

		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>0047720</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Pine Acres Rehab & Living Center</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>1212 South Second Street</u> <u>DeKalb</u> <u>60115</u>																									
Number City Zip Code																									
County: <u>DeKalb</u>																									
Telephone Number: <u>(815) 758-8151</u> Fax # <u>(815) 758-6832</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>												
Officer or Administrator of Provider	(Signed) _____																								
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	(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>																								
Date of Initial License for Current Owners: <u>02/01/2006</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ "Sub-S" Corp.																								
	☒ 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 Pine Acres Rehab & Living Center# 0047720 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>119</u>	Skilled (SNF)	<u>119</u>	<u>43,554</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>119</u>	TOTALS	<u>119</u>	<u>43,554</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>17,633</u>	<u>9,998</u>	<u>6,748</u>	<u>34,379</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>17,633</u>	<u>9,998</u>	<u>6,748</u>	<u>34,379</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 78.93%

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 2/1/06

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

YES ☒Date 2/1/06NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 119 and days of care provided 6,386Medicare 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	328,396	15,681	12,508	356,585		356,585		356,585			1
2	Food Purchase		228,231		228,231		228,231	(2,362)	225,869			2
3	Housekeeping	106,944	13,639		120,583		120,583		120,583			3
4	Laundry	18,243	1,431	108,594	128,268		128,268		128,268			4
5	Heat and Other Utilities			76,212	76,212		76,212		76,212			5
6	Maintenance	111,159	86,911	41,529	239,599		239,599	2,376	241,975			6
7	Other (specify):*											7
8	TOTAL General Services	564,742	345,893	238,843	1,149,478		1,149,478	14	1,149,492			8
	B. Health Care and Programs											
9	Medical Director			15,600	15,600		15,600		15,600			9
10	Nursing and Medical Records	2,498,503	200,933	12,791	2,712,227		2,712,227		2,712,227			10
10a	Therapy											10a
11	Activities	84,460	6,815	3,869	95,144		95,144		95,144			11
12	Social Services	20,357	15	1,111	21,483		21,483		21,483			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,603,320	207,763	33,371	2,844,454		2,844,454		2,844,454			16
	C. General Administration											
17	Administrative	108,368		159,600	267,968		267,968		267,968			17
18	Directors Fees											18
19	Professional Services			136,505	136,505		136,505	(296)	136,209			19
20	Dues, Fees, Subscriptions & Promotions			21,080	21,080		21,080	(4,478)	16,602			20
21	Clerical & General Office Expenses	207,672	18,466	38,231	264,369		264,369	(6,202)	258,167			21
22	Employee Benefits & Payroll Taxes			642,894	642,894		642,894		642,894			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,814	1,814		1,814		1,814			24
25	Other Admin. Staff Transportation			7,201	7,201		7,201		7,201			25
26	Insurance-Prop.Liab.Malpractice			66,789	66,789		66,789	12,158	78,947			26
27	Other (specify):*											27
28	TOTAL General Administration	316,040	18,466	1,074,114	1,408,620		1,408,620	1,182	1,409,802			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,484,102	572,122	1,346,328	5,402,552		5,402,552	1,196	5,403,748			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			53,758	53,758		53,758	121,154	174,912			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,988	36,988		36,988	394,518	431,506			32
33	Real Estate Taxes							86,248	86,248			33
34	Rent-Facility & Grounds			623,600	623,600		623,600	(623,600)				34
35	Rent-Equipment & Vehicles			30,204	30,204		30,204		30,204			35
36	Other (specify):* Mortgage Insurance							39,056	39,056			36
37	TOTAL Ownership			744,550	744,550		744,550	17,376	761,926			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		246,621	891,136	1,137,757		1,137,757		1,137,757			39
40	Barber and Beauty Shops	14,518	211		14,729		14,729		14,729			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			228,206	228,206		228,206		228,206			42
43	Other (specify):* Non-Allowable Co	65,428		116,605	182,033		182,033	(182,033)				43
44	TOTAL Special Cost Centers	79,946	246,832	1,235,947	1,562,725		1,562,725	(182,033)	1,380,692			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,564,048	818,954	3,326,825	7,709,827		7,709,827	(163,461)	7,546,366			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	(2,315)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,735)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(87,579)	30		9
10	Interest and Other Investment Income	(13,232)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,908)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(296)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(81,608)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(619)	43		28
29	Other-Attach Schedule See Pg 5A	(98,749)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (298,041)		\$	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	2	
		Amount	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)	134,580		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 134,580		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (163,461)		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	2	3	4	
		Yes	No	Amount	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

ID#0047720

Report Period Beginning:01/01/12

Ending:12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Labs - Part A	\$ (11,820)	43	1
2	X-Rays - Part A	(424)	43	2
3	Wages-Marketing	(65,428)	43	3
4	Marketing	(8,491)	43	4
5	Offset Vending Machine Income	(47)	2	5
6	Non-Care Real Estate Taxes	(4,027)	32	6
7	Equipment Repair and Maintenance	2,376	6	7
8	Offset Telephone Income	(2,617)	21	8
9	Non-Allowable Chamber of Commerce	(902)	20	9
10	Non-Allowable PAC Contributions	(3,826)	20	10
11	Offset Misc. Income	(3,543)	21	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	(98,749)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steve Jeremias	33	Community Nursing & Rehabilitation Center, LLC	Naperville	Pine Acres Realty,		
Mark Weldler	33	The Springs at Crystal Lake, LLC	Crystal Lake	LLC	Dekalb	Real Estate
Chaim Rajchenbach	11					
The Family Rajchenbach Trust	11			Community Nursing		
Abraham J. Stern	4			and Rehab Realty,		
Susan L. Stern	4			LLC	Naperville	Real Estate
ABM Limited Partnership	4			TS Realty, LLC	Crystal Lake	Real Estate

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

☒ YES ☐ NO

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

1 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	30	Depreciation	\$	Pine Acres Realty, LLC		\$ 208,733	\$ 208,733	1
2	V	32	Interest	310	Pine Acres Realty, LLC		408,060	407,750	2
3	V	33	Real Estate Taxes		Pine Acres Realty, LLC		90,275	90,275	3
4	V	34	Rent Expense	623,600	Pine Acres Realty, LLC			(623,600)	4
5	V	20	Licenses		Pine Acres Realty, LLC		250	250	5
6	V	26	Insurance		Pine Acres Realty, LLC		51,214	51,214	6
7	V	21	Bank Fees	42	Pine Acres Realty, LLC			(42)	7
8	V	19	Professional Fees		Pine Acres Realty, LLC				8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 623,952			\$ 758,532	\$ * 134,580	14

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Steve Jeremias	COO	Administrative	33.00	180,000	25	50.00	Guar Pymnts	\$ 79,800	L17,C3	1
2	Mark Weldler	CFO	Finance	33.00	689,136	25	50.00	Guar Pymnts	79,800	L17,C3	2
3											3
4											4
5			*Mark Welder received \$509,136 from The Springs at Crystal Lake								5
6			*Steve Jeremias and Mark Welder each received \$180,000 from Community Nursing & Rehabilitation Center								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 159,600		13

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

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

Facility Name & ID Number Pine Acres Rehab & Living Center # 0047720 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 N/A
Street Address _____
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	Cambridge Realty Capital LTD		X	Mortgage	\$17,450.05	07/1/08	\$ 6,695,044	\$ 6,405,924	5/1/2049	0.0635	\$ 408,060	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Lake Forest Bank & Trust Co.		X	Line of Credit	None	9/15/12	1,000,000	632,000	9/1/13	0.0500	36,988	6	
7												7	
8												8	
9	TOTAL Facility Related				\$17,450.05		\$ 7,695,044	\$ 7,037,924			\$ 445,048	9	
	B. Non-Facility Related*												
10								Offset interest income			(13,542)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (13,542)	14	
15	TOTALS (line 9+line14)						\$ 7,695,044	\$ 7,037,924			\$ 431,506	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 39,056 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.			\$	85,900	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	\$	85,925	2
3. Under or (over) accrual (line 2 minus line 1).			\$	25	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	90,250	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.				(4,027)	
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.			\$	86,248	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	44,465	8	
		2008	58,394	9	
		2009	60,435	10	
		2010	82,545	11	
		2011	85,925	12	
Assumed approximately a 4% increase on real estate taxes paid during the year					

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 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
Pine Acres Rehab & Living Center

COUNTY
DeKalb

FACILITY IDPH LICENSE NUMBER
0047720

CONTACT PERSON REGARDING THIS REPORT
Mark Weldler

TELEPHONE
(815) 758-8151
FAX #:
(815) 758-6832

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 08-27-279-003	Nursing Home	\$ 81,897.88	\$ 81,897.88
2. 08-27-279-023	Rental House	\$ 4,027.04	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 85,924.92	\$ 81,897.88

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: 37,295

B. General Construction Type: Exterior Brick Frame

Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐ 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	126,760	2006	\$ 196,341	1
2					2
3	TOTALS	126,760		\$ 196,341	3

Facility Name & ID Number Pine Acres Rehab & Living Center

0047720

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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	119		2006	1968	\$ 1,736,051	\$	40	\$ 43,401	\$ 43,401	\$ 300,191	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2 Ton Rooftop System			2007	4,562	456	10	456		2,508	9
10	Replace Heat Cable			2008	2,626	263	10	263		1,183	10
11	Replace Fan Motors			2008	3,441	344	10	344		1,548	11
12	Replace Unit Heater			2008	3,938	394	10	394		1,773	12
13	Replace Doors			2008	2,696	270	10	270		1,215	13
14	Move Electrical Box			2008	6,932	693	10	693		3,118	14
15	Sidewalk			2009	6,312	316	10	631	315	2,209	15
16	Retrofit Mechanical Room with Sprinklers			2009	2,800	140	10	280	140	980	16
17	Security Alarm for Front Doors			2009	4,644	232	10	464	232	1,624	17
18	Telephone System			2009	37,765	1,888	10	3,777	1,889	13,219	18
19	Telephone System Addition			2009	13,143	657	10	1,314	657	4,599	19
20	Fence			2009	5,708	285	10	571	286	1,998	20
21	Renovation & New Construction			2009	2,443,769		40	61,094	61,094	213,829	21
22	Architect Fees			2009	122,501		40	3,063	3,063	10,720	22
23	Demolition of Old House			2009	41,210		40	1,030	1,030	3,605	23
24	Carpet, Flooring & Wallcovering			2009	175,473		40	4,387	4,387	15,354	24
25	Construction Period Interest			2009	108,345		40	2,709	2,709	9,481	25
26	North Dining Room & Corridor Remodel			2009	101,743		40	2,544	2,544	8,904	26
27	Architect Fees			2009	102,207		40	2,555	2,555	8,943	27
28	Draw #11 Construction & Architect Fees			2009	13,159		40	329	329	1,152	28
29	Draw #12			2009	154,568		40	3,864	3,864	13,524	29
30	Doors & Hardware			2009	13,257		40	331	331	1,159	30
31	Panic Hardware			2009	3,730		40	93	93	326	31
32	Old House			2009	173,313		40	4,333	4,333	15,165	32
33	Ice Cube Machine (Expensed for Medicaid purposes)			2009		92			(92)		33
34	Telephone System Addition			2010	6,277		40	157	157	392	34
35	Satellite TV Installation			2010	8,250		10	825	825	2,063	35
36	A/C Unit Replacement (North Dining Room)			2010	10,000		10	1,000	1,000	2,500	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 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	Piping and Wiring (outside lights)	2010	\$ 2,896	\$	40	\$ 72	\$ 72	\$ 180	37
38									38
39	Water Heater	2011	7,442		15	496	496	744	39
40	Rooftop A/C replacement	2011	5,721		20	286	286	429	40
41	Replace 19 window cranks	2011	3,419		7	488	488	732	41
42									42
43	Set Up Wireless Access	2012	4,919		10	246	246	246	43
44	Kitchen HVAC Unit	2012	6,507		10	325	325	325	44
45									45
46									46
47									47
48									48
49	To adjust to financial statement depreciation			15,902			(15,902)		49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,339,324	\$ 21,932		\$ 143,086	\$ 121,154	\$ 645,939	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	\$ 918,015	\$ 31,359	\$ 31,359	\$	10	\$ 490,213	71
72	Current Year Purchases	4,671	467	467		5	467	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 922,686	\$ 31,826	\$ 31,826	\$		\$ 490,680	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	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,458,351	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 53,758	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 174,912	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 121,154	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,136,619	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	North Wing Sprinkler System	\$ 29,520	92
93	North Wing CIP	146,358	93
94	RE CIP	45,314	94
95		\$ 221,192	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
- N/A
- N/A
9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms: N/A
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 21,805
- Description: Non-Med Equip. \$479; Medical Equip \$15993; Computer Equip. \$1519; Copier Equip. \$3814
- (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	2008 Nissan Maxima	\$ 699.90	\$ 8,399	17
18					18
19					19
20					20
21	TOTAL		\$ 699.90	\$ 8,399	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/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)

		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)	\$			

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

HFS 3745 (N-4-99)

IL478-2471

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(2),(3)	hrs	\$	4,003	\$ 288,223	\$ 2,211	4,003	\$ 290,434	1
2	Licensed Speech and Language Development Therapist	39(2),(3)	hrs		1,377	99,167	75	1,377	99,242	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2),(3)	hrs		6,996	503,746	335	6,996	504,081	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				215,598		215,598	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					28,402		28,402	12
13	Other (specify): _____									13
14	TOTAL			\$	12,376	\$ 891,136	\$ 246,621	12,376	\$ 1,137,757	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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 40,317)	1,992,002	1,992,002	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	82,292	95,503	6
7	Other Prepaid Expenses	303,200	303,200	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch 17A	124,678	195,239	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,502,172	\$ 2,585,944	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		196,341	13
14	Buildings, at Historical Cost		1,736,051	14
15	Leasehold Improvements, at Historical Cost	225,041	3,603,273	15
16	Equipment, at Historical Cost	225,866	922,686	16
17	Accumulated Depreciation (book methods)	(148,257)	(1,136,619)	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) See Sch 17A	175,878	798,351	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 478,528	\$ 6,120,083	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,980,700	\$ 8,706,027	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 779,164	\$ 783,425	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	244,527	244,527	30
31	Accrued Taxes Payable (excluding real estate taxes)	48,072	48,072	31
32	Accrued Real Estate Taxes(Sch.IX-B)		90,250	32
33	Accrued Interest Payable	3,367	37,265	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	420,369	174,625	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,495,499	\$ 1,378,164	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	632,000	7,037,924	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 632,000	\$ 7,037,924	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,127,499	\$ 8,416,088	46
47	TOTAL EQUITY(page 18, line 24)	\$ 853,201	\$ 289,939	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,980,700	\$ 8,706,027	48

*(See instructions.)

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

Schedule 17A

XV. Balance Sheet

Line 9 - Other Current Assets (specify)	Operating	After Consolidation
A/R - Employee Loans	881.00	881.00
RE Escrow -MIP		20,853.00
RE Escrow - RE Taxes		28,000.00
RE Escrow - Insurance		21,708.00
Due To/from Adminastar	142,437.00	142,437.00
Due To / from Primary Insurance	(18,640.00)	(18,640.00)
Total Line 9 - Other Current Assets	124,678	195,239
Line 22 - Other Long Term Assets (specify)		
Construction in Progress	175,878	221,192
Escrow Replacement		407,422
Mortgage Costs		188,910
Accum Amort-Org Fees		(19,173)
Total Line 22 - Other Long Term Assets	175,878	798,351
Line 36 - Other Current Liabilities (specify)		
Accrued Assessment Fee #2	85216.00	85,216
Due To State	118,210	118,210
Due To / from Primary Insurance	957	957
Resident Credit Balances	11,672	11,672
Due To/From Pine Acres Realty	245,744	0
Due To/From CNRC	(41,430)	(41,430)
Total Line 36 - Other Current Liabilities	420,369	174,625

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 767,229	1
2	Restatements (describe):		2
3	Prior Period Adjustment	153,739	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 920,968	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	352,233	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	(420,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (67,767)	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)	\$ 853,201	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Pine Acres Rehab & Living Center# 0047720Report 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	\$ 6,185,349	1
2	Discounts and Allowances for all Levels	(459,908)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,725,441	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,050,239	6
7	Oxygen	9,258	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,059,497	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	707	12
13	Barber and Beauty Care	14,959	13
14	Non-Patient Meals	2,315	14
15	Telephone, Television and Radio	2,617	15
16	Rental of Facility Space		16
17	Sale of Drugs	198,040	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	30,160	21
22	Laundry	8,806	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 257,604	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,232	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,232	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	6,286	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,286	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,062,060	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,149,478	31
32	Health Care	2,844,454	32
33	General Administration	1,408,620	33
	B. Capital Expense		
34	Ownership	744,550	34
	C. Ancillary Expense		
35	Special Cost Centers	1,334,519	35
36	Provider Participation Fee	228,206	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,709,827	40
41	Income before Income Taxes (line 30 minus line 40)**	352,233	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 352,233	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,379,610	44
45	Private Pay - Net Inpatient Revenue	1,836,817	45
46	Medicare - Net Inpatient Revenue	1,379,602	46
47	Other-(specify) <u>Managed Care</u>	51,105	47
48	Other-(specify) <u>Hospice</u>	78,307	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,725,441	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.

^ - LLC Members are cash basis tax payers.

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

Schedule 19A

XVII. Income Statement

Line 28 - Other Revenue	
Contribution Income	1,795
Prior Year Adjustment	901
Vending Machine Income	47
Miscellaneous Income	<u>3,543</u>
Total Line 28 - Other Revenue	<u><u>6,286</u></u>

		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	1,848	2,080	\$ 83,057	\$ 39.93	1
2	Assistant Director of Nursing	1,876	2,080	74,475	35.81	2
3	Registered Nurses	20,285	21,587	586,796	27.18	3
4	Licensed Practical Nurses	15,177	16,224	407,530	25.12	4
5	CNAs & Orderlies	81,840	86,631	1,058,297	12.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,932	2,080	34,072	16.38	9
10	Activity Assistants	4,929	5,240	50,388	9.62	10
11	Social Service Workers	1,231	1,231	20,357	16.54	11
12	Dietician					12
13	Food Service Supervisor	1,664	1,919	53,642	27.95	13
14	Head Cook	6,014	6,846	88,356	12.91	14
15	Cook Helpers/Assistants	20,746	21,600	186,398	8.63	15
16	Dishwashers					16
17	Maintenance Workers	5,662	6,025	111,159	18.45	17
18	Housekeepers	11,174	11,854	106,944	9.02	18
19	Laundry	1,846	1,967	18,243	9.27	19
20	Administrator	1,804	2,080	108,368	52.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,922	14,813	207,672	14.02	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	1,637	1,985	24,773	12.48	31
32	Other Health Care See Sch 20A	11,449	12,977	263,575	20.31	32
33	Other(specify) See Sch 20A	2,678	2,951	79,946	27.09	33
34	TOTAL (lines 1 - 33)	207,714	222,170	\$ 3,564,048 *	\$ 16.04	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	90	\$ 12,508	1(3)	35
36	Medical Director	Monthly	15,600	9(3)	36
37	Medical Records Consultant	16	960	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	60	3,869	11(3)	44
45	Social Service Consultant	17	1,111	12(3)	45
46	Other(specify)				46
47	Therapy Management	Monthly	9,600	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	183	\$ 43,648		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	29	\$ 1,722	10(3)	50
51	Licensed Practical Nurses	13	509	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	42	\$ 2,231		53

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

** See instructions.

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

Schedule 20A

XVIII. Staffing & Salary Cost	<u>Hours Wrkd</u>	<u>Hours Pd</u>	<u>Total Wages</u>	<u>Avg Hrly Wage</u>
Line 32 - Other Health Care				
MDS Coordinator	1,923	2,170	60,743	27.99
Dementia Director	1,472	1,904	36,690	19.27
Restoratvie Services	7,790	8,583	150,591	17.55
Case Manager	264	320	15,551	48.60
	<u>11,449</u>	<u>12,977</u>	<u>263,575</u>	
Line 33 - Other				
Beautician	828	830	14,518	17.49
Marketing Wages	1,850	2,121	65,428	30.85
	<u>2,678</u>	<u>2,951</u>	<u>79,946</u>	

STATE OF ILLINOIS

Facility Name & ID Number

0047720

Report Period Beginning:

01/01/12

Ending:

12/31/12

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Pine Acres Rehab & Living Center

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dalena Kemna-Kahn	Administrator	0	\$ 108,368
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 108,368

B. Administrative - Other

Description	Amount
Mark Weldler, Admin - Guar. Pmts.	\$ 79,800
Steve Jeremias, CFO - Guar. Pmts.	79,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 159,600

C. Professional Services

Vendor/Payee	Type	Amount
Marilyn P. Dunn	Legal	\$ 275
Much Shelist	Legal	(630)
Ashman & Stein	Legal	110
Mcgladrey LLP	Accounting	55,604
Paylocity	Payroll Fees	8,781
Personal Planners	Professional Services	2,035
MDI Achieve, Inc.	Software Maintenance	21,744
Innovative LTC Solutions	Computer Services	1,601
Corporate Cost Solutions Inc.	Workers' Compensation	4,203
Singer Network	Computer Services	17,577
Other Vendors	See SCH 21A	25,205
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 136,505

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 138,058
Unemployment Compensation Insurance	49,411
FICA Taxes	274,992
Employee Health Insurance	156,284
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniform Expense	477
Employee Physicals	5,652
Other Employee Benefits	18,020
TOTAL (agree to Schedule V, line 22, col.8)	\$ 642,894

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

Description	Line #	Amount
N/A		
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	584
Health Care Worker Background Check (Indicate # of checks performed 4)	42
Patient Background Checks	139
Miscellaneous Licenses & Fees	4,945
Miscellaneous Dues & Subscriptions	1,475
IL Council on LTC	8,098
Dekalb Chamber of Commerce	902
Less : Chamber of Commerce	(902)
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 16,602

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	1,814
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 1,814

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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

Schedule 21A

XIX.C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Holland & Knight LLP	Legal	2,339.00
Foote Meyers Mielke & Flowers LLC	Legal	2,492.00
Medifax-EDI	Computer Services	1,090.00
Coms Interactive, LLC	Computer Services	16,308.00
Information Controls, Inc.	Computer Services	2,280.00
Vivian	Computer Services	696.00
		<u>25,205</u>
		<u><u>25,205</u></u> To PG21
Total for Page 3, Line 19, Column 3		136,505
Disallowed Legal Fees		<u>(296)</u>
Total for Page 3, Line 19, Column 8		<u><u>136,209</u></u>

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.

IL Council on Long Term Care \$8,098
- (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 \$3,826
- (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 Years
- (6)

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

\$

46,840

Line

10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

228,206

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

0

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$

2,315
- (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?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.