

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: <u>0046177</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Chateau Nursing & Rehab Center, Llc</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>7050 Madison Street</u> <u>Willowbrook</u> <u>60521</u>																									
Number City Zip Code																									
County: <u>Dupage</u>																									
Telephone Number: <u>(630) 323-6380</u> Fax # <u>(630) 323-6416</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Lisa M. Hanlon, C.P.A.</u></td></tr><tr><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Lisa M. Hanlon, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	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												
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	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																								
Date of Initial License for Current Owners: <u>02/01/03</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:																									
Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>150</u>	Skilled (SNF)	<u>150</u>	<u>54,900</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>150</u>	TOTALS	<u>150</u>	<u>54,900</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>34,080</u>	<u>7,105</u>	<u>9,328</u>	<u>50,513</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>34,080</u>	<u>7,105</u>	<u>9,328</u>	<u>50,513</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.01%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 150 and days of care provided 8,904

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

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

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

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc # 0046177 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	309,441	67,888	13,042	390,371		390,371	8,600	398,971			1
2	Food Purchase		309,226		309,226		309,226	(1,270)	307,956			2
3	Housekeeping	183,289	44,056		227,345		227,345	631	227,976			3
4	Laundry	66,558	18,832		85,390		85,390		85,390			4
5	Heat and Other Utilities			198,482	198,482		198,482	912	199,394			5
6	Maintenance	99,347		219,688	319,035		319,035	8,164	327,199			6
7	Other (specify):*							3,354	3,354			7
8	TOTAL General Services	658,635	440,002	431,212	1,529,849		1,529,849	20,391	1,550,240			8
	B. Health Care and Programs											
9	Medical Director			46,500	46,500		46,500		46,500			9
10	Nursing and Medical Records	3,544,071	206,296	13,171	3,763,538		3,763,538	58,788	3,822,326			10
10a	Therapy	195,877		10,000	205,877		205,877		205,877			10a
11	Activities	210,966	41,828		252,794		252,794		252,794			11
12	Social Services	208,709	306		209,015		209,015	23,701	232,716			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							14,023	14,023			15
16	TOTAL Health Care and Programs	4,159,623	248,430	69,671	4,477,724		4,477,724	96,512	4,574,236			16
	C. General Administration											
17	Administrative	131,046			131,046		131,046	91,281	222,327			17
18	Directors Fees											18
19	Professional Services			649,176	649,176	(11,863)	637,313	(484,234)	153,079			19
20	Dues, Fees, Subscriptions & Promotions			51,942	51,942		51,942	(21,363)	30,579			20
21	Clerical & General Office Expenses	103,242	36,636	290,537	430,415		430,415	(67,087)	363,328			21
22	Employee Benefits & Payroll Taxes			736,824	736,824		736,824	(9,144)	727,680			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,816	6,816		6,816	1,825	8,641			24
25	Other Admin. Staff Transportation			15,757	15,757		15,757	870	16,627			25
26	Insurance-Prop.Liab.Malpractice			332,601	332,601		332,601	(2,478)	330,123			26
27	Other (specify):*							39,246	39,246			27
28	TOTAL General Administration	234,288	36,636	2,083,653	2,354,577	(11,863)	2,342,714	(451,084)	1,891,630			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,052,546	725,068	2,584,536	8,362,150	(11,863)	8,350,287	(334,180)	8,016,106			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			58,827	58,827		58,827	73,481	132,308			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,054	22,054		22,054	391,222	413,276			32
33	Real Estate Taxes			58,259	58,259	11,863	70,122	2,893	73,015			33
34	Rent-Facility & Grounds			684,000	684,000		684,000	(684,000)				34
35	Rent-Equipment & Vehicles			19,988	19,988		19,988	825	20,813			35
36	Other (specify):*											36
37	TOTAL Ownership			843,128	843,128	11,863	854,991	(215,579)	639,412			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		667,536	910,401	1,577,937		1,577,937	(10,103)	1,567,834			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			334,862	334,862		334,862		334,862			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		667,536	1,245,263	1,912,799		1,912,799	(10,103)	1,902,696			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,052,546	1,392,604	4,672,927	11,118,077		11,118,077	(559,862)	10,558,215			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	(1,219)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(18,186)	30		9
10	Interest and Other Investment Income	(8,813)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(430)	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	(8,910)	21		18
19	Entertainment				19
20	Contributions	(355)	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	(120,000)	21		24
25	Fund Raising, Advertising and Promotional	(24,674)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(100,021)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (282,609)		\$	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)	(277,254)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (277,254)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (559,862)		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

Report Period Beginning:

Ending:

ID#

0046177

01/01/12

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Office Revenue	\$ (9,804)	21	1
2	Non-allowable Legal Expenses	(8,355)	19	2
3	Bldg. Co. - Legal Fees	(3,055)	19	3
4	Bldg. Co. - Bank Charges	(89)	21	4
5	Bldg. Co. - Filing Fee	(250)	20	5
6	Bldg. Co. - Amortization	(21,680)	36	6
7	Patient Clothing	(360)	10	7
8	Collection Expense	(14,249)	21	8
9	Vending Income	(124)	02	9
10	Annual Report	(250)	20	10
11	Prior Period Equipment Rental	(36,205)	21	11
12	Insurance Refund	(4,101)	26	12
13	Rental Income	(1,500)	06	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(100,021)		49

ID#

0046177

Report Period Beginning:

01/01/12

Ending:

12/31/12

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
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96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc # 0046177 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			263		10,318	(1,981)						8,600	1
2	Food Purchase	(1,773)		503									(1,270)	2
3	Housekeeping			503		128							631	3
4	Laundry													4
5	Heat and Other Utilities			727		185							912	5
6	Maintenance	(1,500)		2,879	6,728	57							8,164	6
7	Other (specify):*				1,645	1,709							3,354	7
8	TOTAL General Services	(3,273)		4,875	8,373	12,397	(1,981)						20,391	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(360)				59,148							58,788	10
10a	Therapy													10a
11	Activities													11
12	Social Services					23,701							23,701	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					14,023							14,023	15
16	TOTAL Health Care and Programs	(360)				96,872							96,512	16
	C. General Administration													
17	Administrative			3,110	14,565	73,606							91,281	17
18	Directors Fees													18
19	Professional Services	(11,410)	3,055	(319,231)		(156,648)							(484,234)	19
20	Fees, Subscriptions & Promotions	(25,529)	250	3,813		103							(21,363)	20
21	Clerical & General Office Expenses	(189,257)	89	13,016	102,238	6,827							(67,087)	21
22	Employee Benefits & Payroll Taxes				(8,845)	(299)							(9,144)	22
23	Inservice Training & Education													23
24	Travel and Seminar			234		1,591							1,825	24
25	Other Admin. Staff Transportation			870									870	25
26	Insurance-Prop.Liab.Malpractice	(4,101)		1,027		596							(2,478)	26
27	Other (specify):*				26,301	12,945							39,246	27
28	TOTAL General Administration	(230,297)	3,394	(297,161)	134,259	(61,279)							(451,084)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(233,929)	3,394	(292,286)	142,632	47,990	(1,981)						(334,180)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(18,186)	82,755	7,310		1,602							73,481	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,813)	365,436	4,546		30,053							391,222	32
33	Real Estate Taxes			2,306		587							2,893	33
34	Rent-Facility & Grounds		(684,000)										(684,000)	34
35	Rent-Equipment & Vehicles			1,124				(299)					825	35
36	Other (specify):*	(21,680)	21,680											36
37	TOTAL Ownership	(48,679)	(214,129)	15,286		32,242		(299)					(215,579)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(603)	(7,682)	(1,550)		(268)		(10,103)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(603)	(7,682)	(1,550)		(268)		(10,103)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(282,609)	(210,735)	(277,000)	142,632	80,232	(2,583)	(7,982)	(1,550)		(268)		(559,862)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 684,000	Chateau Willowbrook Property, LLC	100.00%	\$	\$ (684,000)	1
2	V	33	Rent - Property Taxes	22,831	Chateau Willowbrook Property, LLC	100.00%		(22,831)	2
3	V	19	Legal		Chateau Willowbrook Property, LLC	100.00%	3,055	3,055	3
4	V	21	Bank Service Charge		Chateau Willowbrook Property, LLC	100.00%	89	89	4
5	V	20	Filing Fee		Chateau Willowbrook Property, LLC	100.00%	250	250	5
6	V	30	Depreciation		Chateau Willowbrook Property, LLC	100.00%	82,755	82,755	6
7	V	36	Amortization		Chateau Willowbrook Property, LLC	100.00%	21,680	21,680	7
8	V	33	Real Estate Expense		Chateau Willowbrook Property, LLC	100.00%	22,831	22,831	8
9	V	32	Interest		Chateau Willowbrook Property, LLC	100.00%	365,436	365,436	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 706,831			\$ 496,096	\$ * (210,735)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 263	\$ 263	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	503	503	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	503	503	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	727	727	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,879	2,879	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,110	3,110	20
21	V	19	Professional Fees	323,628	Extended Care Consulting, LLC	100.00%	4,397	(319,231)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,813	3,813	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	13,016	13,016	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	234	234	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	870	870	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,027	1,027	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	7,310	7,310	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	4,546	4,546	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,306	2,306	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%			30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,124	1,124	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 323,628			\$ 46,628	\$ * (277,000)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	6,728	\$ 6,728	15
16	V	06	Maintenance (Direct)	2,139	Extended Care Consulting, LLC	100.00%	2,139		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,236	1,236	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	409	409	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	14,565	14,565	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	102,238	102,238	22
23	V	21	Office and Clerical (Direct)	25,308	Extended Care Consulting, LLC	100.00%	25,308		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	21,460	21,460	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,841	4,841	25
26	V	22	Employee Benefits	8,845	Extended Care Consulting, LLC	100.00%		(8,845)	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			\$ 36,292			\$ 178,924	\$ * 142,632	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 128	\$ 128	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	185	185	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	57	57	17
18	V	19	Professional Fees	159,396	Extended Care Clinical, LLC	100.00%	2,748	(156,648)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	103	103	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,283	2,283	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,591	1,591	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	596	596	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,602	1,602	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	30,053	30,053	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	587	587	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	10,318	10,318	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,709	1,709	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	59,148	59,148	28
29	V								29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	23,701	23,701	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	13,724	13,724	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	73,606	73,606	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	4,544	4,544	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	12,945	12,945	34
35	V	10	Nursing / Medical Record Salary	3,033	Extended Care Clinical, LLC	100.00%	3,033		35
36	V	12	Social Service / Admission Salary		Extended Care Clinical, LLC	100.00%			36
37	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	299	299	37
38	V	22	Employee Benefits	299	Extended Care Clinical, LLC	100.00%		(299)	38
39	Total			\$ 162,728			\$ 242,960	\$ * 80,232	39

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Supplies, Supplements	\$ 7,074	Care Centers Health Systems, Inc.	100.00%	\$ 5,093	\$ (1,981)	15
16	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			16
17	V	39	Ancillary Expense	2,153	Care Centers Health Systems, Inc.	100.00%	1,550	(603)	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			\$ 9,227			\$ 6,644	\$ * (2,583)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ventilator Equipment	13,490	Vent Lease LLC	100.00%	5,808	\$ (7,682)	15
16	V	39	Other Ancillary		Vent Lease LLC	100.00%			16
17	V	35	Matrix Leasing	299	Vent Lease LLC	100.00%		(299)	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			\$ 13,789			\$ 5,808	\$ * (7,982)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	\$ 888,662	Tri Care Rehab	100.00%	\$ 887,112	\$ (1,550)	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			\$ 888,662			\$ 887,112	\$ * (1,550)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 232,677	\$ 232,677	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	232,677	CCS Employee Benefits Group	100.00%		(232,677)	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			\$ 232,677			\$ 232,677	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ancillary Expense	30,092	Reliable Medical of the Midwest, LLC	100.00%	29,824	\$ (268)	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			\$ 30,092			\$ 29,824	\$ * (268)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	ERIC ROTHNER	1.000%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	CHATEAU WILLOWBROOK PR	WILLOWBROOK	BUILDING CO.	1
2	ROTHNER HEALTH VENTURES G II, LLC	99.000%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC BEECHER		EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKK	2
3			BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC CHICAGO		EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4			BRIAR PLACE LTD	INDIAN HEAD PARK	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPL	4
5			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6			DEVON GABLES REHABILITATION CENTER	ARIZONA	ROTHNER VENTS LLC	EVANSTON	VENTALATOR RENTAL	6
7			DYER NURSING & REHAB	DYER, IN	TRICARE REHAB	HILLSIDE	THERAPY	7
8			FOOTHILLS REHABILITATION CENTER LLC	ARIZONA	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLY	8
9			GOLDEN PLAINES REHABILITATION CENTER	KANSAS	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	9
10			GRASMERE PLACE, LLC	CHICAGO				10
11			HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET				11
12			HOMESTEAD NURSING & REAHB	LINCOLN, NE				12
13			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				13
14			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				14
15			LANCASTER MANOR	LINCOLN, NE				15
16			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				16
17			MCKINLEY HEALTH CARE CENTER	CANTON, OH				17
18			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				18
19			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				19
20			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				20
21			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				21
22			RAINBOW BEACH QOC, L.L.C.	CHICAGO				22
23			SEBOS NURSING & REHAB	HOBART, IN				23
24			SHEFFIELD MANOR	DYER, IN				24
25			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				25
26			SNOW VALLEY NURSING AND REHABILITATION CENTER, L.L.C.	LISLE				26
27			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				27
28			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				28
29			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				29
30			WHEATON CARE CENTER	WHEATON				30

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

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	Adam Vales	Relative	Clerical	0.00%	See Attached	2.00	5.00%	Alloc. Sal.	\$ 3,650	22-7	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	3.34	6.07%	Alloc Fee/Sal	11,597	17-7	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	\$ 15,247		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

Ending: 12/31/12

Fax Number**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc # 0046177 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,364,178	31	\$ 7,101	\$	50,513	\$ 263	1
2	02	Food	Patient Days	1,364,178	31	13,586		50,513	503	2
3	03	Housekeeping	Patient Days	1,364,178	31	13,573		50,513	503	3
4	05	Utilities	Patient Days	1,364,178	31	19,636		50,513	727	4
5	06	Maintenance	Patient Days	1,364,178	31	77,756		50,513	2,879	5
6	17	Administrative	Patient Days	1,364,178	31	84,000		50,513	3,110	6
7	19	Professional Fees	Patient Days	1,364,178	31	118,750		50,513	4,397	7
8	20	Dues and Subscriptions	Patient Days	1,364,178	31	102,984		50,513	3,813	8
9	21	Office and Clerical	Patient Days	1,364,178	31	351,528		50,513	13,016	9
10	24	Seminar and Travel	Patient Days	1,364,178	31	6,315		50,513	234	10
11	25	Other Staff Admin. Trans.	Patient Days	1,364,178	31	23,506		50,513	870	11
12	26	Insurance	Patient Days	1,364,178	31	27,741		50,513	1,027	12
13	30	Depreciation	Patient Days	1,364,178	31	197,424		50,513	7,310	13
14	32	Interest	Patient Days	1,364,178	31	122,765		50,513	4,546	14
15	33	Real Estate Taxes	Patient Days	1,364,178	31	62,275		50,513	2,306	15
16	34	Rent - Building	Patient Days	1,364,178	31			50,513		16
17	35	Rent - Equipment & Auto	Patient Days	1,364,178	31	30,363		50,513	1,124	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,259,303	\$		\$ 46,628	25

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc # 0046177 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	06	Maintenance (Pooled)	Patient Days	1,364,178	31	181,713	181,713	50,513	6,728	1
2	06	Maintenance (Direct)	Direct		31	256,754	256,754		2,139	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,364,178	31	33,386		50,513	1,236	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	40,137			409	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,364,178	31	393,362	393,362	50,513	14,565	7
8	21	Office and Clerical (Pooled)	Patient Days	1,364,178	31	2,761,089	2,761,089	50,513	102,238	8
9	21	Office and Clerical (Direct)	Direct		31	368,461	368,461		25,308	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,364,178	31	579,570		50,513	21,460	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	65,039			4,841	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					\$ 4,679,511	\$ 3,961,379		\$ 178,924	25

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc # 0046177 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	03	Housekeeping	Patient Days	611,520	14	\$ 1,549	\$	50,513	\$ 128	1
2	05	Utilities	Patient Days	611,520	14	2,241		50,513	185	2
3	06	Maintenance	Patient Days	611,520	14	691		50,513	57	3
4	19	Professional Fees	Patient Days	611,520	14	33,266		50,513	2,748	4
5	20	Dues and Subscriptions	Patient Days	611,520	14	1,249		50,513	103	5
6	21	Office & Clerical	Patient Days	611,520	14	27,644		50,513	2,283	6
7	24	Travel and Seminar	Patient Days	611,520	14	19,257		50,513	1,591	7
8	26	Insurance	Patient Days	611,520	14	7,216		50,513	596	8
9	30	Depreciation	Patient Days	611,520	14	19,393		50,513	1,602	9
10	32	Interest	Patient Days	611,520	14	363,826		50,513	30,053	10
11	33	Real Estate Taxes	Patient Days	611,520	14	7,106		50,513	587	11
12	01	Dietary Salary	Patient Days	611,520	14	124,907	124,907	50,513	10,318	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	611,520	14	20,691		50,513	1,709	13
14	10	Nursing Salary	Patient Days	611,520	14	716,058	716,058	50,513	59,148	14
15										15
16	12	Social Service Salary	Patient Days	611,520		286,925	286,925	50,513	23,701	16
17	15	Emp. Ben. - Healthcare	Patient Days	611,520		166,142		50,513	13,724	17
18	17	Administration Salary	Patient Days	611,520		891,091	891,091	50,513	73,606	18
19	21	Office Salary	Patient Days	611,520		55,009	55,009	50,513	4,544	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	611,520		156,720		50,513	12,945	20
21	10	Nursing / Medical Record Salary	Direct Allocation			10,300	10,300		3,033	21
22	12	Social Service / Admission Salary	Direct Allocation			6,057	6,057			22
23	15	Emp. Ben. - Healthcare	Direct Allocation			2,077			299	23
24										24
25	TOTALS					\$ 2,919,416	\$ 2,090,347		\$ 242,960	25

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc # 0046177 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Care Centers Health Systems, Inc.
Street Address 200 Howard
City / State / Zip Code Des Plaines, Illinois 60018
Phone Number (224) 612-5662
Fax Number (224) 612-5862

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary Supplies, Supplements	Direct Allocation			\$	\$		5,093	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						1,550	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					\$	\$		6,644	25

VIII. ALLOCATION OF INDIRECT COSTS

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

	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	39	Ventilator Equipment	Direct Allocation						5,808	1
2	39	Other Ancillary	Direct Allocation							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					\$	\$		\$ 5,808	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc # 0046177 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 TriCare Rehab
Street Address 150 Fencil Lane
City / State / Zip Code Hillside, IL 60162
Phone Number (773) 449-9400
Fax Number (773) 449-9700

	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	39	Therapy	Direct Allocation		\$	\$		\$ 887,112	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				\$	\$		\$ 887,112	25

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc # 0046177 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			\$	\$		\$ 232,677	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					\$	\$		\$ 232,677	25

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc # 0046177 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	39	Ancillary Expense	Direct Allocation					29,824	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				\$	\$		\$ 29,824	25

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc # 0046177 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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	Business Partners (Net)		X	Mortgage			\$	2,256,407			\$	365,436	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	DAIWA LOC		X	LOC				412,716				22,054	6
7	Allocated from ECC Consulting		X									4,546	7
8	See Supplemental Schedule											30,053	8
9	TOTAL Facility Related						\$	2,669,123			\$	422,089	9
	B. Non-Facility Related*												
10	Interest Income		X									(8,813)	10
11													11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	(8,813)	14
15	TOTALS (line 9+line14)						\$	2,669,123			\$	413,276	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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	Allocated from ECC Clinical		X				\$	\$			\$ 30,053	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital										30,053	14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	51,459	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.)		\$	56,414	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	4,955	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	56,197	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.		\$	11,863	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 \$ 35,428 For 2009 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.		\$	73,015	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	55,075	8	
		2008	57,460	9	
		2009	81,456	10	
		2010	49,008	11	
		2011	53,521	12	
2012 Accrual: \$53,521 x 1.05 = \$56,197					
Allocated from ECC Consulting: \$2,306					
Allocated from ECC Clinical: \$587					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	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.

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	<u>Chateau Nursing & Rehab Center, Llc</u>	COUNTY	<u>Dupage</u>
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CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. 09-23-407-043	Long Term Care Property	\$ 53,520.58	\$ 53,520.58
2. See Attached	Alloc from 2201 Main	\$ 127,119.67	\$ 2,298.45
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 180,640.25	\$ 55,819.03

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Chateau Nursing & Rehab Center, Llc COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0046177

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,447

B. General Construction Type: Exterior BrickFrame Masonry & SteelNumber of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	273,121	2003	\$ 295,367	1
2	Allocated from 2201 Main/Clinical			14,826	2
3	TOTALS	273,121		\$ 310,193	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150		2003	1987	\$ 2,658,301	\$ 82,755	39	\$ 68,162	\$ (14,593)	\$ 1,264,424	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2003		51,953		20	1,641	1,641	30,938	9
10	Various		2004		98,684		20	4,650	4,650	45,747	10
11	Various		2005		69,862		20	3,493	3,493	24,952	11
12	Various		2006		50,399		20	3,226	3,226	20,904	12
13	Various		2007		126,729		20	6,725	6,725	37,573	13
14	Various		2008		39,099		20	1,803	1,803	16,854	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		238,642			11,932	11,932	83,154	67
68		60,115	4,086		4,086		36,635	68
69			58,827			(58,827)		69
70		\$ 3,393,784	\$ 145,668		\$ 105,718	\$ (39,950)	\$ 1,561,182	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,393,784	\$ 145,668		\$ 105,718	\$ (39,950)	\$ 1,561,182	1
2	Water Heater	2009	6,710		20	1,342	1,342	4,809	2
3	1St Floor And Hallway - Flooring	2009	15,616		20	781	781	2,407	3
4	Generator	2009	3,256		20	163	163	502	4
5	Heat Exchanger	2010	5,600		20	280	280	817	5
6	1St Floor Therapy Room And Hallway - Tile Flooring	2010	4,001		20	267	267	778	6
7	Doors In Kitchen	2010	3,170		20	159	159	357	7
8	Xcel - Cubicle Curtains	2011	6,191		20	619	619	877	8
9	2Nd Floor Hallway - Solid Vinyl Wood Look Flooring	2011	15,060		20	753	753	1,255	9
10	Shower Rooms - New Showers, Water Lines, Floor, Walls, Grab B	2011	57,000		20	2,850	2,850	4,038	10
11	On-Line Communication Cable To Extend Nurse Call Audio	2011	2,832		20	142	142	189	11
12	Fox Valley Fire - Pulled Fire, Built Relays, Programming	2011	18,362		20	918	918	1,148	12
13	Hallways - Paint	2011	7,443		20	372	372	403	13
14	New Sidewall Sprinkler Head In Elevator Shaft	2011	3,530		20	177	177	250	14
15	Pipe And Fittings	2012	3,900		20	163	163	163	15
16	Resurfacing - Add Layer To Level Driveway	2012	5,800		20	290	290	290	16
17	Water Heater	2012	8,500		20	213	213	213	17
18	1St Floor Wing 400 - Medium Grade Vinyl Plank Flooring	2012	13,250		20	883	883	883	18
19	Remote E-Stop - Install Conduit And Wiring	2012	2,644		20	33	33	33	19
20	Millwork, Elevator Subflooring, Vinyl Floor	2012	22,650		20	1,133	1,133	1,133	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,599,299	\$ 145,668		\$ 117,254	\$ (28,414)	\$ 1,581,724	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,599,299	\$ 145,668		\$ 117,254	\$ (28,414)	\$ 1,581,724	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)		\$ 3,599,299	\$ 145,668		\$ 117,254	\$ (28,414)	\$ 1,581,724	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,599,299	\$ 145,668		\$ 117,254	\$ (28,414)	\$ 1,581,724	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)		\$ 3,599,299	\$ 145,668		\$ 117,254	\$ (28,414)	\$ 1,581,724	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,599,299	\$ 145,668		\$ 117,254	\$ (28,414)	\$ 1,581,724	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)		\$ 3,599,299	\$ 145,668		\$ 117,254	\$ (28,414)	\$ 1,581,724	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Life Safety Code Improvements (Net of Settlement)	2005	231,242		20	11,562	11,562	80,934	9
10	Professional Fees-Architect	2007	7,400		20	370	370	2,220	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Building Company Information Continued		\$	\$		\$	\$	\$	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 (12F & 12G lines 1 thru 33)		\$ 238,642	\$		\$ 11,932	\$ 11,932	\$ 83,154	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center, Llc

0046177

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocated from Extended Care Clinical, 2201 Main LLC	2002	4,146	106	39	106		1,094	3
4	Allocated from Extended Care Consulting, 2201 Main LLC	2002	16,286	418	39	418		4,298	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting LLC	2007	170	9	20	9		51	9
10	Allocated from Extended Care Consulting LLC	2009	102	5	20	5		20	10
11	Allocated from Extended Care Consulting LLC	2010	999	50	20	50		150	11
12	Allocated from Extended Care Consulting LLC	2011	360	18	20	18		36	12
13	Allocated from Extended Care Consulting LLC	2012	118	6	20	6		6	13
14									14
15	Allocated from Extended Care Consulting, 2201 Main LLC	2002	13,453	1,229	20	1,229		11,077	15
16	Allocated from Extended Care Consulting, 2201 Main LLC	2003	15,854	1,449	20	1,449		13,054	16
17	Allocated from Extended Care Consulting, 2201 Main LLC	2005	788	84	20	84		535	17
18	Allocated from Extended Care Consulting, 2201 Main LLC	2009	142	7	20	7		28	18
19									19
20	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	3,425	313	20	313		2,820	20
21	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2003	4,036	369	20	369		3,323	21
22	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2005	200	21	20	21		136	22
23	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2009	36	2	20	2		7	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								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 (12H & 12I lines 1 thru 33)		\$ 60,115	\$ 4,086		\$ 4,086	\$	\$ 36,635	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$113,708	\$3,003	\$12,629	\$9,626	10	\$93,020	71
72	Current Year Purchases	8,759		601	601	10	601	72
73	Fully Depreciated Assets	533,294				10	533,294	73
74								74
75	TOTALS	\$655,761	\$3,003	\$13,231	\$10,228		\$626,915	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2003 FORD ECONO VAN	2003	\$33,833	\$	\$		5	\$33,833	76
77		TRUCK REPAIR	2004	1,083				5	1,083	77
78		Allocated from ECC Clinical	2012	4,244	676	676		5	406	78
79		Allocated from ECC Consult.	2012	5,739	1,148	1,148		5	5,739	79
80	TOTALS			\$44,899	\$1,824	\$1,824			\$41,061	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$4,610,153	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$150,495	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$132,309	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(18,186)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,249,700	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

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

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

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: \$20,814
- 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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$		\$ 298,282	\$		\$ 298,282	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			126,421			126,421	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			464,358			464,358	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				417,700		417,700	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					21,340	249,836		271,176	13
14	TOTAL			\$		\$ 910,401	\$ 667,536		\$ 1,577,937	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,315	\$ 36,007	1
2	Cash-Patient Deposits	52,878	52,878	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,001,513	2,001,513	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	220,868	220,868	6
7	Other Prepaid Expenses	4,969	6,469	7
8	Accounts Receivable (owners or related parties)	752,067	709,293	8
9	Other(specify): See Attached Schedule	10,063	57,984	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,044,673	\$ 3,085,012	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		295,367	13
14	Buildings, at Historical Cost		3,805,411	14
15	Leasehold Improvements, at Historical Cost	548,450	548,450	15
16	Equipment, at Historical Cost	266,035	266,035	16
17	Accumulated Depreciation (book methods)	(482,297)	(2,303,503)	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			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 332,188	\$ 2,611,760	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,376,861	\$ 5,696,772	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,990,582	\$ 1,990,581	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,712	45,712	28
29	Short-Term Notes Payable	412,716	412,716	29
30	Accrued Salaries Payable	324,241	324,241	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,216	19,216	31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,197	56,197	32
33	Accrued Interest Payable		29,979	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule		851,959	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,848,664	\$ 3,730,601	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,256,407	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 2,256,407	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,848,664	\$ 5,987,008	46
47	TOTAL EQUITY(page 18, line 24)	\$ 528,197	\$ (290,236)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,376,861	\$ 5,696,772	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$282,305	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$282,302	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	245,895	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)	\$245,895	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)	\$528,197	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$11,140,519	1
2	Discounts and Allowances for all Levels	(4,095,259)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$7,045,260	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,560,165	6
7	Oxygen	635	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$3,560,800	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,942	13
14	Non-Patient Meals	1,219	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,500	16
17	Sale of Drugs	419,596	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	85,681	19
20	Radiology and X-Ray	12,560	20
21	Other Medical Services	175,144	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$699,642	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,813	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$8,813	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	49,457	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$49,457	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$11,363,972	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,529,849	31
32	Health Care	4,477,724	32
33	General Administration	2,354,577	33
	B. Capital Expense		
34	Ownership	843,128	34
	C. Ancillary Expense		
35	Special Cost Centers	1,577,937	35
36	Provider Participation Fee	334,862	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$11,118,077	40
41	Income before Income Taxes (line 30 minus line 40)**	245,895	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$245,895	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$4,376,474	44
45	Private Pay - Net Inpatient Revenue	1,552,537	45
46	Medicare - Net Inpatient Revenue	501,944	46
47	Other-(specify) Hospice	653,403	47
48	Other-(specify) Insurance	(39,098)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$7,045,260	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,802	2,028	\$ 96,737	\$ 47.70	1
2	Assistant Director of Nursing	1,937	2,156	85,480	39.65	2
3	Registered Nurses	36,408	39,748	1,265,874	31.85	3
4	Licensed Practical Nurses	23,874	26,250	741,379	28.24	4
5	CNAs & Orderlies	95,971	105,327	1,288,936	12.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,628	11,529	195,877	16.99	8
9	Activity Director	2,002	2,074	42,311	20.40	9
10	Activity Assistants	12,081	13,358	147,227	11.02	10
11	Social Service Workers	8,871	9,645	208,709	21.64	11
12	Dietician	1,003	1,059	17,420	16.45	12
13	Food Service Supervisor	2,018	2,327	47,215	20.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,932	6,595	83,796	12.71	15
16	Dishwashers	15,953	17,431	161,010	9.24	16
17	Maintenance Workers	4,716	5,469	99,347	18.17	17
18	Housekeepers	17,068	18,842	183,289	9.73	18
19	Laundry	6,156	6,840	66,558	9.73	19
20	Administrator	1,986	2,169	77,955	35.94	20
21	Assistant Administrator	1,965	2,192	53,091	24.22	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,900	6,714	103,242	15.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,404	2,629	44,079	16.77	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,514	2,688	43,014	16.00	33
34	TOTAL (lines 1 - 33)	261,189	287,070	\$ 5,052,546 *	\$ 17.60	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	275	\$ 13,042	01-03	35
36	Medical Director	Monthly	46,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,569	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	10,000	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	ECC - MDS		3,033	10-3	48
49	TOTAL (lines 35 - 48)	275	\$ 82,144		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	13	\$ 569	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	13	\$ 569		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberChateau Nursing & Rehab Center, Llc# 0046177Report Period Beginning:01/01/12Ending:12/31/12Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Stephanie Mohr	Administrator	0	\$ 41,055
Rafi Zimmerman	Administrator	0	36,900
Amanda Bushey	Assist. Admin.	0	6,309
Margie Thompson	Assist. Admin.	0	46,782
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 131,046

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg& Rothblatt	Accounting	\$ 28,783
Personnel Planners	Unemployment Consult	2,930
See Attached	Legal	67,612
Extended Care Consult	Home Office Expense	323,628
Extended Care Clinical	Home Office Expense	159,396
Pinnacle Consulting	Customer Satis. Interv. Rep.	3,073
Blymas, Inc.	Tax Credit	170
Prospect Resources	Natural Gas Procurement	1,842
GJN Organizational Cost	Customer Serv. Consult.	450
Allen A Lefkovitz	R/E Assessment	11,863
Hamlin & Burton Liability	Liability Management	456
See Supplemental Schedule		48,973
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 649,177

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 108,201
Unemployment Compensation Insurance	96,083
FICA Taxes	384,358
Employee Health Insurance	123,804
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	9,169
Holiday Expense	3,121
Other Employee Benefits	2,944
TOTAL (agree to Schedule V, line 22, col.8)	

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	\$ 1,990
Advertising: Employee Recruitment	1,482
Health Care Worker Background Check (Indicate # of checks performed 54)	1,334
Patient Background Checks	
Dues and Subscriptions	16,341
License and Fees	5,516
Allocated from ECC Consulting	3,813
Allocated from ECC Clinical	103
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	6,816
Allocated from ECC Consulting	234
Allocated from ECC Clinical	1,591
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 8,641

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes
IL Council on LTC \$14,130
- (3)

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

Yes
Yes
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10 Years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$62,947
Line10
- (7)

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

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
N/A
- (9)

Are you presently operating under a sublease agreement?

YESXNO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YESN/A
NOX
N/A
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$334,862
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No
- (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?
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.

No
- (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. \$1,219
- (16)

Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
N/A
None
N/A
N/A
N/A
No
N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No
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)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.

Yes

SEE ACCOUNTANTS' COMPILATION REPORT