

		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>0049957</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Claremont - Hanover Park</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>2000 West Lake Street</u> <u>Hanover Park</u> <u>60133</u>																																																	
Number City Zip Code																																																	
County: <u>Cook</u>																																																	
Telephone Number: <u>(630) 556-2000</u> Fax # <u>(630) 823-5454</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>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>McGladrey LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u></td></tr><tr><td>(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>McGladrey LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>	(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>																																				
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Date of Initial License for Current Owners: <u>01/11/2011</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></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:		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																																															
Name: <u>Amanda Springborn</u> Telephone Number: <u>(314) 925-3838</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number Claremont - Hanover Park# 0049957 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 bedsN/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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>366</u>	<u>1,585</u>	<u>25,497</u>	<u>27,448</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>366</u>	<u>1,585</u>	<u>25,497</u>	<u>27,448</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 50.00%

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?

YesG. 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 1/11/11

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 1/11/11NO ☐

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 20,985Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

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	370,448	20,938	19,551	410,937		410,937		410,937			1
2	Food Purchase		232,807		232,807		232,807	(10,633)	222,174			2
3	Housekeeping	127,105	45,056		172,161		172,161		172,161			3
4	Laundry	42,812	27,968		70,780		70,780	(648)	70,132			4
5	Heat and Other Utilities			418,014	418,014		418,014	1,664	419,678			5
6	Maintenance	78,688	52,449	115,202	246,339		246,339	4,321	250,660			6
7	Other (specify):*											7
8	TOTAL General Services	619,053	379,218	552,767	1,551,038		1,551,038	(5,296)	1,545,742			8
	B. Health Care and Programs											
9	Medical Director			1,675	1,675		1,675		1,675			9
10	Nursing and Medical Records	2,884,669	236,425	125,481	3,246,575		3,246,575	13,497	3,260,072			10
10a	Therapy											10a
11	Activities	105,753	4,638	693	111,084		111,084	333	111,417			11
12	Social Services	118,853		8,876	127,729		127,729		127,729			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,109,275	241,063	136,725	3,487,063		3,487,063	13,830	3,500,893			16
	C. General Administration											
17	Administrative	153,635		702,000	855,635		855,635	(680,799)	174,836			17
18	Directors Fees											18
19	Professional Services			144,514	144,514		144,514	20,965	165,479			19
20	Dues, Fees, Subscriptions & Promotions			23,486	23,486		23,486	351	23,837			20
21	Clerical & General Office Expenses	301,440	28,942	241,922	572,304		572,304	125,543	697,847			21
22	Employee Benefits & Payroll Taxes			633,106	633,106		633,106		633,106			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,184	7,184		7,184	(427)	6,757			24
25	Other Admin. Staff Transportation			762	762		762	1,048	1,810			25
26	Insurance-Prop.Liab.Malpractice			13,077	13,077		13,077	108,011	121,088			26
27	Other (specify):* Home Office Benefit							27,599	27,599			27
28	TOTAL General Administration	455,075	28,942	1,766,051	2,250,068		2,250,068	(397,709)	1,852,359			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,183,403	649,223	2,455,543	7,288,169		7,288,169	(389,175)	6,898,994			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			75,801	75,801		75,801	600,461	676,262			30
31	Amortization of Pre-Op. & Org.			1,550	1,550		1,550		1,550			31
32	Interest			45,750	45,750		45,750	1,215,362	1,261,112			32
33	Real Estate Taxes							832,424	832,424			33
34	Rent-Facility & Grounds			2,381,269	2,381,269		2,381,269	(2,380,977)	292			34
35	Rent-Equipment & Vehicles			44,453	44,453		44,453	3,582	48,035			35
36	Other (specify):*											36
37	TOTAL Ownership			2,548,823	2,548,823		2,548,823	270,852	2,819,675			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,254,281	2,536,806	3,791,087		3,791,087		3,791,087			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			116,970	116,970		116,970		116,970			42
43	Other (specify):* Non-Allowable Co			558,614	558,614		558,614	(558,614)				43
44	TOTAL Special Cost Centers		1,254,281	3,212,390	4,466,671		4,466,671	(558,614)	3,908,057			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,183,403	1,903,504	8,216,756	14,303,663		14,303,663	(676,937)	13,626,726			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,633)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,186)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(648)	4		8
9	Non-Straightline Depreciation	28,157	30		9
10	Interest and Other Investment Income	(2,423)	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	440	43		18
19	Entertainment	(2,928)	43		19
20	Contributions	(14,725)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	3,179	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(290,500)	43		24
25	Fund Raising, Advertising and Promotional	(62,142)	43		25
	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 See Pg 5A	40,534	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (314,875)		\$	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)	(362,062)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (362,062)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (676,937)		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

Claremont - Hanover Park

Report Period Beginning:

Ending:

ID#0049957

01/01/12

12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Non-Reimbursed Enter	\$ (1,155)	43	1
2	Skin Care Specialist	(7,230)	43	2
3	X-Rays - Part A	(90,066)	43	3
4	Labs - Part A	(80,122)	43	4
5	Misc. Income	(606)	21	5
6	Settlement	(7,000)	43	6
7	Chamber of Commerce Dues	(250)	20	7
8	Non-Allowable Travel	(691)	24	8
9	Real Estate Tax - PY Under Accrual	227,654	33	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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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	40,534		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
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	19	Professional Fees	\$	Church Street Station Properties, LLC	100.00%	\$ 15,500	\$ 15,500	1
2	V	20	Dues, Fees, Subs. & Promotions		Church Street Station Properties, LLC	100.00%	248	248	2
3	V	26	Insurance		Church Street Station Properties, LLC	100.00%	107,861	107,861	3
4	V	30	Depreciation		Church Street Station Properties, LLC	100.00%	564,542	564,542	4
5	V	32	Amortization		Church Street Station Properties, LLC	100.00%	10,801	10,801	5
6	V	32	Interest	35,811	Church Street Station Properties, LLC	100.00%	1,241,620	1,205,809	6
7	V	33	Real Estate Taxes		Church Street Station Properties, LLC	100.00%	600,000	600,000	7
8	V	34	Rent	2,381,269	Church Street Station Properties, LLC	100.00%		(2,381,269)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,417,080			\$ 2,540,572	\$ * 123,492	14

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

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	5	Utilities	\$	NuCare Management Company	70.00%	\$ 1,664	\$ 1,664	15
16	V	6	Repairs and Maintenance		NuCare Management Company	70.00%	4,280	4,280	16
17	V	10	Clinical Salaries		NuCare Management Company	70.00%	5,246	5,246	17
18	V	17	Management Fees	702,000	NuCare Management Company	70.00%	21,201	(680,799)	18
19	V	19	Professional Fees		NuCare Management Company	70.00%	2,286	2,286	19
20	V	20	Dues, Subscriptions		NuCare Management Company	70.00%	296	296	20
21	V	21	Office Expense		NuCare Management Company	70.00%	111,089	111,089	21
22	V	24	Education and Seminars		NuCare Management Company	70.00%	77	77	22
23	V	25	Other Admin Transportation		NuCare Management Company	70.00%	805	805	23
24	V	26	Insurance		NuCare Management Company	70.00%	85	85	24
25	V	27	Employee Benefits		NuCare Management Company	70.00%	26,609	26,609	25
26	V	30	Depreciation Expense		NuCare Management Company	70.00%	5,812	5,812	26
27	V	32	Interest & Amortization		NuCare Management Company	70.00%	1,113	1,113	27
28	V	33	Real Estate Taxes		NuCare Management Company	70.00%	4,770	4,770	28
29	V	34	Facility Rent		NuCare Management Company	70.00%	292	292	29
30	V	35	Equipment Rental		NuCare Management Company	70.00%	1,011	1,011	30
31	V	35	Auto Rental		NuCare Management Company	70.00%	2,337	2,337	31
32	V	30	Depreciation Expense		NuCare Management Company	70.00%	1,836	1,836	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 702,000			\$ 190,809	\$ * (511,191)	39

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

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	6	Minor Equipment	\$	Cinical Consulting Services, LLC		\$ 41	\$ 41	15
16	V	10	Nursing and Medical Records		Cinical Consulting Services, LLC		8,251	8,251	16
17	V	11	Activities		Cinical Consulting Services, LLC		333	333	17
18	V	19	Professional Fees		Cinical Consulting Services, LLC		0		18
19	V	20	Dues, Subscriptions		Cinical Consulting Services, LLC		57	57	19
20	V	21	Office Expense		Cinical Consulting Services, LLC		15,060	15,060	20
21	V	24	Education and Seminars		Cinical Consulting Services, LLC		187	187	21
22	V	25	Other Admin Transportation		Cinical Consulting Services, LLC		243	243	22
23	V	26	Insurance		Cinical Consulting Services, LLC		65	65	23
24	V	27	Employee Benefits		Cinical Consulting Services, LLC		990	990	24
25	V	30	Depreciation Expense		Cinical Consulting Services, LLC		85	85	25
26	V	32	Interest & Amortization		Cinical Consulting Services, LLC		62	62	26
27	V	35	Auto Rental		Cinical Consulting Services, LLC		234	234	27
28	V	30	Depreciation Expense		Cinical Consulting Services, LLC		29	29	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			\$			\$ 25,637	\$ * 25,637	39

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

Facility Name & ID Number

Claremont - Hanover Park

0049957

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	David Hartman	10%	Bronzeville Park	Chicago	Nucare Services	Lincolnwood	Bookeeping Mgmt	1
2	Rajchenbach Fam	40%	California Gardens Corp.	Chicago	7527 N. Lincoln Ave, I	Lincolnwood	Building Rental	2
3	Robert Hartman	40%	Claremont Rehab. & Living	Buffalo Grove	Diamond Insurance	Northbrook	Work Comp Ins.	3
4	Gerald Jenich	10%	Claremont - Hanover Park	Hanover Park	Seasons Hospice	Park Ridge	Hospice	4
5			Claridge Imperial, LTD.	Chicago	JLR Financial Svcs. C	Lincolnwood	Management Co.	5
6			Jackson Corp	Chicago	KFT Services, LLC	Lincolnwood	Management Co.	6
7			Monroe Pavillion	Chicago	Drake Louis Enterpris	Lincolnwood	Management Co.	7
8			Renaissance at 87th Street	Chicago	Clinical Consulting Se	Lincolnwood	Clinical Consult	8
9			Renaissance at Midway	Chicago	Quest Services Corp.	Lincolnwood	Marketing	9
10			Renaissance at South Shore	Chicago	Integra Healthcare Eq	Elmhurst	DME & Med. Suppl	10
11			Renaissance Park South	Chicago				11
12			Aria Post Acute Care	Hillside				12
13			Seven Oaks	Glendale, WI	Symphony Healthcare	Morton Grove	Sub Lessor	13
14			Renaissance East	Mesa, Arizona	Symphony M.L., LLC	Morton Grove	Main Lessor	14
15			Renaissance West	Mesa, Arizona	Symphony HMG, LLC	Morton Grove	Sub Lessor	15
16			Renaissance Village IL	Mesa, Arizona	Symphony Financial S	Morton Grove	Mgmt Co.	16
17			Renaissance Village AL	Mesa, Arizona				17
18								18
19								19
20			Symphony Aspen Ridge, LLC D/B/A Symphony Decatur					20
21			Symphony Countryside, LLC D/B/A Countrysid Aurora					21
22			Symphony Crestwood, LLC D/B/A Symphony o Crestwood					22
23			Symphony Deerbrook, LLC D/B/A Symphony o Joliet					23
24			Symphony Maple Crest, LLC D/B/A Maple Crest Belvidere					24
25			Symphony Maple Ridge, LLC D/B/A Symphony Lincoln					25
26			Symphony McKinley, LLC D/B/A McKinley Co Decatur					26
27			Symphony Northwoods, LLC D/B/A Northwood Belvidere					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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	N/A, no owners receive compensation from this facility.								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES

X

NO

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

Name of Related Organization

NuCare Management Company

Street Address

7257 North Lincoln Avenue

City / State / Zip Code

Lincolnwood, IL 60645

Phone Number

(847) 933-2600

Fax Number

(847) 933-2601

	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	5	Utilities	Bed days available	1,228,556	15	\$ 37,226	\$	54,900	\$ 1,664	1
2	6	Repairs and Maintenance	Bed days available	1,228,556	15	95,768		54,900	4,280	2
3	10	Clinical Salaries	Bed days available	1,228,556	15	117,394	117,394	54,900	5,246	3
4	17	Management Fees	Bed days available	1,228,556	15	474,443	474,443	54,900	21,201	4
5	19	Professional Fees	Bed days available	1,228,556	15	51,153		54,900	2,286	5
6	20	Dues, Subscriptions	Bed days available	1,228,556	15	6,629		54,900	296	6
7	21	Office Expense	Bed days available	1,228,556	15	2,485,957	2,260,083	54,900	111,089	7
8	24	Education and Seminars	Bed days available	1,228,556	15	1,734		54,900	77	8
9	25	Other Admin Transportation	Bed days available	1,228,556	15	18,004		54,900	805	9
10	26	Insurance	Bed days available	1,228,556	15	1,913		54,900	85	10
11	27	Employee Benefits	Bed days available	1,228,556	15	595,462		54,900	26,609	11
12	30	Depreciation Expense	Bed days available	1,228,556	15	130,061		54,900	5,812	12
13	32	Interest & Amortization	Bed days available	1,228,556	15	24,917		54,900	1,113	13
14	33	Real Estate Taxes	Bed days available	1,228,556	15	106,750		54,900	4,770	14
15	34	Facility Rent	Bed days available	1,228,556	15	6,532		54,900	292	15
16	35	Equipment Rental	Bed days available	1,228,556	15	22,618		54,900	1,011	16
17	35	Auto Rental	Bed days available	1,228,556	15	52,299		54,900	2,337	17
18	30	Depreciation Expense	Direct allocation			1,836			1,836	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,230,696	\$ 2,851,920		\$ 190,809	25

Facility Name & ID Number Claremont - Hanover Park # 0049957 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 Cinical Consulting Services, LLC
Street Address 7257 North Lincoln Avenue
City / State / Zip Code Lincolnwood, IL 60645
Phone Number (847) 933-2600
Fax Number (847) 933-2601

	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	6	Minor Equipment	Bed days available	1,228,556	15	\$ 920	\$	54,900	\$ 41	1
2	10	Nursing and Medical Records	Bed days available	1,228,556	15	184,643	184,643	54,900	8,251	2
3	11	Activities	Bed days available	1,228,556	15	7,452		54,900	333	3
4	19	Professional Fees	Bed days available	1,228,556	15			54,900		4
5	20	Dues, Subscriptions	Bed days available	1,228,556	15	1,272		54,900	57	5
6	21	Office Expense	Bed days available	1,228,556	15	337,009	320,385	54,900	15,060	6
7	24	Education and Seminars	Bed days available	1,228,556	15	4,175		54,900	187	7
8	25	Other Admin Transportation	Bed days available	1,228,556	15	5,436		54,900	243	8
9	26	Insurance	Bed days available	1,228,556	15	1,447		54,900	65	9
10	27	Employee Benefits	Bed days available	1,228,556	15	22,150		54,900	990	10
11	30	Depreciation Expense	Bed days available	1,228,556	15	1,892		54,900	85	11
12	32	Interest & Amortization	Bed days available	1,228,556	15	1,384		54,900	62	12
13	35	Auto Rental	Bed days available	1,228,556	15	5,242		54,900	234	13
14	30	Depreciation Expense	Direct allocation			29			29	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 573,051	\$ 505,028		\$ 25,637	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	Greystone Servicing Corporation		X	Mortgage	\$109,880.11		\$ 18,320,600	\$ 18,134,875		0.0670	\$ 1,241,620	1	
2	The Village of Hanover Park		X	Land	Variable	07/01/10	700,000	457,963		None		2	
3												3	
4												4	
5												5	
	Working Capital												
6	The Private Bank and Trust Co.		X	Line of Credit	Interest Only	11/1/12	1,000,000	1,000,000	10/31/13	Variable	45,750	6	
7												7	
8												8	
9	TOTAL Facility Related				\$109,880.11		\$ 20,020,600	\$ 19,592,838			\$ 1,287,370	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(38,234)	10	
11								Management Company Allocation			1,175	11	
12								Amortization of loan costs			10,801	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (26,258)	14	
15	TOTALS (line 9+line14)						\$ 20,020,600	\$ 19,592,838			\$ 1,261,112	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	495,250	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.)		2011		\$	722,904	2
3. Under or (over) accrual (line 2 minus line 1).				\$	227,654	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	600,000	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.			Home Office Allocation		4,770	
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.				\$	832,424	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2007

8

2008

9

2009

10

2010

90,714

11

2011

722,904

12

Market Value 18,986,430 X 10%= Assessed Value 1,898,643 X State Equalization Factor 3.3 = 6,265,522

Equalized Assessed Value 6,265,522 X Local Tax Rate 0.0895 = 560,764. Use 600,000.

	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.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Claremont - Hanover Park

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0049957

CONTACT PERSON REGARDING THIS REPORT

Jay Flatt

TELEPHONE

(847) 933-2600 x 23

FAX #:

(847) 745-0915

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</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	06-36-407-021-0000	Land and Property	\$716,592.22	\$716,592.22
2.	06-36-309-033-0000	Land and Property	\$6,311.83	\$6,311.83
3.	10-27-319-028-0000	Land and Property Mgmt Co.	\$84,353.24	\$4,770.00
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$807,257.29	\$727,674.05

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,800

B. General Construction Type: Exterior Brick Frame Steel

Number of Stories Two

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).

N/A

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: N/A

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

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

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	Land (Allocation)		2011	\$ 1,524,000	1
2	See Schedule 11A			6,792	2
3	TOTALS			\$ 1,530,792	3

Claremont - Hanover Park
12/31/12

Schedule 11A

<u>Use</u>	<u>Sq. Ft.</u>	<u>Year Acquired</u>	<u>Cost</u>
1 Allocation from Management Company - NuCare			6,435
2 Allocation from Management Company - CCS			357
3 Totals			<u>6,792</u>

Facility Name & ID Number Claremont - Hanover Park

0049957

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Allocation			2011	\$ 17,410,854	\$	40	\$ 439,469	\$ 439,469	\$ 878,938	4
5											5
6											6
7	HO Allocation - NuCare		2004		57,914		35	1,655	1,655	15,099	7
8	HO Allocation - CCS		2004		3,217		35	92	92	839	8
	Improvement Type**										
9	Installation of PA System and Telephone Paging System			2011	14,840		20	742	742	1,113	9
10	Fabricate and Install Syringe Disposal Cabinets to Wall			2011	10,000		20	500	500	750	10
11	Install and Furnish Door Control along with Back Door			2011	6,227		20	311	311	467	11
12	Boiler #1 - Fireye Flame Amplifier Module			2012	3,537		20	88	88	88	12
13	Current Booked Depre For FY12			2012		75,801			(75,801)		13
14											14
15	2011 Allocation from NuCare Management Company:										15
16	Alarm System			2003	523		20	26	26	239	16
17	Buildout of Offices			2004	10,627		20	532	532	4,633	17
18	Security & Fire Alarm System			2004	1,151		20	58	58	489	18
19	Data Cables, Lights & Heat Exchanger			2005	630		20	32	32	247	19
20	Fire Alarm System			2005	5,279		20	341	341	2,491	20
21	Cooling Unit			2006	854		20	43	43	272	21
22	Asphalt & Carpet			2008	900		20	45	45	192	22
23	Landscaping, 2nd Floor Reconst. (including Phone, Sprinklers,			2009	14,498		20	724	724	2,617	23
24	Alarm Systems, Kitchen Remodel, Wallcovings, etc.)										24
25	HVAC, Paint/Wallpaper, Electrical, Sprinkler, & Generator Repair			2010	2,228		20	111	111	279	25
26	Hot Water Heater			2011	120		20	6	6	12	26
27	Paint 2nd Floor Windows			2012	134			5	5	5	27
28											28
29	2011 Allocation from CCS:										29
30	Installation of Security Equipment			2004	64		20	3	3	28	30
31	Fire Alarm & Sprinkler System Installation			2005	293		20	19	19	138	31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 17,543,890	\$ 75,801		\$ 444,803	\$ 369,002	\$ 908,937	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	\$ 230,609	\$	\$ 82,124	\$ 82,124	3-10	\$ 123,186	71
72	Current Year Purchases	100,962		20,192	20,192	5-10	20,192	72
73	Fully Depreciated Assets							73
74	See Schedule 13A	1,311,148		129,064	129,064	10	281,604	74
75	TOTALS	\$ 1,642,719	\$	\$ 231,380	\$ 231,380		\$ 424,982	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated from NuCare Management Company			\$ 396	\$	\$ 79	\$ 79		\$ 191	76
77										77
78										78
79										79
80	TOTALS			\$ 396	\$	\$ 79	\$ 79		\$ 191	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)	\$ 20,717,797	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 75,801	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 676,262	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 600,461	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,334,110	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	N/A	\$	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.

Category of Equipment	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Component Life	Accumulated Depreciation
1 Allocated from NuCare Management Company	60,418		3,991	3,991	10	31,458
2 Allocated from RE Entity	1,250,730		125,073	125,073	10	250,146
Totals	1,311,148	-	129,064	129,064		281,604

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	Home Office Allocation				292			6
7	TOTAL				\$ 292			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: \$ 45,464
- Description: \$13,220 - Copy Machine; \$31,233 -Bed Rental; \$1,011 Mgmt. Alloc.
- (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	Home Office Allocation		\$	\$ 2,571	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 2,571	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

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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	39(3)	hrs	\$	12,396	\$ 892,539	\$	12,396	\$ 892,539	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,857	133,713		1,857	133,713	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2,3)	hrs		20,278	1,460,045	500	20,278	1,460,545	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				1,228,591		1,228,591	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	39(2,3)			480	34,525	4,264	480	38,789	12
13	Other (specify): <u>See Sch 16A</u>	39(2,3)				15,984	20,926		36,910	13
14	TOTAL			\$	35,011	\$ 2,536,806	\$ 1,254,281	35,011	\$ 3,791,087	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.

SPECIAL SERVICES (Ancillary Costs) - Schedule 16A

XIV. SPECIAL SERVICES (Direct Cost) Line 14

Service	Schedule V Line & Col. Ref.	Outside Practitioner		
		Units	Costs	Supplies
Oxygen	39(2)			20,926
Ambulance	39(3)		15,984	
		-	15,984	20,926

XV. BALANCE SHEET - Unrestricted Operating Fund.

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	\$ 2,200	\$ 372,242	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 137,289)	2,031,702	2,396,958	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	82,657	563,543	6
7	Other Prepaid Expenses	10,857	18,328	7
8	Accounts Receivable (owners or related parties)	2,699	2,699	8
9	Other(specify): See Schedule 17A	56,487	274,243	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,186,602	\$ 3,628,013	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,530,792	13
14	Buildings, at Historical Cost		17,471,985	14
15	Leasehold Improvements, at Historical Cost	61,567	71,905	15
16	Equipment, at Historical Cost	746,965	1,643,115	16
17	Accumulated Depreciation (book methods)	(123,271)	(1,334,110)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 685,261	\$ 19,383,687	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,871,863	\$ 23,011,700	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 279,273	\$ 471,215	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	343,998	343,998	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,339	32,339	31
32	Accrued Real Estate Taxes(Sch.IX-B)		600,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	3,114,908	2,804,488	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,770,518	\$ 4,252,040	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,000,000	1,000,000	39
40	Mortgage Payable		18,134,875	40
41	Bonds Payable		457,963	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)	\$ 1,000,000	\$ 19,592,838	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,770,518	\$ 23,844,878	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,898,655)	\$ (833,178)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,871,863	\$ 23,011,700	48

*(See instructions.)

Church Street Station Skilled Nursing

FYE: 12/31/12

Schedule 17A

	<u>Operating</u>	<u>After Consolidation</u>
Line 9		
Escrow - Replacement Reserve	-	217,756
Due from Shareholders	11,913	11,913
Accrued Management Fees - Quest	33,412	33,412
Acrued management Fees - CCS	11,162	11,162
Total to L 9	56,487	274,243

Line 36		
Closing Costs	-	(14,994)
Deferred Loan Costs	-	(417,028)
Accumulated Amortization - Closing	-	750
Accumulated Amortization - Loan Costs - HUD	-	20,852
Accrued Interest	-	100,000
Accrued Accounts Payable	512,268	512,268
Accrued Utilities	29,329	29,329
Accrued Management Fees - Nucare	496,598	496,598
Accrued Deductions - Wage Assignments	(277)	(277)
Due to Claremont Expense	149,738	149,738
Due to Renaissance at Hillside Expenses	(283)	(283)
Due to Renaissance at 87th Street Expense	1,082	1,082
Due to Quest Services Expense	(90,020)	(90,020)
Due to Clinical Consulting Expense	(38,046)	(38,046)
Due to NuCare Services Corp Expense	721,256	721,256
Due NuVision Holdings Expense	1,333,263	1,333,263
Total to L 36	3,114,908	2,804,488

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,140,690)	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(522,032)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,662,722)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(235,933)	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)	\$ (235,933)	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)	\$ (1,898,655)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Claremont - Hanover Park# 0049957Report Period Beginning: 01/01/12Ending: 12/31/12

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,261,113	1
2	Discounts and Allowances for all Levels	(2,944,270)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,316,843	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,892,020	6
7	Oxygen	122,649	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,014,669	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	564	13
14	Non-Patient Meals	10,633	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	265	16
17	Sale of Drugs	2,145,899	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	165,218	19
20	Radiology and X-Ray	171,651	20
21	Other Medical Services	219,245	21
22	Laundry	648	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,714,123	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,423	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,423	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income & Prior Year Adjustment	19,672	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 19,672	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,067,730	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,551,038	31
32	Health Care	3,487,063	32
33	General Administration	2,250,068	33
	B. Capital Expense		
34	Ownership	2,548,823	34
	C. Ancillary Expense		
35	Special Cost Centers	4,349,701	35
36	Provider Participation Fee	116,970	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,303,663	40
41	Income before Income Taxes (line 30 minus line 40)**	(235,933)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (235,933)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 52,559	44
45	Private Pay - Net Inpatient Revenue	438,912	45
46	Medicare - Net Inpatient Revenue	3,534,124	46
47	Other-(specify) <u>Managed Care</u>	281,798	47
48	Other-(specify) <u>Hospice</u>	9,450	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,316,843	49

* 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.

*** 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.

^ - Entity is a cash basis taxpayer.

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	1,960	2,080	\$ 98,598	\$ 47.40	1
2	Assistant Director of Nursing	1,960	2,080	85,822	41.26	2
3	Registered Nurses	34,799	37,609	1,154,342	30.69	3
4	Licensed Practical Nurses	19,084	20,680	543,539	26.28	4
5	CNAs & Orderlies	52,619	56,503	694,055	12.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,180	5,477	79,332	14.48	8
9	Activity Director	2,152	2,320	44,577	19.21	9
10	Activity Assistants	5,435	5,799	61,176	10.55	10
11	Social Service Workers	4,501	4,761	118,853	24.96	11
12	Dietician	2,236	2,296	81,625	35.55	12
13	Food Service Supervisor					13
14	Head Cook	7,916	8,568	141,320	16.49	14
15	Cook Helpers/Assistants	14,728	15,379	147,503	9.59	15
16	Dishwashers					16
17	Maintenance Workers	4,042	4,293	78,688	18.33	17
18	Housekeepers	12,119	12,830	127,105	9.91	18
19	Laundry	3,835	4,157	42,812	10.30	19
20	Administrator	1,960	2,080	102,851	49.45	20
21	Assistant Administrator	1,976	2,080	50,784	24.42	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,212	21,516	301,440	14.01	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	1,543	1,581	30,565	19.33	31
32	Other Health Care <u>Care Plan Coord.</u>	5,684	6,235	198,416	31.82	32
33	Other(specify) _____					33
34	TOTAL (lines 1 - 33)	203,941	218,324	\$ 4,183,403 *	\$ 19.16	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	416	\$ 19,551	1(3)	35
36	Medical Director	11	1,675	9(3)	36
37	Medical Records Consultant	130	19,554	10(3)	37
38	Nurse Consultant	154	4,846	10(3)	38
39	Pharmacist Consultant	Monthly	936	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	693	11(3)	44
45	Social Service Consultant	28	1,652	12(3)	45
46	Other(specify) _____				46
47	_____				47
48	_____				48
49	TOTAL (lines 35 - 48)	751	\$ 48,907		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	933	\$ 47,589	10(3)	50
51	Licensed Practical Nurses	758	33,460	10(3)	51
52	Certified Nurse Assistants/Aides	322	7,284	10(3)	52
53	TOTAL (lines 50 - 52)	2,013	\$ 88,333		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Lisa Ulm	Administrator	0	\$ 102,851
Lisa Williams	Asst. Administrator	0	50,784
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 153,635
B. Administrative - Other			
Description			Amount
General and Administrative - Management Service (Eliminated on Sch. V, Col. 7)			\$ 702,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 702,000
C. Professional Services			
Vendor/Payee	Type		Amount
McGladrey LLP	Accounting		\$ 24,200
CDW COMPUTER CENTERS, INC	Computer Consulting		701
COMPUTRITION	Computer Consulting		1,488
DELL	Computer Consulting		3,435
E-HEALTH DATA SOLUTIONS	Computer Consulting		1,516
EITECHS CORPORATION	Computer Consulting		238
HEALTH DATA SYSTEMS INC	Computer Consulting		4,233
HEALTH DATA SOLUTIONS	Computer Consulting		253
IT'S NEVER2 LATE	Computer Consulting		3,800
IVANS, INC.	Computer Consulting		1,162
MDI ACHIEVE, INC	Computer Consulting		20,779
See Sch. 21C	See Sch. 21C		82,710
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 144,514
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 123,617
Unemployment Compensation Insurance			
FICA Taxes			403,209
Employee Health Insurance			85,630
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Other Employee Benefits			15,370
Employee Retirement			2,405
Employee Uniforms			2,875
TOTAL (agree to Schedule V, line 22, col.8)			\$ 633,106
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			\$ 1,658
Advertising: Employee Recruitment			1,897
Health Care Worker Background Check (Indicate # of checks performed 381)			4,568
Patient Background Checks 381			4,568
Miscellaneous Licenses & Fees			6,001
Miscellaneous Dues & Subscriptions			1,150
Newspaper Subscription			3,394
Allocated from Mgmt. Co.			601
Less: Public Relations Expense	(		)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 23,837
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			6,493
Allocated from Mgmt. Co.			264
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 6,757

*** Attach copy of IMRF notifications**

****See instructions.**

Church Street Station Skilled Nursing
FYE: 12/31/12

Schedule 21C

MEDIFAX	Computer Consulting	1,666
OPTIMA HEALTHCARE SOLUTIONS IN	Computer Consulting	1,420
NSC	Computer Consulting	9,264
PSD SOLUTIONS	Computer Consulting	21,571
EFAX	Computer Consulting	4,000
AVENUE WEB MEDIA	Internet Expenses	45
COMCAST CABLE	Internet Expenses	2,791
PAETEC	Internet Expenses	10,992
Personal Planners, Inc	UC Tax Consulting	1,238
ACHIEVE ACCREDITATION	JCAHO Consultation	11,151
C.E.S. CONSULTING OF IL	Computer Services	71
CONFETTI GOURMET CATERING	Professional Caterers	2,156
ELITE RX PARTNERS, LLC	Pharmacy Bill Consult	1,065
PINNACLE QUALITY INSIGHT	QA Consulting	1,350
REGINA SMITH	HR Consulting	250
Much Shelist	Legal	2,162
Polsinelli Shughart	Legal	411
Stone, McGuire & Siegel	Legal	14,513
Stone Pogrund & Korey, LLC	Legal	500
Ungaretti & Harris LLP	Legal	1,452
Legal Accrual	Legal	(5,357)
<i>Subtotal</i>		<u>82,710</u>
Total Line 19 Col 3		<u><u>144,514</u></u>
To adjust to allowable legal invoices		3,179
Allocated from NuCare Management	Accounting	2,286
		<u>2,286</u>
Church Street Station Properties	Accounting	15,500

Total Line 19 Col 8

165,479

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			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3										N/A			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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? No
If YES, give association name and amount. N/A

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,161 Line 10(3)

(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. \$ 116,970
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. \$ 10,633

(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.