	V	20	FEES, SUBSCRIPTIONS		MOSAIC HEALTHCARE	100.00%	209	209	24
25	V	21	CLERICAL AND GENERAL SALARIES		MOSAIC HEALTHCARE	100.00%	55,238	55,238	25
26	V	21	CLERICAL AND GENERAL EXP	9,396	MOSAIC HEALTHCARE	100.00%	6,787	(2,609)	26
27	V	24	SEMINARS		MOSAIC HEALTHCARE	100.00%	99	99	27
28	V	25	ADMIN. STAFF TRANS.		MOSAIC HEALTHCARE	100.00%	295	295	28
29	V	26	INSURANCE		MOSAIC HEALTHCARE	100.00%	239	239	29
30	V	27	GEN. ADMIN. EMP. BEN.		MOSAIC HEALTHCARE	100.00%	16,825	16,825	30
31	V	34	RENT - BUILDING (RELATED)		MOSAIC HEALTHCARE	100.00%	8,258	8,258	31
32	V	35	EQUIPMENT RENTAL		MOSAIC HEALTHCARE	100.00%	269	269	32
33	V								33
34	V	19	MANAGED CARE/BOOKKEEPING	24,414	MOSAIC HEALTHCARE	100.00%		(24,414)	34
35	V	19	ADMINISTRATIVE	16,560	MOSAIC HEALTHCARE	100.00%		(16,560)	35
36	V	10	MDS CONSULTANT	16,560	MOSAIC HEALTHCARE	100.00%		(16,560)	36
37	V	21	OFFICE CONSULTANT	24,840	MOSAIC HEALTHCARE	100.00%		(24,840)	37
38	V								38
39	Total			$ 91,770			$ 161,683	$ * 69,913	39

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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	3	HOUSEKEEPING	$	4600 TOUHY, LLC	100.00%	$	$	15
16	V	5	UTILITIES		4600 TOUHY, LLC	100.00%	159	159	16
17	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	423	423	17
18	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	61	61	18
19	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	15	15	19
20	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	11	11	20
21	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	102	102	21
22	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	1,253	1,253	22
23	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	2,288	2,288	23
24	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	2,450	2,450	24
25	V								25
26	V	34	RENT	8,258	4600 TOUHY, LLC	100.00%		(8,258)	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			$ 8,258			$ 6,761	$ * (1,497)	39

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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	6	MAINTENANCE & REPAIR	$	PLATINUM BILLING SOLUTIONS	30.00%	$ 152	$ 152	15
16	V	19	PROFESSIONAL SERVICES		PLATINUM BILLING SOLUTIONS	30.00%	804	804	16
17	V	21	CLERICAL & GENERAL		PLATINUM BILLING SOLUTIONS	30.00%	5,379	5,379	17
18	V	21	CLERICAL & GENERAL- SALARY		PLATINUM BILLING SOLUTIONS	30.00%	29,378	29,378	18
19	V	24	BUSINESS SEMINAR		PLATINUM BILLING SOLUTIONS	30.00%	390	390	19
20	V	25	AUTO & TRAVEL		PLATINUM BILLING SOLUTIONS	30.00%	1,901	1,901	20
21	V	26	INSURANCE		PLATINUM BILLING SOLUTIONS	30.00%	132	132	21
22	V	27	EMPLOYEE BENEFITS/TAXES		PLATINUM BILLING SOLUTIONS	30.00%	5,837	5,837	22
23	V	34	RENT		PLATINUM BILLING SOLUTIONS	30.00%	1,138	1,138	23
24	V								24
25	V	19	AR MANAGEMENT SERVICES	70,247	PLATINUM BILLING SOLUTIONS	30.00%		(70,247)	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			$ 70,247			$ 45,111	$ * (25,136)	39

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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	CENTRAL ILLINOIS OPERATIONS LLC	99.99%	The Mosaic of Beacon	Chicago	4600 TOUHY, LLC	LINCOLNWOOD	BUILDING CO.	1
2	TETRAD MANAGEMENT LLC	0.01%	The Mosaic of Lakeshore	Chicago	MANAGCARE, INC.	LINCOLNWOOD	BOOKKEEPING	2
3			The Mosaic of Mayfield	Chicago	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	ADMIN. CONSULTANT	3
4			The Mosaic of Uptown	Chicago	PLATINUM BILLING SOLUTION	LAKEWOOD, NJ	AR MANAGEMENT SERVICI	4
5			The Mosaic of Springfield	Springfield	Worthy Insurance Group, LLC	Skokie	Insurance Company	5
6			The Heights Healthcare & Rehabilitation Centre	Peoria Heights				6
7			Morton Terrace Healthcare & Rehabilitation Centre	Morton				7
8			Morton Villa Healthcare & Rehabilitation Centre	Morton				8
9			Rivershores Healthcare & Rehabilitation Centre	Marseilles				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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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 Colonial Healthcare And Rehabilitation Cen # 0052167 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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: MOSAIC HEALTHCARE
Street Address: 4600 W. TOUHY AVENUE, SUITE 200
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	483,176	10	$ 625	$	25,456	$ 33	1
2	3	HOUSEKEEPING	PATIENT DAYS	483,176	10	8,235		25,456	434	2
3	5	UTILITIES	PATIENT DAYS	483,176	10	14,454		25,456	762	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	483,176	10	18,179		25,456	958	4
5	10	NURSING SALARIES	PATIENT DAYS	483,176	10	580,592	580,592	25,456	30,588	5
6	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	483,176	10	54,655	54,655	25,456	2,879	6
7	15	NURSING EMP BENS & PR TAX	PATIENT DAYS	483,176	10	124,964		25,456	6,584	7
8	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	483,176	10	574,906	574,906	25,456	30,289	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	483,176	10	17,800		25,456	938	9
10	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	483,176	10	3,962		25,456	209	10
11	21	CLERICAL AND GENERAL SAI	PATIENT DAYS	483,176	10	1,048,463	1,048,463	25,456	55,238	11
12	21	CLERICAL AND GENERAL EX	PATIENT DAYS	483,176	10	128,829		25,456	6,787	12
13	24	SEMINARS	PATIENT DAYS	483,176	10	1,876		25,456	99	13
14	25	ADMIN. STAFF TRANS.	PATIENT DAYS	483,176	10	5,603		25,456	295	14
15	26	INSURANCE	PATIENT DAYS	483,176	10	4,543		25,456	239	15
16	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	483,176	10	319,345		25,456	16,825	16
17	34	RENT - BUILDING (RELATED)	PATIENT DAYS	483,176	10	156,750		25,456	8,258	17
18	35	EQUIPMENT RENTAL	PATIENT DAYS	483,176	10	5,104		25,456	269	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,068,885	$ 2,258,616		$ 161,683	25

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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: 4600 TOUHY, LLC
Street Address: 4600 W. TOUHY AVENUE, SUITE 200
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((773) 463-1313
Fax Number: ((773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSKEEPING	MNGCR. PATIENT DAYS	483,176	10	$	$	25,456	$	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	483,176	10	3,010		25,456	159	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	483,176	10	8,036		25,456	423	3
4	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	483,176	10	1,150		25,456	61	4
5	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	483,176	10	293		25,456	15	5
6	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	483,176	10	209		25,456	11	6
7	26	INSURANCE	MNGCR. PATIENT DAYS	483,176	10	1,941		25,456	102	7
8	30	DEPRECIATION	MNGCR. PATIENT DAYS	483,176	10	23,779		25,456	1,253	8
9	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	483,176	10	43,419		25,456	2,288	9
10	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	483,176	10	46,499		25,456	2,450	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 128,334	$		$ 6,761	25

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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: PLATINUM BILLING SOLUTIONS
Street Address: 1100 TOWBIN AVENUE, UNIT C
City / State / Zip Code: LAKEWOOD, NJ 08701
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	6	MAINTENANCE & REPAIR	PATIENT DAYS	483,176	10	$ 2,885	$	25,456	$ 152	1
2	19	PROFESSIONAL SERVICES	PATIENT DAYS	483,176	10	15,260		25,456	804	2
3	21	CLERICAL & GENERAL	PATIENT DAYS	483,176	10	102,097		25,456	5,379	3
4	21	CLERICAL & GENERAL- SALA	PATIENT DAYS	483,176	10	557,621	557,621	25,456	29,378	4
5	24	BUSINESS SEMINAR	PATIENT DAYS	483,176	10	7,400		25,456	390	5
6	25	AUTO & TRAVEL	PATIENT DAYS	483,176	10	36,080		25,456	1,901	6
7	26	INSURANCE	PATIENT DAYS	483,176	10	2,507		25,456	132	7
8	27	EMPLOYEE BENEFITS/TAXES	PATIENT DAYS	483,176	10	110,789		25,456	5,837	8
9	34	RENT	PATIENT DAYS	483,176	10	21,600		25,456	1,138	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					$ 856,240	$ 557,621		$ 45,111	25

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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
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14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 Report Period Beginning: 01/01/16 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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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 Colonial Healthcare And Rehabilitation Cent # 0052167 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							$	$			$	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	Allocated from 4600 Touhy	X									2,288	6
7												7
8					-							8
9	TOTAL Facility Related						$	$			$ 2,288	9
	B. Non-Facility Related*											
10	Interest Income		X								(204)	10
11												11
12												12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (204)	14
15	TOTALS (line 9+line14)						$	$			$ 2,085	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 Colonial Healthcare And Rehabilitation Centı # 0052167 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 Colonial Healthcare And Rehabilitation Centre, Llc **#** 0052167 **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.**	$ 27,273	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.)		$ 37,639	2
3. Under or (over) accrual (line 2 minus line 1).		$ 10,366	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 27,977	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 38,343	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	60,975	8
	2012	63,679	9
	2013	32,454	10
	2014	33,331	11
	2015	35,189	12

2016 Accrual: $35,189 x 0.80 = $27,977 (Rounded)

Allocated from 4600 Touhy LLC: $2,450

	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 Colonial Healthcare And Rehabilitation Centre, Llc COUNTY Bureau

FACILITY IDPH LICENSE NUMBER 0052167

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.	16-15-301-008	Long Term Care Property	$ 573.48	$ 573.48
2.	16-15-301-009	Long Term Care Property	$ 573.48	$ 573.48
3.	16-15-303-020	Long Term Care Property	$ 34,041.78	$ 34,041.78
4.	See Attached	Home Office Allocation	$ 89,919.35	$ 2,368.69
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 125,108.09	$ 37,557.43

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 Colonial Healthcare And Rehabilitation Centre, Llc COUNTY Bureau

FACILITY IDPH LICENSE NUMBER 0052167

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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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		2013	$ 372,705	1
2	Allocated from 4600 Touhy LLC			4,742	2
3	TOTALS			$ 377,447	3

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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	92		2013	1973	$ 2,866,814	$	35	$ 81,909	$ 81,909	$ 320,395	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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)								67
68	Related Party Allocations (Pages 12H & 12I)		55,234	1,254		2,311	1,057	11,278	68
69	Financial Statement Depreciation			22,140			(22,140)		69
70	TOTAL (lines 4 thru 69)		$ 2,922,048	$ 23,394		$ 84,220	$ 60,826	$ 331,673	70

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 Report Period Beginning: 01/01/16 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		$ 2,922,048	$ 23,394		$ 84,220	$ 60,826	$ 331,673	1
2	Installed New 5 Ton Condensing Unit For North A/C	2013	2,734		20	273	273	957	2
3	Installed New Building Signage	2013	6,896		20	690	690	2,356	3
4	Install New Window Treatments & Floor In Therapy Gym	2014	6,268		20	313	313	679	4
5	New Receptacles	2015	7,897		20	527	527	790	5
6	Installation Of Lighting And 23 Bulb Flood Fixtures	2015	8,184		20	546	546	818	6
7	Sealing Of The Blacktop In The Parking Lot	2015	6,957		20	464	464	502	7
8	Installation Of Wiremold/Electrical Boxes In Office Area	2015	3,362		20	168	168	252	8
9	Generator	2016	8,587		20	429	429	429	9
10	Ac Wall Unit	2016	2,501		20	125	125	125	10
11	Repaired Doors - Crossbars	2016	5,097		20	255	255	255	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,980,531	$ 23,394		$ 88,010	$ 64,616	$ 338,837	34

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 Report Period Beginning: 01/01/16 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		$ 2,980,531	$ 23,394		$ 88,010	$ 64,616	$ 338,837	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,980,531	$ 23,394		$ 88,010	$ 64,616	$ 338,837	34

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 Report Period Beginning: 01/01/16 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		$ 2,980,531	$ 23,394		$ 88,010	$ 64,616	$ 338,837	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,980,531	$ 23,394		$ 88,010	$ 64,616	$ 338,837	34

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 Report Period Beginning: 01/01/16 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		$ 2,980,531	$ 23,394		$ 88,010	$ 64,616	$ 338,837	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,980,531	$ 23,394		$ 88,010	$ 64,616	$ 338,837	34

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 Report Period Beginning: 01/01/16 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									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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 4600 Touhy LLC	2012	27,051	694	30	902	208	4,509	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Mosaic HC	2013	454		20	23	23	91	9
10	Allocated from Mosaic HC	2012	5,648		20	282	282	1,412	10
11									11
12	Allocated from 4600 Touhy LLC	2012	17,421	449	20	871	422	4,355	12
13	Allocated from 4600 Touhy LLC	2013	4,239	100	20	212	112	848	13
14	Allocated from 4600 Touhy LLC	2014	421	11	20	21	10	63	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)		$ 55,234	$ 1,254		$ 2,311	$ 1,057	$ 11,278	34

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 Report Period Beginning: 01/01/16 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		$ 55,234	$ 1,254		$ 2,311	$ 1,057	$ 11,278	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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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)		$ 55,234	$ 1,254		$ 2,311	$ 1,057	$ 11,278	34

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 Report Period Beginning: 01/01/16 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	$ 1,378,407	$	$ 150,064	$ 150,064	10	$ 572,483	71
72	Current Year Purchases	17,868		1,787	1,787	10	1,787	72
73	Fully Depreciated Assets	13,530				10	13,530	73
74								74
75	TOTALS	$ 1,409,804	$	$ 151,851	$ 151,851		$ 587,799	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Mosaic HC	2016	$ 5,005	$	$	$	5	$ 5,005	76
77										77
78										78
79										79
80	TOTALS			$ 5,005	$	$	$		$ 5,005	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,772,787	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 23,394	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 239,861	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 216,467	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 931,641	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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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: ARC Healthcare II Operating Partnership (Sale Leaseback Arrangement)
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		92		$ 471,260			3
4	Additions							4
5					(471,260)			5
6	Allocated from Platinum				1,138			6
7	TOTAL		92		$ 1,138 **			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 [ ] NO
16. Rental Amount for movable equipment: $ 1,065 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2014 Ford	$ 938	$ 11,257	17
18					18
19					19
20					20
21	TOTAL		$ 938	$ 11,257	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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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 Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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	$		$ 151,619	$		$ 151,619	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			38,109			38,109	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			237,673			237,673	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				67,721		67,721	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					9,720	10,145		19,865	13
14	TOTAL			$		$ 437,121	$ 77,866		$ 514,987	14

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

STATE OF ILLINOIS

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 **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	$ 150,842	$	1
2	Cash-Patient Deposits	12,205		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	858,623		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	78,557		6
7	Other Prepaid Expenses	13,174		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	125,737		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,239,138	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	39,234		15
16	Equipment, at Historical Cost	136,065		16
17	Accumulated Depreciation (book methods)	(65,965)		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	2,289,442		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,398,776	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,637,914	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,440,992	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,205		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	174,956		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,255		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,977		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	13,262		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,673,647	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,019,684		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,019,684	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,693,331	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 944,583	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,637,914	$	48

***(See instructions.)**

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 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**	$ 693,316	1
2	Restatements (describe):		2
3	PY Depreciation	(810)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 692,506	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	252,077	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)**	$ 252,077	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)**	$ 944,583	24 *

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 Report Period Beginning: 01/01/16 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	$ 4,328,294	1
2	Discounts and Allowances for all Levels	224,626	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,552,920	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	733,147	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 733,147	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,113	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	67,263	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	769	19
20	Radiology and X-Ray	619	20
21	Other Medical Services	54,764	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 124,528	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	204	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 204	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	3,326	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,326	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,414,125	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	846,225	31
32	Health Care	1,769,621	32
33	General Administration	1,263,614	33
	B. Capital Expense		
34	Ownership	541,345	34
	C. Ancillary Expense		
35	Special Cost Centers	564,794	35
36	Provider Participation Fee	176,449	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,162,048	40
41	**Income before Income Taxes (line 30 minus line 40)****	252,077	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 252,077	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,778,366	44
45	Private Pay - Net Inpatient Revenue	1,796,142	45
46	Medicare - Net Inpatient Revenue	751,385	46
47	Other-(specify) Hospice, Managed Care Medicare	194,312	47
48	Other-(specify) Insurance	32,715	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,552,920	49

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

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

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

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 Report Period Beginning: 01/01/16 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	1,873	2,036	$ 76,552	$ 37.60	1
2	Assistant Director of Nursing	1,241	1,349	45,470	33.71	2
3	Registered Nurses	15,489	16,836	490,335	29.12	3
4	Licensed Practical Nurses	10,705	11,636	252,732	21.72	4
5	CNAs & Orderlies	45,858	49,846	620,577	12.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,797	1,953	28,933	14.81	9
10	Activity Assistants	2,876	3,126	28,309	9.06	10
11	Social Service Workers	1,894	2,059	35,354	17.17	11
12	Dietician					12
13	Food Service Supervisor	1,863	2,025	39,579	19.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,023	17,417	168,291	9.66	15
16	Dishwashers					16
17	Maintenance Workers	1,842	2,003	57,955	28.93	17
18	Housekeepers	74	80	886	11.08	18
19	Laundry	11	12	106	8.83	19
20	Administrator	1,929	2,160	96,229	44.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,987	2,160	38,473	17.81	23
24	Clerical	4,226	4,593	61,780	13.45	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	1,934	2,103	30,791	14.64	31
32	Other Health Care(specify)					32
33	Other(specify)	3,006	3,267	54,849	16.79	33
34	TOTAL (lines 1 - 33)	114,628	124,661	$ 2,127,201 *	$ 17.06	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	Monthly	$ 6,936	01-03	35
36	Medical Director	Monthly	13,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	25,021	10-03	38
39	Pharmacist Consultant	Monthly	6,006	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Per Visit	552	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Quarterly	1,323	11-03	44
45	Social Service Consultant	Per Visit	427	12-03	45
46	Other(specify)				46
47	MDS Consultant	Monthly	16,560	10-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 69,825		49

C. CONTRACT NURSES

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

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc # 0052167 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Louanne Kenwick	Administrator	0.00%	$ 96,229
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,229

B. Administrative - Other

Description	Amount
Management Fee - Tetrad Management	$ 114,354
TOTAL (agree to Schedule V, line 17, col. 3)	$ 114,354
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 20,912
Madison Specs	Cost Segregation	1,812
Mosaic HC	Bookkeeping Fees	24,414
Personnel Planners	Unemployment Tax Consult	2,365
Creative Teach	Data Processing	2,100
Galaxy Software	Data Processing	1,460
Health MedX LLC	Data Processing	10,833
Provinet Solutions	Data Processing	540
SIKICH LLP	Data Processing	1,392
Smartlinx Solutions LLC	Data Processing	16,708
See Attached	Legal	43,794
See Supplemental Schedule		88,307
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 214,636

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,504
Unemployment Compensation Insurance	21,501
FICA Taxes	150,995
Employee Health Insurance	85,351
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	30,203
Other Employee Benefits	10,307
Holiday Expense	315
TOTAL (agree to Schedule V, line 22, col.8)	$ 339,175

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	$
Advertising: Employee Recruitment	5,556
Health Care Worker Background Check	1,263
(Indicate # of checks performed 126)	
Patient Background Checks	
Dues and Subscriptions	7,116
License and Permits	4,779
Allocated from Mosaic HC	209
Allocated from 4600 Touhy LLC	15
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,938

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,503
Allocated from Mosaic HC	99
Allocated from Platinum	390
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,992

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Colonial Healthcare And Rehabilitation Centre, Llc **#** 0052167 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on Long Term Care: $8,527**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,063** Line **10**

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

(8) Are you presently operating under a sale and leaseback arrangement? **Yes**
If YES, give effective date of lease. **12/31/2014**

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **176,449**
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. $ **1,113**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **No**
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