

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0047720 Facility Name: Pine Acres Rehab & Living Center, LLC Address: 1212 S. Second Street DeKalb 60115 County: DeKalb Telephone Number: (815) 758-8151 Fax #: (815) 758-6832 HFS ID Number: Date of Initial License for Current Owners: 02/01/2006 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Michael W. Martin Telephone Number: (217) 258-8888 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) (Title) Paid Preparer (Signed) SEE ACCOUNTANTS' PREPARATION REPORT (Print Name and Title) (Firm Name & Address) McGladrey & Pullen, LLP 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173 (Telephone) (847) 517-7070 Fax #: (847) 517-7067 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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Facility Name & ID Number Pine Acres Rehab & Living Center, LLC

0047720 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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>119</u>	Skilled (SNF)	<u>119</u>	<u>43,435</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>119</u>	TOTALS	<u>119</u>	<u>43,435</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>14,471</u>	<u>10,654</u>	<u>6,695</u>	<u>31,820</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>14,471</u>	<u>10,654</u>	<u>6,695</u>	<u>31,820</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.26%

D. How many bed-hold days during this year were paid by the Department? 0 (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 ☐ Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 2/1/06

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 2/1/06 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 119 and days of care provided 6,273

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: 12/31/11 Fiscal Year: 12/31/11
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Pine Acres Rehab & Living Center, LLC # 0047720 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	344,065	13,299	8,877	366,241		366,241		366,241			1
2	Food Purchase		217,842		217,842		217,842	(3,465)	214,377			2
3	Housekeeping	103,827	14,869		118,696		118,696	(15,000)	103,696			3
4	Laundry	11,158	489	91,041	102,688		102,688	15,000	117,688			4
5	Heat and Other Utilities			177,412	177,412		177,412		177,412			5
6	Maintenance	111,737	63,635	58,709	234,081		234,081	4,855	238,936			6
7	Other (specify):*											7
8	TOTAL General Services	570,787	310,134	336,039	1,216,960		1,216,960	1,390	1,218,350			8
	B. Health Care and Programs											
9	Medical Director			13,100	13,100		13,100		13,100			9
10	Nursing and Medical Records	2,357,473	167,779	16,669	2,541,921		2,541,921		2,541,921			10
10a	Therapy		4,486	690,838	695,324		695,324		695,324			10a
11	Activities	86,615	8,146	2,275	97,036		97,036		97,036			11
12	Social Services	51,322	14	1,040	52,376		52,376		52,376			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,495,410	180,425	723,922	3,399,757		3,399,757		3,399,757			16
	C. General Administration											
17	Administrative	100,523		120,000	220,523		220,523		220,523			17
18	Directors Fees											18
19	Professional Services			187,271	187,271		187,271	(4,282)	182,989			19
20	Dues, Fees, Subscriptions & Promotions			21,192	21,192		21,192	250	21,442			20
21	Clerical & General Office Expenses	209,594	36,777	53,851	300,222		300,222	(2,682)	297,540			21
22	Employee Benefits & Payroll Taxes			711,258	711,258		711,258		711,258			22
23	Inservice Training & Education			375	375		375		375			23
24	Travel and Seminar			1,913	1,913		1,913		1,913			24
25	Other Admin. Staff Transportation			5,014	5,014		5,014		5,014			25
26	Insurance-Prop.Liab.Malpractice			68,255	68,255		68,255	11,700	79,955			26
27	Other (specify):*											27
28	TOTAL General Administration	310,117	36,777	1,169,129	1,516,023		1,516,023	4,986	1,521,009			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,376,314	527,336	2,229,090	6,132,740		6,132,740	6,376	6,139,116			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			42,415	42,415		42,415	190,159	232,574			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			581	581		581	405,359	405,940			32
33	Real Estate Taxes							102,234	102,234			33
34	Rent-Facility & Grounds			627,720	627,720		627,720	(627,720)				34
35	Rent-Equipment & Vehicles			18,962	18,962		18,962	1,214	20,176			35
36	Other (specify):* Mortgage Insurance							72,805	72,805			36
37	TOTAL Ownership			689,678	689,678		689,678	144,051	833,729			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		259,240		259,240		259,240		259,240			39
40	Barber and Beauty Shops	18,276	324		18,600		18,600		18,600			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			143,372	143,372		143,372		143,372			42
43	Other (specify):* Non-Allow Costs	34,086		63,329	97,415		97,415	(97,415)				43
44	TOTAL Special Cost Centers	52,362	259,564	206,701	518,627		518,627	(97,415)	421,212			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,428,676	786,900	3,125,469	7,341,045		7,341,045	53,012	7,394,057			45

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

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	(2,880)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,237)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(18,574)	30		9
10	Interest and Other Investment Income	(5,378)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,050)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,868)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,896)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(996)	43		28
29	Other-Attach Schedule See Pg 5A	(56,645)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (130,524)		\$	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)	183,536		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 183,536		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 53,012		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:

ID# 0047720

Ending:

1/1/2011

12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs - Part A	\$ (12,913)	43	1
2	X-Rays - Part A	(375)	43	2
3	Wages-Marketing	(34,086)	43	3
4	Marketing	(6,862)	43	4
5	Offset Vending Machine Income	(585)	2	5
6	Non-Care Real Estate Taxes	(3,955)	33	6
7	Equipment Repair and Maintenance	4,855	6	7
8	Offset Telephone Income	(2,724)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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32				32
33				33
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36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(56,645)		49

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
Steve and Bluma Jeremias	33	Community Nursing & Rehabilitation Center, LLC	Naperville	Pine Acres Realty,		
Mark and Chana Weldler	33	The Springs at Crystal Lake, LLC	Crystal Lake	LLC	Dekalb	Real Estate
Chaim Rajchenbach	11					
The Family Rajchenbach Trust	11			Community Nursing		
Abraham J. Stern	4			and Rehab Realty,		
Susan L. Stern	4			LLC	Naperville	Real Estate
AMN Limited Partnership	4			TS Realty, LLC	Crystal Lake	Real Estate

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			\$			\$		1
2	V	30	Depreciation		Pine Acres Realty, LLC		208,733	208,733	2
3	V	32	Interest		Pine Acres Realty, LLC		410,737	410,737	3
4	V	33	Real Estate Taxes		Pine Acres Realty, LLC		106,189	106,189	4
5	V	34	Rent Expense	627,720	Pine Acres Realty, LLC			(627,720)	5
6	V	20	Licenses		Pine Acres Realty, LLC		250	250	6
7	V	26	Insurance		Pine Acres Realty, LLC		11,700	11,700	7
8	V	21	Bank Fees		Pine Acres Realty, LLC		42	42	8
9	V	19	Professional Fees		Pine Acres Realty, LLC		800	800	9
10	V	36	Mortgage Insurance		Pine Acres Realty, LLC		72,805	72,805	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 627,720			\$ 811,256	\$ * 183,536	14

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

Facility Name & ID Number Pine Acres Rehab & Living Center, LLC # 0047720 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	Steve Jeremias	COO	Administrative	33.00	375,000	15	30.00	Guar Pymnts	\$ 60,000	L17,C3	1
2	Mark Weldler	CFO	Finance	33.00	375,000	10	20.00	Guar Pymnts	60,000	L17,C3	2
3											3
4											4
5											5
6			*Steve Jeremias and Mark Weldler each received \$375,000 from Community Nursing & Rehabilitation Center.								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 120,000		13

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

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

Facility Name & ID Number Pine Acres Rehab & Living Center, LLC # 0047720 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

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 N/A
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				N/A						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	Brickyard Bank		X	Mortgage	\$17,919.51	01/01/06	\$ 2,350,000	\$	2/1/11	0.7750	\$	1	
2	Cambridge Realty Capital LTD		X	Mortgage	\$17,450.05	07/1/08	6,695,044	6,449,422	5/1/2049	0.0635	410,737	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Lake Forest Bank & Trust Co.		X	Line of Credit	None	9/15/11	550,000	325,000	9/1/12	0.0550		6	
7	Finance Charges										581	7	
8												8	
9	TOTAL Facility Related				\$35,369.56		\$ 9,595,044	\$ 6,774,422			\$ 411,318	9	
	B. Non-Facility Related*												
10												10	
11								Disallow Finance charges			(581)	11	
12								Offset interest income			(4,797)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (5,378)	14	
15	TOTALS (line 9+line14)						\$ 9,595,044	\$ 6,774,422			\$ 405,940	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 72,805 Line # 36

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	62,255	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.)		2010		\$	82,545	2
3. Under or (over) accrual (line 2 minus line 1).				\$	20,290	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	85,900	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.		Rental House Taxes- Non-Allowable			(3,956)	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	102,234	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2006	47,403	8			
	2007	44,465	9			
	2008	58,394	10			
	2009	60,435	11			
	2010	82,545	12			
Assumed approximately a 4% increase on real estate taxes paid during the year.						

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	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.**

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Pine Acres Rehab & Living Center, LLC

COUNTY

DeKalb

FACILITY IDPH LICENSE NUMBER

0047720

CONTACT PERSON REGARDING THIS REPORT

Mark Weldler

TELEPHONE

(815) 758-8151

FAX #:

(815) 758-6832

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>08-27-279-003</u>	<u>Nursing Home</u>	\$ <u>78,589.22</u>	\$ <u>78,589.22</u>
2.	<u>08-27-279-023</u>	<u>Rental House</u>	\$ <u>3,955.46</u>	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ <u>82,544.68</u>	\$ <u>78,589.22</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,295

B. General Construction Type: Exterior Brick Frame Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
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	Resident Use	126,760	2006	\$ 196,341	1
2					2
3	TOTALS	126,760		\$ 196,341	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	119		2006	1968	\$ 1,736,051	\$	40	\$ 43,401	\$ 43,401	\$ 256,790	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2 Ton Rooftop System			2007	4,562	456	10	456		2,052	9
10	Replace Heat Cable			2008	2,626	263	10	263		920	10
11	Replace Fan Motors			2008	3,441	344	10	344		1,204	11
12	Replace Unit Heater			2008	3,938	394	10	394		1,379	12
13	Replace Doors			2008	2,696	270	10	270		945	13
14	Move Electrical Box			2008	6,932	693	10	693		2,425	14
15	Sidewalk			2009	6,312	316	10	631	315	1,578	15
16	Retrofit Mechanical Room with Sprinklers			2009	2,800	140	10	280	140	700	16
17	Security Alarm for Front Doors			2009	4,644	232	10	464	232	1,160	17
18	Telephone System			2009	37,765	1,888	10	3,777	1,889	9,442	18
19	Telephone System Addition			2009	13,143	657	10	1,314	657	3,285	19
20	Fence			2009	5,708	285	10	571	286	1,427	20
21	Renovation & New Construction			2009	2,443,769		40	61,094	61,094	152,735	21
22	Architect Fees			2009	122,501		40	3,063	3,063	7,657	22
23	Demolition of Old House			2009	41,210		40	1,030	1,030	2,575	23
24	Carpet, Flooring & Wallcovering			2009	175,473		40	4,387	4,387	10,967	24
25	Construction Period Interest			2009	108,345		40	2,709	2,709	6,772	25
26	North Dining Room & Corridor Remodel			2009	101,743		40	2,544	2,544	6,360	26
27	Architect Fees			2009	102,207		40	2,555	2,555	6,388	27
28	Draw #11 Construction & Architect Fees			2009	13,159		40	329	329	823	28
29	Draw #12			2009	154,568		40	3,864	3,864	9,660	29
30	Doors & Hardware			2009	13,257		40	331	331	828	30
31	Panic Hardware			2009	3,730		40	93	93	233	31
32	Old House			2009	173,313		40	4,333	4,333	10,832	32
33	Ice Cube Machine (Expensed for Medicaid purposes)			2009		92			(92)		33
34	Telephone System Addition			2010	6,277		40	157	157	235	34
35	Satellite TV Installation			2010	8,250		10	825	825	1,238	35
36	A/C Unit Replacement (North Dining Room)			2010	10,000		10	1,000	1,000	1,500	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Piping and Wiring (outside lights)	2010	\$ 2,896	\$	40	\$ 72	\$ 72	\$ 108	37
38								38
39 Water Heater	2011	7,442		15	248	248	248	39
40 Rooftop A/C replacement	2011	5,721		20	143	143	143	40
41 Replace 19 window cranks	2011	3,419		7	244	244	244	41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49 To adjust Financial Statement Depreciation			14,502			(14,502)		49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 5,327,898	\$ 20,532		\$ 141,879	\$ 121,347	\$ 502,853	70

**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	\$830,485	\$12,644	\$82,766	\$70,122	10	\$450,925	71
72	Current Year Purchases	87,530	9,239	7,929	(1,310)	5-10	7,929	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$918,015	\$21,883	\$90,695	\$68,812		\$458,854	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$6,442,254	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$42,415	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$232,574	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$190,159	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$961,707	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	North Wing Sprinkler System	\$52,455	92
93			93
94			94
95		\$52,455	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:				\$ N/A			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
- N/A
N/A

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

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: \$ 11,777
- Description: Non-Med Equip. \$4,565; Medical Equip \$5,573; Computer Equip. \$1,639
(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	2008	Nissan Maxima	\$ 699.90	\$ 8,399	17
18					18
19					19
20					20
21	TOTAL		\$ 699.90	\$ 8,399	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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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	10A(3,2)	hrs	\$	3,002	\$ 216,172	\$ 3,127	3,002	\$ 219,299	1
2	Licensed Speech and Language Development Therapist	10A(3,2)	hrs		1,264	91,038	149	1,264	91,187	2
3	Licensed Recreational Therapist		hrs		5,328	383,628	1,210	5,328	384,838	3
4	Licensed Physical Therapist	10A(3,2)	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				229,576		229,576	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					29,664		29,664	12
13	Other (specify): <u></u>									13
14	TOTAL			\$	9,595	\$ 690,838	\$ 263,726	9,595	\$ 954,564	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,866	\$ 34,076	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (66,215))	1,955,371	1,955,371	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	74,383	89,227	6
7	Other Prepaid Expenses	72,999	72,999	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch 17A	113,580	451,026	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,219,199	\$ 2,602,699	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		196,341	13
14	Buildings, at Historical Cost		1,736,051	14
15	Leasehold Improvements, at Historical Cost	213,614	3,591,847	15
16	Equipment, at Historical Cost	218,819	918,015	16
17	Accumulated Depreciation (book methods)	(94,499)	(961,707)	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 (spe See Sch 17A	52,455	597,788	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 390,389	\$ 6,078,335	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,609,588	\$ 8,681,034	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 813,561	\$ 825,261	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	226,205	226,205	30
31	Accrued Taxes Payable (excluding real estate taxes)	57,905	57,905	31
32	Accrued Real Estate Taxes(Sch.IX-B)		85,900	32
33	Accrued Interest Payable	581	34,706	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	419,107	419,107	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,517,359	\$ 1,649,084	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	325,000	6,774,422	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 325,000	\$ 6,774,422	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,842,359	\$ 8,423,506	46
47	TOTAL EQUITY(page 18, line 24)	\$ 767,229	\$ 257,528	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,609,588	\$ 8,681,034	48

*(See instructions.)

Pine Acres Rehab & Living Center, LLC

Provider #: 0047720

01/01/11 - 12/31/11

Schedule 17A

XV. Balance Sheet

	Operating	After Consolidation
Line 9 - Other Current Assets (specify)		
RE Escrow - RE Taxes	-	28,333
RE Escrow - Insurance	-	23,000
Due To/from Adminastar	92,543.00	92,543
NH RE Escrow-MIP	-	20,054
Due To / from CNRC	21,037.00	287,096
Total Line 9 - Other Current Assets	113,580	451,026
Line 22 - Other Long Term Assets (specify)		
Escrow Construction in Progress	52,455	52,455
Escrow Replacement	-	371,413
Mortgage Costs	-	188,910
Accum Amort-Org Fees	-	(14,990)
Total Line 22 - Other Long Term Assets	52,455	597,788
Line 36 - Other Current Liabilities (specify)		
Due To State	103,095	103,095
Resident Credit Balances	49,954	49,954
Due To/From Pine Acres Realty	266,058	266,058
Total Line 36 - Other Current Liabilities	419,107	419,107

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 509,406	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(30,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 479,406	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	767,823	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	(480,000)	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)	\$ 287,823	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)	\$ 767,229	24 *

* This must agree with page 17, line 47.

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.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,732,570	1
2	Discounts and Allowances for all Levels	(479,539)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,253,031	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,488,132	6
7	Oxygen	26,838	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,514,970	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	14,197	13
14	Non-Patient Meals	2,880	14
15	Telephone, Television and Radio	2,724	15
16	Rental of Facility Space		16
17	Sale of Drugs	217,034	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	720	20
21	Other Medical Services	81,522	21
22	Laundry	10,078	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 329,155	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	11,712	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,712	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,108,868	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,216,960	31
32	Health Care	3,399,757	32
33	General Administration	1,516,023	33
	B. Capital Expense		
34	Ownership	689,678	34
	C. Ancillary Expense		
35	Special Cost Centers	375,255	35
36	Provider Participation Fee	143,372	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,341,045	40
41	Income before Income Taxes (line 30 minus line 40)**	767,823	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 767,823	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Provider is a cash basis taxpayer.

*** 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.

Pine Acres Rehab & Living Center, LLC
Provider #: 0047720
01/01/11 - 12/31/11

Schedule 19A

XVII. Income Statement

Line 28 - Other Revenue

Contribution Income	2,185
Interest Income	4,433
Vending Machine Income	585
Miscellaneous Income	<u>4,509</u>
Total Line 28 - Other Revenue	<u><u>11,712</u></u>

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	1,918	2,080	\$ 90,288	\$ 43.41	1
2	Assistant Director of Nursing	1,912	2,160	72,824	33.71	2
3	Registered Nurses	14,175	14,873	483,589	32.51	3
4	Licensed Practical Nurses	18,889	20,279	464,048	22.88	4
5	CNAs & Orderlies	83,534	88,206	1,054,729	11.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,677	6,193	71,455	11.54	8
9	Activity Director	1,962	2,156	36,297	16.84	9
10	Activity Assistants	4,512	5,074	50,318	9.92	10
11	Social Service Workers	2,928	2,928	51,322	17.53	11
12	Dietician					12
13	Food Service Supervisor	2,014	2,209	43,730	19.80	13
14	Head Cook	5,298	5,767	69,842	12.11	14
15	Cook Helpers/Assistants	22,524	23,704	230,493	9.72	15
16	Dishwashers					16
17	Maintenance Workers	5,922	6,501	111,737	17.19	17
18	Housekeepers	9,259	10,005	88,827	8.88	18
19	Laundry	2,431	2,787	26,158	9.39	19
20	Administrator	1,848	2,080	100,523	48.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,531	13,526	209,594	15.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,835	1,999	23,026	11.52	31
32	Other Health C; See Sch 20A	3,840	4,216	97,514	23.13	32
33	Other(specify) See Sch 20A	2,816	3,139	52,362	16.68	33
34	TOTAL (lines 1 - 33)	205,825	219,882	\$ 3,428,676 *	\$ 15.59	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	209	\$ 8,877	1(3)	35
36	Medical Director	Monthly	13,100	9(3)	36
37	Medical Records Consultant	19	1,160	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	2,275	11(3)	44
45	Social Service Consultant	16	1,040	12(3)	45
46	Other(specify)			10(3)	46
47	Therapy Management	Monthly	12,000	10(3)	47
48				10(3)	48
49	TOTAL (lines 35 - 48)	274	\$ 38,452		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10(3)	50
51	Licensed Practical Nurses	87	3,509	10(3)	51
52	Certified Nurse Assistants/Aides			10(3)	52
53	TOTAL (lines 50 - 52)	87	\$ 3,509		53

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

** See instructions.

Pine Acres Rehab & Living Center, LLC

Provider #: 0047720

01/01/11 - 12/31/11

Schedule 20A

XVIII. Staffing & Salary Cost	<u>Hours Wrkd</u>	<u>Hours Pd</u>	<u>Total Wages</u>	<u>Avg Hrly Wage</u>
Line 32 - Other Health Care				
MDS Coordinator	1,924	2,136	59,032	27.64
Dementia Director	1,916	2,080	38,482	18.50
	3,840	4,216	97,514	23.13
Line 33 - Other				
Beautician	1,818	2,099	18,276	8.71
Marketing Wages	998	1,040	34,086	32.78
	2,816	3,139	52,362	16.68

STATE OF ILLINOIS

Facility Name & ID Number

Pine Acres Rehab & Living Center, LLC

0047720

Report Period Beginning:

1/1/2011

Page 21

Ending:

12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Dalena Kemna-Kahn

Administrator

0

\$ 100,523

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 100,523

B. Administrative - Other

Description

Amount

Mark Weldler, Admin - Guar. Pmts.

\$ 60,000

Steve Jeremias, CFO - Guar. Pmts.

60,000

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 120,000

C. Professional Services

Vendor/Payee

Type

Amount

Marilyn P. Dunn

Legal

\$ 325

Much Shelist

Legal

42,727

Ashman & Stein

Legal

438

McGladrey & Pullen

Accounting

54,019

RSM McGladrey

Accounting

10,708

Paylocity

Payroll Fees

8,376

Personnel Planners, Inc.

Unemployment Consultant

1,430

MDI Achieve, Inc.

Software Maintenance

21,744

Innovative LTC Solutions

Computer Services

10,606

Corporate Cost Solutions Inc.

Workers' Compensation

626

Other Vendors

See SCH 21A

36,272

TOTAL (agree to Schedule V, line 19, column 3)

(If total legal fees exceed \$5,000, attach copy of invoices.)

\$ 187,271

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 218,551

Unemployment Compensation Insurance

42,896

FICA Taxes

254,111

Employee Health Insurance

181,801

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Uniform Expense

593

Employee Physicals

4,485

Other Employee Benefits

8,821

TOTAL (agree to Schedule V, line 22, col.8)

\$ 711,258

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

Description

Line #

Amount

N/A

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

2,342

Health Care Worker Background Check

(Indicate # of checks performed 9)

110

Patient Background Checks

114

Miscellaneous Licenses & Fees

2,950

Miscellaneous Dues & Subscriptions

2,118

IL Council on LTC

12,282

Allocated from RE Entity

250

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 21,442

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

1,913

Seminar Expense

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 1,913

* Attach copy of IMRF notifications

**See instructions.

Pine Acres Rehab & Living Center, LLC
Provider #: 0047720
01/01/11 - 12/31/11

Schedule 21A

XIX.C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Singer Networks	Hardware Maintenance	23,757
Medifax-EDI	Software Maintenance	215
Coms Interactive, LLC	Computer Services	5,200
Information Controls, Inc.	Computer Services	1,981
IVANS	Computer Services	1,214
Ardent Communications	Computer Services	3,905
		<u>36,272</u> To PG21C
Total for Page 3, Line 19, Column 3		187,271
Disallowed Legal Fees		(3,868)
Reclassify Computer Services to Computer Equip.		(1,214)
Real Estate Addition for Professional Fees		<u>800</u>
Total for Page 3, Line 19, Column 8		<u>182,989</u>

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on Long Term Care \$ 12,282
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 48,043 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 143,372
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,880
- (16) Travel and Transportation

a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients? 0

d. Have vehicle usage logs been maintained? Adequate records have been maintained.

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.