

		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: 0044750

Facility Name: Community Nursing & Rehabilitation Center

Address: 1136 North Mill Street Naperville 60563
Number City Zip Code

County: DuPage

Telephone Number: (630) 355-3300 Fax # (630) 355-1417

HFS ID Number:

Date of Initial License for Current Owners: 04/01/2000

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Amanda Springborn Telephone Number: (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 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)
	(Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone)

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number Community Nursing & Rehabilitation Center# 0044750 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>153</u>	Skilled (SNF)	<u>153</u>	<u>55,998</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>153</u>	TOTALS	<u>153</u>	<u>55,998</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>26,834</u>	<u>4,304</u>	<u>11,640</u>	<u>42,778</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>26,834</u>	<u>4,304</u>	<u>11,640</u>	<u>42,778</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 76.39%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

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 04/01/2000

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

YES ☒Date 04/01/2000NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 153 and days of care provided 9,542Medicare 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	415,644	72,531		488,175		488,175		488,175			1
2	Food Purchase		259,408		259,408		259,408	(20,210)	239,198			2
3	Housekeeping	223,471	8,567		232,038		232,038		232,038			3
4	Laundry	62,079	24,572		86,651		86,651		86,651			4
5	Heat and Other Utilities			212,147	212,147		212,147		212,147			5
6	Maintenance	68,266	55,477	73,309	197,052		197,052	1,857	198,909			6
7	Other (specify):*											7
8	TOTAL General Services	769,460	420,555	285,456	1,475,471		1,475,471	(18,353)	1,457,118			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	3,133,831	248,640	51,147	3,433,618		3,433,618	750	3,434,368			10
10a	Therapy											10a
11	Activities	149,272	3,452	4,061	156,785		156,785		156,785			11
12	Social Services	82,550		1,037	83,587		83,587		83,587			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,365,653	252,092	77,845	3,695,590		3,695,590	750	3,696,340			16
	C. General Administration											
17	Administrative	184,923		360,000	544,923		544,923		544,923			17
18	Directors Fees											18
19	Professional Services			201,842	201,842		201,842	9,118	210,960			19
20	Dues, Fees, Subscriptions & Promotions			29,941	29,941		29,941	(5,665)	24,276			20
21	Clerical & General Office Expenses	181,763	30,651	119,778	332,192		332,192	(21,870)	310,322			21
22	Employee Benefits & Payroll Taxes			949,291	949,291		949,291	14,260	963,551			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,016	14,016		14,016	(6,556)	7,460			24
25	Other Admin. Staff Transportation			15,386	15,386		15,386		15,386			25
26	Insurance-Prop.Liab.Malpractice			147,324	147,324		147,324	16,537	163,861			26
27	Other (specify):*											27
28	TOTAL General Administration	366,686	30,651	1,837,578	2,234,915		2,234,915	5,824	2,240,739			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,501,799	703,298	2,200,879	7,405,976		7,405,976	(11,779)	7,394,197			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			146,811	146,811		146,811	212,017	358,828			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,879	17,879		17,879	404,906	422,785			32
33	Real Estate Taxes							107,314	107,314			33
34	Rent-Facility & Grounds			738,025	738,025		738,025	(738,025)				34
35	Rent-Equipment & Vehicles			62,714	62,714		62,714		62,714			35
36	Other (specify):* Mortgage Insurance							34,196	34,196			36
37	TOTAL Ownership			965,429	965,429		965,429	20,408	985,837			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	5,563	684,389	1,664,959	2,354,911		2,354,911		2,354,911			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			285,801	285,801		285,801		285,801			42
43	Other (specify):* Non-Allowable Co	126,193		315,589	441,782		441,782	(441,782)				43
44	TOTAL Special Cost Centers	131,756	684,389	2,266,349	3,082,494		3,082,494	(441,782)	2,640,712			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,633,555	1,387,687	5,432,657	11,453,899		11,453,899	(433,153)	11,020,746			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	(949)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,660)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	65,388	30		9
10	Interest and Other Investment Income	(2,529)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(291)	43		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	(1,430)	43		18
19	Entertainment				19
20	Contributions	(750)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,362)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(189,720)	43		24
25	Fund Raising, Advertising and Promotional	(148,934)	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	(120,801)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (408,038)		\$	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)	(25,115)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (25,115)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (433,153)		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

STATE OF ILLINOIS
Community Nursing & Rehabilitation Center

Page 5A

ID# 0044750
Report Period Beginning: 01/01/12
Ending: 12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (7,068)	43	1
2	Café Income	(5,001)	2	2
3	NH X Ray	(81,585)	43	3
4	Contributions Income	(300)	43	4
5	Miscellaneous Income	(8,678)	21	5
6	Cable TV	(11,704)	43	6
7	Chamber of Commerce	(1,500)	20	7
8	Non-Allowable Lobbying Expense	(4,965)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(120,801)		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
Mark Weldler	29.50	Pine Acres Rehab & Living Center, LLC	DeKalb	Community Nursing & Rehab Realty,LLC	Naperville	Real Estate
Steve Jeremias	29.50					
Malka Mermelstein	.50	The Springs at Crystal Lake, LLC	Crystal Lake			
Herman Mermelstein	.50			Pine Acres Realty, LL	DeKalb	Real Estate
Joseph Neumann	30.00					
Hirsch Wolf	10.00			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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Building - Repairs & Mtce	\$	Community Nursing & Rehab Realty, LLC		\$	\$	1
2	V	21	Bank Fees	1	Community Nursing & Rehab Realty, LLC			(1)	2
3	V	26	Insurance		Community Nursing & Rehab Realty, LLC		50,733	50,733	3
4	V	30	Depreciation		Community Nursing & Rehab Realty, LLC		146,629	146,629	4
5	V	32	Interest	95	Community Nursing & Rehab Realty, LLC		407,530	407,435	5
6	V	33	Real Estate Tax		Community Nursing & Rehab Realty, LLC		107,314	107,314	6
7	V	20	Licenses		Community Nursing & Rehab Realty, LLC		800	800	7
8	V	34	Building Rent	738,025	Community Nursing & Rehab Realty, LLC			(738,025)	8
9	V	36	Mortgage Insurance		Community Nursing & Rehab Realty, LLC				9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 738,121			\$ 713,006	\$ * (25,115)	14

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

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	29.50	79,800	35	70.00	Guar Pymnts	\$ 180,000	L17, C3	1
2	Mark Weldler	CFO	Finance	29.50	588,936	35	70.00	Guar Pymnts	180,000	L17, C3	2
3											3
4											4
5			* Steve Jeremias and Mark Weldler each received \$79,800 from Pine Acres.								5
6			* Mark Weldler received \$509,136 from The Springs at Crystal Lake.								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 360,000		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 Community Nursing & Rehabilitation Center # 0044750 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 ☒

Name of Related Organization _____
Street Address N/A _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

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

	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				N/A		\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1	Chase - Subaru Motors		X	Facility Vehicle	\$633.16	03/3/11	\$ 35,281	\$ 23,493	03/3/16	0.0290	\$ 789	1							
2	Ally Vehicle Finance		X	Facility Vehicle	\$789.28	10/1/11	43,628	33,364	10/1/16	0.0324	1,226	2							
3	Cambridge Reality		X	Mortgage	\$43,339.00	03/20/08	7,267,500	6,797,362	02/20/48	0.0595	407,530	3							
4	MaxxSource		X	Facility Equipment	\$600.00	06/15/11	12,000	3,600	02/15/13			4							
5	Marlin - Dish Machine & Booster		X	Facility Equipment	\$247.10	04/15/11	13,954	10,287	04/15/16	0.0625	720	5							
	Working Capital																		
6												6							
7	Lake Forest Bank		X	Working Capital	Varies	9/15/11	1,000,000		9/1/12	0.0550	15,144	7							
8												8							
9	TOTAL Facility Related				\$45,608.54		\$ 8,372,363	\$ 6,868,106			\$ 425,409	9							
	B. Non-Facility Related*																		
10								Less: Interest Income Offset		(2,624)		10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (2,624)	14							
15	TOTALS (line 9+line14)						\$ 8,372,363	\$ 6,868,106			\$ 422,785	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 34,196 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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.			\$	97,400	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		\$	99,814	2
3. Under or (over) accrual (line 2 minus line 1).			\$	2,414	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	104,900	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. 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.			\$	107,314	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	118,575	8		
	2008	111,973	9		
	2009	92,745	10		
	2010	95,046	11		
	2011	99,814	12		
Real estate tax accrual based on 102% of prior years tax bill					

	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 Community Nursing & Rehabilitation Center COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0044750

CONTACT PERSON REGARDING THIS REPORT Mark Weldler

TELEPHONE (630) 355-3300 FAX #: (630) 355-1417

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.	<u>07-12-403-042</u>	<u>Nursing Home</u>	\$ <u>99,813.72</u>	\$ <u>99,813.72</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u><u>99,813.72</u></u>	\$ <u><u>99,813.72</u></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? YES X 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:62,087

B. General Construction Type:ExteriorBrickFrameSteel

Number of StoriesTwo

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: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	Resident Use	164,335	2000	\$453,622	1
2					2
3	TOTALS	164,335		\$453,622	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	153		2000	1986	\$ 4,184,589	\$	40	\$ 104,615	\$ 104,615	\$ 1,333,847
5										
6										
7										
8										
	Improvement Type**									
9	CABLE		2000		4,305	108	40	108		1,377
10	ELEVATOR DOOR		2000		4,389	110	40	110		1,393
11	PARKING LOT		2000		38,200	955	40	955		12,097
12	LANDSCAPING		2000		8,736	218	40	218		2,743
13	SIGN		2000		4,541	114	40	114		1,434
14	ARCHITECT FEES		2000		3,060	77	40	77		979
15	DOOR LOCK		2000		2,248	56	40	56		705
16	CLOSETS		2000		7,729	193	40	193		2,396
17	COVE BASE		2000		4,459	111	40	111		1,360
18	HANDRAILS AND KICKPLATES		2000		15,146	379	40	379		4,643
19	LIGHTING		2000		65,796	1,645	40	1,645		20,151
20	TILE		2000		2,317	58	40	58		710
21	FLOORING		2000		16,378	409	40	409		4,961
22	EXIT DOORS		2000		1,598	40	40	40		490
23	WINDOW AND CUBICLE TREATMENTS		2000		34,021	851	40	851		10,425
24	LIGHTING		2000		1,729	43	40	43		527
25	CARPETING		2000		27,139	678	40	678		8,306
26	FIRE PANEL		2000		4,500	113	40	113		1,384
27	NURSE'S STATION		2000		8,913	223	40	223		2,713
28	DOOR HANDLES		2000		1,644	41	40	41		499
29	CUBICLE TRACK		2000		915	23	40	23		278
30	MOTOR		2000		13,276	332	40	332		4,150
31	STOVE HOODS		2000		1,429	36	40	36		435
32	COVER BASE - RESIDENTS' ROOMS		2001		865		10			865
33	CERAMIC TILES		2001		10,930		10			10,930
34	CEILING & LIGHTING		2001		9,063		10			9,063
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Community Nursing & Rehabilitation Center

0044750

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	RENOVATIONS - THERAPY ROOM	2001	\$ 10,558	\$	10	\$	\$	\$ 10,558	37
38	TILE & COVE BASE - BASEMENT	2001	2,327		10			2,327	38
39	SHAMPOO STATION	2001	5,431		10			5,431	39
40	COVE BASE - SECOND FLOOR	2001	1,699		10			1,699	40
41	WALLPAPER/COVEBASE/CARPETING/LIGHTING	2001	1,403		10			1,403	41
42	ABS PUMP	2001	11,908		10			11,908	42
43	CARPETING	2001	14,572		10			14,572	43
44	FLOORING	2001	1,320		10			1,320	44
45	2ND FLOOR RENOVATIONS	2001	38,875		10			38,875	45
46	AVERY	2001	2,419		10			2,419	46
47	KITCHEN - COOLING AIR UNIT	2001	2,275		10			2,275	47
48	WALLCOVERINGS	2001	12,289		10			12,289	48
49	SIGNAGE/ELECTRIC BALLAST (ADMISSIONS OFFICE)	2001	3,131		10			3,131	49
50	ROOM CURTAIN DIVIDER	2001	2,003		10			2,003	50
51	HANDRAILS & BUMPER GUARDS	2001	17,855		10			17,855	51
52	FIRE ALARM TRANSFORMER	2001	1,715		10			1,715	52
53	TEMP CONTROL ON AIR HANDLER	2001	9,519		10			9,519	53
54	COVEBASE/LANDSCAPING/LIGHTING/FLOORING	2001	2,642		10			2,642	54
55	LIGHTING - CORRIDORS & RESIDENT ROOMS	2001	20,544		10			20,544	55
56	NEW BEARING & SHAFT	2001	1,402		10			1,402	56
57	DIALYSIS ROOM RENOVATIONS	2001	23,351		10			23,351	57
58	ASPHALT SEALCOATING & STRIPING	2001	1,405		10			1,405	58
59	KITCHEN TILE	2001	930		10			930	59
60	SEPTIC TANK PUMPS	2001	13,862		10			13,862	60
61	CARPETING	2001	5,729		10			5,729	61
62	PAINTING & WALLPAPER	2001	20,440		10			20,440	62
63	PAINTING & WALLPAPER	2001	11,875		10			11,875	63
64	PAINTING & WALLPAPER	2001	4,500		10			4,500	64
65	NEW DOORS	2002	1,731	87	10	87		1,731	65
66	MURAL FOR SECOND FLOOR DINING ROOM	2002	7,000	350	10	350		7,000	66
67	NEW TROUGH IN LAUNDRY ROOM	2002	6,300	315	10	315		6,300	67
68	WINDOW MOLDINGS	2002	210	10	10	10		210	68
69	NEW THRESHHOLDS	2002	205	6	10	6		205	69
70	TOTAL (lines 4 thru 69)		\$ 4,739,340	\$ 7,581		\$ 112,196	\$ 104,615	\$ 1,700,286	70

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

Facility Name & ID Number Community Nursing & Rehabilitation Center

0044750

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,739,340	\$ 7,581		\$ 112,196	\$ 104,615	\$ 1,700,286	1
2	NEW PVC PIPING IN KITCHEN	2002	1,320	66	10	66		1,320	2
3	UPGRADE BACKFLOW SYSTEM	2002	1,695	80	10	80		1,695	3
4	ALARM FOR RAMP EXIT	2002	1,443	75	10	75		1,443	4
5	FLOORING IN ELEVATOR	2002	856	39	10	39		856	5
6	CORNER GUARDS/WATER SOFTENER	2002	1,328	65	10	65		1,328	6
7	NEW DRAINAGE PIPES - DISPOSAL	2002	9,985	495	10	495		9,985	7
8	CORNER GUARDS	2003	276	24	10	24		276	8
9	UPGRADE DIALYSIS ROOM	2003	28,103	2,810	10	2,810		28,100	9
10	NEW AWNINGS FOR PATIO	2003	3,940	394	10	394		3,940	10
11	INSTALL GREASE TRAP IN KITCHEN	2003	3,250	325	10	325		3,250	11
12	NEW COIL FOR AIR HANDLER	2003	3,493	349	10	349		3,490	12
13	INSTALL LASER EYE ON ELEVATOR	2003	1,590	159	10	159		1,590	13
14	UPGRADE DIALYSIS ROOM	2004	30,778	3,078	10	3,078		27,702	14
15	NEW ROOF	2004	8,600	860	10	860		7,740	15
16	REMODEL VESTIBULE, NEW FLOORING	2004	10,044	1,004	10	1,004		9,036	16
17	INSTALL NEW SMOKE DETECTORS	2004	4,911	491	10	491		4,419	17
18	NEW OXYGEN ROOM	2004	5,688	569	10	569		5,121	18
19	NEW ELEVATOR TANK, PUMP AND MOTOR	2004	11,960	1,196	10	1,196		10,764	19
20	ROOF REPLACEMENT	2005	5,800	580	10	580		4,350	20
21	WIRE GLASS FOR RECEPTION WINDOW	2005	1,348	135	10	135		1,015	21
22	NEW CEMENT WALKWAYS	2005	2,400	240	10	240		1,800	22
23	NEW WALL HUNG SINK	2006	3,410	341	10	341		2,045	23
24	MOTOR FOR A/C	2006	664	66	10	66		396	24
25	NEW PUMP SYSTEM	2006	5,108	511	10	511		3,065	25
26	NEW HOT WATER HEATER	2006	7,998	800	10	800		4,800	26
27	SOLID STATE STARTER	2006	3,900	390	10	390		2,340	27
28	PUMP	2006	1,553	155	10	155		929	28
29	NEW FIRE ALARM	2006	6,800	680	10	680		4,080	29
30	NEW PUMP FOR BASEMENT A/C	2006	988	99	10	99		593	30
31	PAVE PARKING LOT	2006	3,500	350	10	350		2,100	31
32	NEW TIME CLOCK	2006	4,345	435	10	435		2,609	32
33	REPLACE HVAC ROOF TOP UNIT	2007	3,511	351	10	351		1,931	33
34	TOTAL (lines 1 thru 33)		\$ 4,919,925	\$ 24,793		\$ 129,408	\$ 104,615	\$ 1,854,394	34

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

Facility Name & ID Number Community Nursing & Rehabilitation Center

0044750

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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,919,925	\$ 24,793		\$ 129,408	\$ 104,615	\$ 1,854,394	1
2	BALANCE OF TIME CLOCK	2007	4,345	434	10	434		2,387	2
3	HOT WATER HEATER	2007	9,212	921	10	921		5,066	3
4	SECURITY CAMERAS	2008	5,458	546	10	546		2,457	4
5	RELOCATE GAS LINE	2008	21,900	2,190	10	2,190		9,855	5
6	FRONT & BACK LANDSCAPING	2008	33,000	3,300	10	3,300		14,850	6
7									7
8	Architect Services	2009	29,257	2,926	10	2,926		10,240	8
9	Roof	2009	230,100	23,010	10	23,010		80,535	9
10	Construction Period Interest	2009	32,240	3,224	10	3,224		11,284	10
11	1st floor resident room baths - remove existing vinyl floor,								11
12	floor prep, installation of sheet vinyl, ceramic tile	2009	22,546	2,255	10	2,255		7,891	12
13	1st floor dining room - remove existing cove base and sheet								13
14	vinyl, floor prep, pvt install, pvt wallcovering	2009	32,001	3,200	10	3,200		11,200	14
15	Activity room - wall covering, remove cove base, install pvt &								15
16	cove base, cornices, custom built in computer work station,								16
17	remove existing ceiling tile, furnish & install new acoustic								17
18	ceiling tile, furnish & install new can lights	2009	20,443	2,044	10	2,044		7,155	18
19	Shower room - install 4 shower stalls, remove existing cove								19
20	base & sheet vinyl, install new ceramic tile	2009	43,873	4,387	10	4,387		15,356	20
21	Basement corridor - cove base, flooring, paint doors & frames,								21
22	wallpaper purchase & installation	2009	46,436	4,644	10	4,644		16,253	22
23	Therapy room - wallcovering, remove existing cove base and								23
24	vct installation of pvt, glue down carpet, remove cinder-								24
25	block wall and office separating OT & PT rooms, demo of								25
26	old and installation of new acoustical ceiling	2009	30,482	3,048	10	3,048		10,668	26
27	Foyer - remove old flooring, install new ceramic flooring &								27
28	pedimat, wallcovering	2009	12,181	1,218	10	1,218		4,263	28
29	Lobby - remove old cove base and flooring, install new ceramic								29
30	tile and cove base, wallcovering, built in reception desk,								30
31	remove mirror, door, frame & glass. Install new moldings,								31
32	remove existing receptionist wall and rebuild wall, re-								32
33	install door 3 feet from current location	2009	34,706	3,471	10	3,471		12,147	33
34	TOTAL (lines 1 thru 33)		\$ 5,528,105	\$ 85,611		\$ 190,226	\$ 104,615	\$ 2,076,002	34

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

Facility Name & ID Number Community Nursing & Rehabilitation Center

0044750

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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,528,105	\$ 85,611		\$ 190,226	\$ 104,615	\$ 2,076,002	1
2	Building Facade & Renovation								2
3	- General requirements	2009	19,795	1,981	10	1,981		6,930	3
4	- Permits	2009	5,000	500	10	500		1,750	4
5	- Excavation and site demolition	2009	22,626	2,263	10	2,263		7,919	5
6	- Asphalt Patching	2009	5,928	593	10	593		2,075	6
7	- Mansard and patio canopy demolition	2009	9,300	930	10	930		3,255	7
8	- Concrete work	2009	23,807	2,381	10	2,381		8,332	8
9	- Brick pavers	2009	13,440	1,344	10	1,344		4,704	9
10	- Masonry columns & Screen wall	2009	16,190	1,619	10	1,619		5,667	10
11	- Steel	2009	9,700	970	10	970		3,395	11
12	- Wood fencing	2009	1,580	158	10	158		553	12
13	- Pylon Sign	2009	8,000	800	10	800		2,800	13
14	- Room framing and sheathing	2009	81,769	8,177	10	8,177		28,619	14
15	- Cut and patch existing roofing for new construction	2009	17,310	1,731	10	1,731		6,059	15
16	- Roofing and sheetmetal	2009	40,835	4,084	10	4,084		14,293	16
17	- Electrical	2009	4,150	415	10	415		1,453	17
18	- Dry fire sprinkler system	2009	7,000	700	10	700		2,450	18
19	- Duct demolition	2009	2,160	216	10	216		756	19
20	- Homosote sheathing	2009	7,549	755	10	755		2,642	20
21	- Eifs	2009	13,350	1,335	10	1,335		4,673	21
22	- Fypon Moldings	2009	6,790	679	10	679		2,377	22
23	- Painting	2009	3,400	340	10	340		1,190	23
24	- Main extrace roof tower	2009	47,588	4,759	10	4,759		16,656	24
25	- Asphalt sidewalk on north side of bldg	2009	4,920	492	10	492		1,722	25
26	- Landscaping	2009	18,000	1,800	10	1,800		6,300	26
27	- Landscape demo	2009	5,566	557	10	557		1,948	27
28	- Insurance	2009	3,562	357	10	357		1,247	28
29	- General contractor fee	2009	13,685	1,369	10	1,369		4,790	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,941,105	\$ 126,916		\$ 231,531	\$ 104,615	\$ 2,220,557	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 5,941,105	\$ 126,916		\$ 231,531	\$ 104,615	\$ 2,220,557	1
2	1st floor elevator lobby - remove old flooring and install new								2
3	pvt tile, wallcovering	2009	2,699	270	10	270		945	3
4	1st floor corridor - corner guard, remove old and install new								4
5	wood look pvt flooring and carpet, wallcovering	2009	55,531	5,553	10	5,553		19,436	5
6	1st floor wallcovering and paint	2009	38,491	3,849	10	3,849		13,472	6
7	2nd floor shower rooms - remove existing ceramic tile, furnish								7
8	and install new ceramic tile	2009	7,067	707	10	707		2,473	8
9	1st floor resident rooms - cove base, built in double wardrobe,								9
10	remove old wallpaper and glue, paint ceilings, walls, doors								10
11	and radiators, custom built in wardrobes, cornices and								11
12	cubicle curtains	2009	159,255	15,926	10	15,926		55,741	12
13									13
14									14
15	Landmark-building façade renovation	2009	9,419	942	10	942		3,297	15
16	Satellite TV-Installation and wiring	2009	9,000	900	10	900		3,150	16
17	Architect Fees	2009	713	71	10	71		250	17
18	Sprinkler System	2009	134,000	13,400	10	13,400		46,900	18
19	Window Treatments	2009	44,355	4,436	10	4,436		15,525	19
20	Alzheimers Nurses Station Remodel	2009	18,328	1,833	10	1,833		6,415	20
21	Adjust for accounts payable invoice	2009	(23,592)						21
22									22
23	Pump Motor	2010	7,004	700	10	700		1,750	23
24	Telephone Paging System	2010	7,047	176	40	176		440	24
25	Wanderguard	2010	12,289	308	40	308		770	25
26	2nd Floor Common Area Flooring	2010	6,860	686	10	686		1,715	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,429,571	\$ 176,673		\$ 281,288	\$ 104,615	\$ 2,392,836	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 6,429,571	\$ 176,673		\$ 281,288	\$ 104,615	\$ 2,392,836	1
2	Compressor Replacement	2011	9,763	976	10	976		1,464	2
3	Sprinkler system	2011	9,933	497	20	497		745	3
4	Patio	2011	3,708	185	20	185		278	4
5	Business office thermostat	2011	5,988	1,198	5	1,198		1,797	5
6	Transformer	2011	13,500	675	20	675		1,013	6
7	Rehab corridor(Flooring, wallcovering)	2011	40,509	5,787	7	5,787		8,681	7
8	Rehab corridor(Handrails, Door & Frame)	2011	43,724	2,186	20	2,186		3,279	8
9	Nursing home (Relaminate)	2011	13,483	1,348	10	1,348		2,022	9
10									10
11	3 Broan fans, sheet metal work - Entire Facility	2012	4,300	215	10	215		215	11
12	Roof Chiller - Roof of Main Building	2012	4,455	223	10	223		223	12
13	Automatic Door - Homeward Bound Unit	2012	4,200	210	10	210		210	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30	Adjust book depreciation to financial statements			(116,429)			116,429		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,583,134	\$ 73,744		\$ 294,788	\$ 221,044	\$ 2,412,763	34

**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	\$395,720	\$55,932	\$46,905	\$ (9,027)	3-40	\$293,634	71
72	Current Year Purchases	18,532	1,853	1,853		5	1,853	72
73	Fully Depreciated Assets	990,049					990,049	73
74								74
75	TOTALS	\$1,404,301	\$57,785	\$48,758	\$ (9,027)		\$1,285,536	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	Facility	GMC Truck	2011	\$43,628	\$8,726	\$8,726	\$	5	\$13,089	76
77	Facility	Subaru	2011	32,781	6,556	6,556		5	10,134	77
78										78
79										79
80	TOTALS			\$76,409	\$15,282	\$15,282	\$		\$23,223	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$8,517,466	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$146,811	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$358,828	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$212,017	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,721,522	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	Construction in Progress	\$1,866	92
93			93
94			94
95		\$1,866	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
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: \$55,291
- Description: See Attached Schedule 14A
- (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	Administrative	2009 Toyota Avalon	\$619.00	\$7,423	17
18					18
19					19
20					20
21	TOTAL		\$619.00	\$7,423	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 EndingAnnual 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.

Community Nursing & Rehabiliitation Center, LLC

Provider #: 0044750

12/31/2012

Schedule 14A

Sch 12, Sec B, Line 16 - Detail of Movable Rental Equipment

<u>Description</u>	<u>Amount</u>
Non-Medical Equipment	19,703
Nursing Equipment	9,665
Copiers	23,403
Water Cooler	1,597
Maintenance Equipment	923
TOTAL	<u>55,291</u>

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	\$	8,292	\$ 596,999	\$	8,292	\$ 596,999	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,984	214,829		2,984	214,829	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		9,939	715,621		9,939	715,621	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				673,120		673,120	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Resp Therapy/Oxygen</u>	39(1)(2)	199	5,563			11,269	199	16,832	12
13	Other (specify): <u>Dialysis Services</u>	39(3)				137,510			137,510	13
14	TOTAL			\$ 5,563	21,215	\$ 1,664,959	\$ 684,389	21,414	\$ 2,354,911	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	\$ 98,752	\$ 129,700	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (252,150))	3,061,640	3,061,640	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	151,596	168,514	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	368,950	340,121	8
9	Other(specify): See Schedule 17A	28,010	335,582	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,708,948	\$ 4,035,557	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		453,622	13
14	Buildings, at Historical Cost		4,184,589	14
15	Leasehold Improvements, at Historical Cost	1,483,426	2,398,545	15
16	Equipment, at Historical Cost	449,879	1,480,710	16
17	Accumulated Depreciation (book methods)	(924,342)	(3,721,522)	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 (spec CIP	1,866	1,866	22
23	Other(specify): Mortgage Costs, Net		156,204	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,010,829	\$ 4,954,014	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,719,777	\$ 8,989,571	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,133,517	\$ 1,150,326	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	21,515	140,346	29
30	Accrued Salaries Payable	251,080	251,080	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,362	33,362	31
32	Accrued Real Estate Taxes(Sch.IX-B)		104,900	32
33	Accrued Interest Payable	440	34,144	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	927,464	927,464	36
37	Due To/From Insurance	4,931	4,931	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,372,309	\$ 2,646,553	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	49,229	49,229	39
40	Mortgage Payable		6,678,531	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Resident Refunds	9,515	9,515	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 58,744	\$ 6,737,275	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,431,053	\$ 9,383,828	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,288,724	\$ (394,257)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,719,777	\$ 8,989,571	48

*(See instructions.)

Community Nursing & Rehabilitation Center, LLC

Provider # 0044750

1/1/12-12/31/12

Schedule 17A

Other Current Asset

Line 9	<u>Operating</u>	<u>After Consolidation</u>
NH A/R-Employee Loans	112	112
NH Escrow-MIP	-	30,625
NH Escrow-Insurance	-	32,486
NH Escrow-Real Estate	-	125,689
NH Escrow-Replacement	-	118,772
NH Escrow-Due to/from AdminiStar	27,898	27,898
Total	<u>28,010</u>	<u>335,582</u>

Other Current Liabilities

Line 36	<u>Operating</u>	<u>After Consolidation</u>
Provider Tax Payable	-	-
Accrued Management Fees	345,000	345,000
Accrued Assessment Fee	100,482	100,482
Insurance Payable	209,119	209,119
Due to State	312,605	312,605
Resident Credit Balances	9,440	9,440
Due To/From BC-BS	892	892
Due To/From Pine Acres	41,430	41,430
Due To/From The Springs	(41,504)	(41,504)
Total	<u>977,464</u>	<u>977,464</u>

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,042,204	1
2	Restatements (describe):		2
3	Real Estate Entity Post Closing Adjustment	165,740	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,207,944	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	80,780	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)	\$ 80,780	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)	\$ 2,288,724	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Community Nursing & Rehabilitation Center# 0044750Report 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	\$ 9,425,439	1
2	Discounts and Allowances for all Levels	(1,962,411)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,463,028	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,204,453	6
7	Oxygen	17,290	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,221,743	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	5,001	12
13	Barber and Beauty Care	4,867	13
14	Non-Patient Meals	949	14
15	Telephone, Television and Radio	5,660	15
16	Rental of Facility Space		16
17	Sale of Drugs	630,503	17
18	Sale of Supplies to Non-Patients	394	18
19	Laboratory	134,930	19
20	Radiology and X-Ray	81,530	20
21	Other Medical Services	(27,275)	21
22	Laundry	3,012	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 839,571	23
	D. Non-Operating Revenue		
24	Contributions	300	24
25	Interest and Other Investment Income***	2,529	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,829	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue	7,508	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,508	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,534,679	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,475,471	31
32	Health Care	3,695,590	32
33	General Administration	2,234,915	33
	B. Capital Expense		
34	Ownership	965,429	34
	C. Ancillary Expense		
35	Special Cost Centers	2,796,693	35
36	Provider Participation Fee	285,801	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,453,899	40
41	Income before Income Taxes (line 30 minus line 40)**	80,780	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 80,780	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,785,072	44
45	Private Pay - Net Inpatient Revenue	1,089,482	45
46	Medicare - Net Inpatient Revenue	2,016,092	46
47	Other-(specify) <u>Managed Care</u>	68,788	47
48	Other-(specify) <u>Hospice</u>	503,594	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,463,028	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.

^ - Provider 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	880	1,019	\$ 43,711	\$ 42.90	1
2	Assistant Director of Nursing	3,912	4,198	164,429	39.17	2
3	Registered Nurses	25,829	27,734	842,031	30.36	3
4	Licensed Practical Nurses	16,189	16,882	353,987	20.97	4
5	CNAs & Orderlies	84,372	90,970	1,251,827	13.76	5
6	CNA Trainees					6
7	Licensed Therapist	199	199	5,563	27.95	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,880	2,080	43,038	20.69	9
10	Activity Assistants	9,288	9,762	106,234	10.88	10
11	Social Service Workers	3,824	4,111	82,550	20.08	11
12	Dietician	1,772	1,868	50,123	26.83	12
13	Food Service Supervisor	4,227	4,672	82,542	17.67	13
14	Head Cook	11,170	12,306	114,962	9.34	14
15	Cook Helpers/Assistants	13,601	14,471	168,017	11.61	15
16	Dishwashers					16
17	Maintenance Workers	4,066	4,493	68,266	15.19	17
18	Housekeepers	19,990	21,813	223,471	10.24	18
19	Laundry	5,732	5,898	62,079	10.53	19
20	Administrator	1,536	1,728	184,923	107.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,244	8,964	181,763	20.28	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	1,979	2,099	34,714	16.54	31
32	Other Health C: SCH20A	16,571	18,159	443,132	24.40	32
33	Other(specify) Marketing & Hosp	3,625	4,065	126,193	31.04	33
34	TOTAL (lines 1 - 33)	238,886	257,491	\$ 4,633,555 *	\$ 18.00	34

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

** See instructions.

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		\$		35
36	Medical Director	Monthly	21,600	9(3)	36
37	Medical Records Consultant	Monthly	750	10(7)	37
38	Nurse Consultant	Monthly	17,767	10(3)	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	32	4,838	10(3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant	18	991	11(3)	44
45	Social Service Consultant	17	1,037	12(3)	45
46	Other(specify)				46
47	Nurse Consultant	554	28,542	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	621	\$ 75,525		49

C. CONTRACT NURSES

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

Community Nursing & Rehabilitation Center, LLC
Provider # 0044750
1/1/12-12/31/12

Schedule 20A

Staffing & Salary

<u>Description</u>	<u>Hours Worked</u>	<u>Hours Paid</u>	<u>Amount</u>
MDS Coordinator	3,154	3,446	105,659
Restorative Aides	8,199	8,671	130,141
Treatment Nurse	2,352	2,400	66,331
Program Development Consultant	926	926	34,682
Case Manager	60	640	37,248
Transitional Care Coordinator	1,880	2,076	69,071
	16,571	18,159	443,132

STATE OF ILLINOIS

Facility Name & ID Number

Community Nursing & Rehabilitation Center

0044750

Report Period Beginning:

01/01/12

Page 21

Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Larry Banks	Adminstrator	0	\$ 184,923
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 184,923

B. Administrative - Other

Description	Amount
Steve Jeremias-COO	\$ 180,000
Mark Weldler-CFO	180,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 360,000

C. Professional Services

Vendor/Payee	Type	Amount
McGladrey LLP	Accounting	\$ 56,631
Corporate Cost Solutions	Workman's Comp	745
MDI Achieve	Computer Consultant	23,124
Innovative LTC Solutions	Computer Services	4,750
Allscripts	Data Processing	3,063
Meyer Magence	Legal	250
Paylocity	Payroll Fees	8,960
Personnel Planners	Unemployment Consultant	2,158
Medifax - EDI	Software Maintenance	1,129
See Schedule 21A	See Schedule 21A	101,032
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 201,842

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 254,347
Unemployment Compensation Insurance	
FICA Taxes	467,365
Employee Health Insurance	181,561
Employee Meals	14,260
Illinois Municipal Retirement Fund (IMRF)*	
Flowers	678
Other Employee Benefits	45,340
TOTAL (agree to Schedule V, line 22, col.8)	\$ 963,551

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	\$ 1,990
Advertising: Employee Recruitment	2,612
Health Care Worker Background Check (Indicate # of checks performed 15)	210
Patient Background Checks 222	3,140
IL Council LTC Dues	13,824
Recruitment Expense	18
Miscellaneous Dues & Subscriptions	1,867
See Schedule 21B	615
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 24,276

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	7,460
Seminar Expense	
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 7,460

* Attach copy of IMRF notifications

**See instructions.

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Schedule 21A

C. Professional Services

Vendor	Type	Amount
Stone Pogrund & Korey	Legal	23,137
Much Shelist	Legal	24,913
Marliyn P Dunn	Legal	150
Foote, Meyers, Mielke & Flowers	Legal	1,510
Holland & Knight, LLP	Legal	3,049
Ashman & Stein	Legal	8,978
Meyer Magence	Legal	62
Adobe	Software	21
Information Controls, Inc.	Computer Services	1,623
I-Tunes	Computer Services	34
Ivans	Billing Service	1,370
Microsoft	Software	85
Milner	Computer Services	312
Nebo Systems Inc.	BC BS Claims System	80
Nitrodesk	Email Service	60
Pat Sutton	Computer Services	97
Silverchair Learning Systems	Online Curriculum	6,300
Singer Networks LLC	Computer Services	28,370
Web312	Annual Hosting	200
Wet Works Solutions	Software	87
Ziprecruiter	Online Job Applications	594
To Page 21C		101,032
From Sch V L19 C3		201,842
Add : Achieve Accreditation		11,480
Less: Nonallowable legal expense		(2,362)

To Sch V L19 C8

210,960

Community Nursing & Rehabilitation Center, LLC
Provider # 0044750
1/1/12-12/31/12

Schedule 21B

Dues, Fees, Subscriptions and Promotions

Description	Amount
Dupage County Health	850
Naperville Chamber of Commerce	1,500
Illinois Secretary of State	800
IIT Source Tech	1,345
JCHO	1,285
Miscellaneous License	500
Real Estate Entity Allocation	800
Total Column 4	7,080
Less : Chamber of Commerce	(1,500)
Less : Lobbying Expense	(4,965)
Total Column 8	615

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? Yes
If YES, give association name and amount. Illinois Council -LTC - \$13,824
- (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? 3-7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,083 Line 10(2)
- (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. \$ 285,801
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. \$ 14,260 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 949
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? 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 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.