		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0049957

Facility Name: CLAREMONT - HANOVER PARK

Address: 2000 West Lake Street (Number) Hanover Park (City) 60133 (Zip Code)

County: Cook

Telephone Number: (630) 556-2000 **Fax #** (630) 823-5454

HFS ID Number:

Date of Initial License for Current Owners: 01/11/2011

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' PREPARATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	53,250	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	150	TOTALS	150	53,250	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	57	291	17,108	17,456	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57	291	17,108	17,456	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 32.78%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] 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 [X]

I. On what date did you start providing long term care at this location?
Date started 01/11/2011

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 150 and days of care provided 14,605

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	317,806	27,077	19,459	364,342		364,342		364,342			1
2	Food Purchase		190,376		190,376		190,376	(13,291)	177,085			2
3	Housekeeping	108,380	50,332		158,712		158,712		158,712			3
4	Laundry	14,650	24,834		39,484		39,484	(193)	39,291			4
5	Heat and Other Utilities			371,383	371,383		371,383	1,544	372,927			5
6	Maintenance	90,181	83,119	109,482	282,782		282,782	6,316	289,098			6
7	Other (specify):*											7
8	TOTAL General Services	531,017	375,738	500,324	1,407,079		1,407,079	(5,624)	1,401,455			8
	B. Health Care and Programs											
9	Medical Director			8,000	8,000		8,000		8,000			9
10	Nursing and Medical Records	2,090,333	211,820	206,095	2,508,248		2,508,248	5,183	2,513,431			10
10a	Therapy	908,011	13,403	560,427	1,481,841		1,481,841		1,481,841			10a
11	Activities	68,414	3,904	2,697	75,015		75,015		75,015			11
12	Social Services	87,435		50,968	138,403		138,403		138,403			12
13	CNA Training											13
14	Program Transportation							4,253	4,253			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,154,193	229,127	828,187	4,211,507		4,211,507	9,436	4,220,943			16
	C. General Administration											
17	Administrative	127,744		470,024	597,768		597,768	(460,350)	137,418			17
18	Directors Fees											18
19	Professional Services			158,841	158,841		158,841	24,554	183,395			19
20	Dues, Fees, Subscriptions & Promotions			18,091	18,091		18,091	746	18,837			20
21	Clerical & General Office Expenses	256,285	58,539	38,823	353,647		353,647	135,485	489,132			21
22	Employee Benefits & Payroll Taxes			633,421	633,421		633,421	33,209	666,630			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,733	9,733		9,733	323	10,056			24
25	Other Admin. Staff Transportation			4,071	4,071		4,071	(3,627)	444			25
26	Insurance-Prop.Liab.Malpractice			53,908	53,908		53,908	67,207	121,115			26
27	Other (specify):*											27
28	TOTAL General Administration	384,029	58,539	1,386,912	1,829,480		1,829,480	(202,453)	1,627,027			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,069,239	663,404	2,715,423	7,448,066		7,448,066	(198,641)	7,249,425			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.

Facility Name & ID Number CLAREMONT - HANOVER PARK #0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			47,470	47,470		47,470	565,264	612,734			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,000	37,000		37,000	1,230,210	1,267,210			32
33	Real Estate Taxes							591,147	591,147			33
34	Rent-Facility & Grounds			1,870,000	1,870,000		1,870,000	(1,869,727)	273			34
35	Rent-Equipment & Vehicles			69,332	69,332		69,332	2,140	71,472			35
36	Other (specify):*											36
37	TOTAL Ownership			2,023,802	2,023,802		2,023,802	519,034	2,542,836			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		933,884	988	934,872		934,872		934,872			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			83,160	83,160		83,160		83,160			42
43	Other (specify):* Non-Allow Costs			264,231	264,231		264,231	(264,231)				43
44	TOTAL Special Cost Centers		933,884	348,379	1,282,263		1,282,263	(264,231)	1,018,032			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,069,239	1,597,288	5,087,604	10,754,131		10,754,131	56,162	10,810,293			45

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

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,291)	1		4
5	Telephone, TV & Radio in Resident Rooms	(3,230)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(193)	4		8
9	Non-Straightline Depreciation	(5,631)	30		9
10	Interest and Other Investment Income	(257)	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	(1,212)	43		18
19	Entertainment	(4,596)	43		19
20	Contributions	(10,240)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(15,157)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(42,000)	43		24
25	Fund Raising, Advertising and Promotional	(97,146)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(106,740)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (299,693)		$	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)	355,855		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 355,855		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 56,162		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

CLAREMONT - HANOVER PARK

ID# 0049957

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non Reimbursed Enter	$ (44)	43	1
2	Skin Care Specialist	(21,567)	43	2
3	X-Rays - Part A	(56,716)	43	3
4	Labs - Part A	(27,480)	43	4
5	Misc. Income	(933)	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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**	(106,740)		49

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1 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	19	Professional Fees	$	Church Street Station Properties, LLC	100.00%	$ 22,831	$ 22,831	1
2	V	21	Bank Charges		Church Street Station Properties, LLC	100.00%	22,922	22,922	2
3	V	26	Insurance		Church Street Station Properties, LLC	100.00%	66,726	66,726	3
4	V	30	Depreciation		Church Street Station Properties, LLC	100.00%	564,207	564,207	4
5	V	32	Amortization		Church Street Station Properties, LLC	100.00%	11,136	11,136	5
6	V	32	Interest		Church Street Station Properties, LLC	100.00%	1,217,577	1,217,577	6
7	V	33	Property Taxes		Church Street Station Properties, LLC	100.00%	585,964	585,964	7
8	V	34	Rent	1,870,000	Church Street Station Properties, LLC	100.00%		(1,870,000)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,870,000			$ 2,491,363	$ * 621,363	14

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

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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)	
15	V	5	Utilities	$	NuCare Management Company	80.00%	$ 1,544	$ 1,544	15
16	V	6	Repairs and Maintenance		NuCare Management Company	80.00%	6,139	6,139	16
17	V	17	Management Fees	470,024	NuCare Management Company	80.00%	9,674	(460,350)	17
18	V	19	Professional Fees		NuCare Management Company	80.00%	16,880	16,880	18
19	V	20	Dues, Subscriptions		NuCare Management Company	80.00%	725	725	19
20	V	21	Office Expense		NuCare Management Company	80.00%	102,773	102,773	20
21	V	24	Education and Seminars		NuCare Management Company	80.00%	185	185	21
22	V	25	Other Admin Transportation		NuCare Management Company	80.00%	430	430	22
23	V	26	Insurance		NuCare Management Company	80.00%	481	481	23
24	V	27	Employee Benefits		NuCare Management Company	80.00%	32,552	32,552	24
25	V	30	Depreciation Expense		NuCare Management Company	80.00%	5,551	5,551	25
26	V	32	Interest & Amortization		NuCare Management Company	80.00%	1,662	1,662	26
27	V	33	Real Estate Taxes		NuCare Management Company	80.00%	5,183	5,183	27
28	V	34	Facility Rent		NuCare Management Company	80.00%	273	273	28
29	V	35	Equipment Rental		NuCare Management Company	80.00%	2,140	2,140	29
30	V	30	Depreciation Expense		NuCare Management Company	80.00%	1,028	1,028	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 470,024			$ 187,220	$ * (282,804)	39

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

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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)	
15	V	6	Minor Equipment	$	Cinical Consulting Services, LLC		$ 177	$ 177	15
16	V	10	Nursing and Medical Records		Cinical Consulting Services, LLC		5,183	5,183	16
17	V	19	Professional Fees		Cinical Consulting Services, LLC				17
18	V	20	Dues, Subscriptions		Cinical Consulting Services, LLC		21	21	18
19	V	21	Office Expense		Cinical Consulting Services, LLC		10,723	10,723	19
20	V	24	Education and Seminars		Cinical Consulting Services, LLC		138	138	20
21	V	25	Other Admin Transportation		Cinical Consulting Services, LLC		196	196	21
22	V	27	Employee Benefits		Cinical Consulting Services, LLC		657	657	22
23	V	30	Depreciation Expense		Cinical Consulting Services, LLC		81	81	23
24	V	32	Interest & Amortization		Cinical Consulting Services, LLC		92	92	24
25	V	30	Depreciation Expense		Cinical Consulting Services, LLC		28	28	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 17,296	$ * 17,296	39

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

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	David Hartman	10%	Bronzeville Park	Chicago	Nucare Services	Lincolnwood	Bookkeeping Mgmt	1
2	Rajchenbach Fam	40%	California Gardens Corp.	Chicago	7257 N.	Lincolnwood	Bldg. Rental	2
3	Robert Hartman	40%	Claremont Rehab. & Living	Buffalo Grove	Lincoln Avenue,			3
4	Gerald Jenich	10%	Claremont - Hanover Park	Hanover Park	LLC			4
5			Claridge Imperial, Ltd.	Chicago	Diamond	Northbrook	Worker's Comp	5
6			Forest Villa	Niles	Insurance		Insurance	6
7			Jackson Corp.	Chicago	Seasons Hospice	Park Ridge	Hospice	7
8			Monroe Pavilion	Chicago	JLR Mgmt.	Lincolnwood	Management Co.	8
9			Renaissance at 87th Street	Chicago	KFT Services	Lincolnwood	Management Co.	9
10			Renaissance at Hillside	Hillside	LLC			10
11			Renaissance at Midway	Chicago	Drake Louis	Lincolnwood	Management Co.	11
12			Renaissance at South Shore	Chicago	Enterprises, LLC			12
13			Renaissance at South Shore	Chicago	Jem Rehab. Serv.	Chicago	Psych. Services	13
14			Renaissance at East	Mesa, Arizona	Serv			14
15			Renaissance at West	Mesa, Arizona	DBD Rehabilitation	Chicago	Psych Services	15
16			Renaissance Village IL	Mesa, Arizona	Serv.			16
17			Renaissance Village AL	Mesa, Arizona	Clinical Consulting	Lincolnwood	Clinical Consulting	17
18			Carlton at the Lake	Chicago	Serv.			18
19			Glenview Terrace N.C.	Glenview	Quest Services	Lincolnwood	Marketing	19
20			Harmony Nursing & Rehab	Chicago	Corp.			20
21			Whitehall North	Deerfield	ITEX / A.K.	Lincolnwood	Bookkeeping/	21
22					Care		Management Co.	22
23					JLR Mgmt.	Lincolnwood	Management Co.	23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A, No owners receive compensation from this facility.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: NuCare Management Company
Street Address: 7257 N. Lincoln #100
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: ((847) 933-2600
Fax Number: ((847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Bed days available	1,283,340	14	$ 36,192	$	54,750	$ 1,544	1
2	6	Repairs and Maintenance	Bed days available	1,283,340	14	143,887		54,750	6,139	2
3	17	Management Fees	Bed days available	1,283,340	14	226,766		54,750	9,674	3
4	19	Professional Fees	Bed days available	1,283,340	14	395,673	395,673	54,750	16,880	4
5	20	Dues, Subscriptions	Bed days available	1,283,340	14	16,986		54,750	725	5
6	21	Office Expense	Bed days available	1,283,340	14	2,408,992		54,750	102,773	6
7	24	Education and Seminars	Bed days available	1,283,340	14	4,332		54,750	185	7
8	25	Other Admin Transportation	Bed days available	1,283,340	14	10,088		54,750	430	8
9	26	Insurance	Bed days available	1,283,340	14	11,273		54,750	481	9
10	27	Employee Benefits	Bed days available	1,283,340	14	763,008		54,750	32,552	10
11	30	Depreciation Expense	Bed days available	1,283,340	14	130,120		54,750	5,551	11
12	32	Interest & Amortization	Bed days available	1,283,340	14	38,953		54,750	1,662	12
13	33	Real Estate Taxes	Bed days available	1,283,340	14	121,491		54,750	5,183	13
14	34	Facility Rent	Bed days available	1,283,340	14	6,400		54,750	273	14
15	35	Equipment Rental	Bed days available	1,283,340	14	50,154		54,750	2,140	15
16	30	Depreciation Expense	Direct allocation		1	1,028			1,028	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,365,343	$ 395,673		$ 187,220	25

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Cinical Consulting Services, LLC
Street Address: 7257 N. Lincoln #100
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: ((847) 933-2600
Fax Number: ((847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Minor Equipment	Bed days available	1,283,340	14	$ 4,147	$	54,750	$ 177	1
2	10	Nursing and Medical Records	Bed days available	1,283,340	14	121,500		54,750	5,183	2
3	20	Dues, Subscriptions	Bed days available	1,283,340	14	500		54,750	21	3
4	21	Office Expense	Bed days available	1,283,340	14	251,339	235,467	54,750	10,723	4
5	24	Education and Seminars	Bed days available	1,283,340	14	3,225		54,750	138	5
6	25	Other Admin Transportation	Bed days available	1,283,340	14	4,586		54,750	196	6
7	27	Employee Benefits	Bed days available	1,283,340	14	15,390		54,750	657	7
8	30	Depreciation Expense	Bed days available	1,283,340	14	1,896		54,750	81	8
9	32	Interest & Amortization	Bed days available	1,283,340	14	2,164		54,750	92	9
10	30	Depreciation Expense	Direct allocation		1	28			28	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					$ 404,775	$ 235,467		$ 17,296	25

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Greystone Servicing Corporation		X	Mortgage	$109,880.11		$ 18,234,739	$ 18,234,739		0.0670	$ 1,217,577	1
2	The Village of Hanover Park		X	Land	Variable	07/01/10	700,000	700,000		None		2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank and Trust Co.		X	Line of Credit	Interest Only	11/03/11	1,000,000		11/01/12	Variable	37,000	6
7												7
8												8
9	TOTAL Facility Related				$109,880.11		$ 19,934,739	$ 18,934,739			$ 1,254,577	9
	B. Non-Facility Related*											
10								Interest Income Offset			(257)	10
11								Management Company allocation			12,890	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 12,633	14
15	TOTALS (line 9+line14)						$ 19,934,739	$ 18,934,739			$ 1,267,210	15

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

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

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

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2010	$ 90,714	2
3. Under or (over) accrual (line 2 minus line 1).		$ 90,714	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 495,250	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
	Home Office Allocation	5,183	
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.		$ 591,147	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2006	8
	2007	9
	2008	10
	2009	11
	2010 495,250	12

Market Value 17,000,000 X 10%= Assessed Value 1,700,000 X State Equalization Factor 3.3 = 5,610,000

Equalized Assessed Value 5,610,000 X Local Tax Rate 0.08875 = 497,888. Use 495,250.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CLAREMONT - HANOVER PARK COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049957

CONTACT PERSON REGARDING THIS REPORT Jay Flatt

TELEPHONE (847) 933-2600 x 23 FAX #: (847) 745-0915

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-36-407-021-0000	Land and Property	$ 86,770.08	$ 86,770.08
2.	06-36-309-033-0000	Land and Property	$ 3,943.87	$ 3,943.87
3.	10-27-319-028-0000	Land and Property Mgmt Co.	$ 81,875.48	$ 5,183.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 172,589.43	$ 95,896.95

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,800 B. General Construction Type: Exterior Brick Frame Steel Number of Stories Two

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized:
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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land		2011	$ 1,524,000	1
2	See Schedule 11A			6,484	2
3	TOTALS			$ 1,530,484	3

Church Street Station Skilled Nursing
FYE: 12/31/11

	Use	Sq. Ft.	Year Acquired	Cost
1	Allocation from management company - NuCare			6,143
2	Allocation from management company - CCS			341
3	**Totals**			**6,484**

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	Allocation			2011	$ 17,578,767	$	40	$ 439,135	$ 439,135	$ 439,469	4
5											5
6											6
7	HO Allocation - NuCare		2004		55,290	1,418	35	1,580	162	12,835	7
8	HO Allocation - CCS		2004		3,072	79	35	88	9	713	8
	Improvement Type**										
9	Installation of PA System and Telephone Paging System			2011	14,840	371	20	371		371	9
10	Fabricate and Install Syringe Disposal Cabinets to Wall			2011	10,000	250	20	250		250	10
11	Install and Furnish Door Control along with Back Door			2011	6,227	156	20	156		156	11
12											12
13											13
14											14
15	2011 Allocation from NuCare Management Company:										15
16	Alarm System			2003	500	22	20	25	3	203	16
17	Buildout of Offices			2004	39,870	441	20	508	67	3,916	17
18	Security & Fire Alarm System			2004	1,099		20	55	55	412	18
19	Data Cables, Lights & Heat Exchanger			2005	600	26	20	30	4	206	19
20	Fire Alarm System			2005	5,040	38	20	325	287	2,053	20
21	Cooling Unit			2006	816	35	20	41	6	219	21
22	Asphalt & Carpet			2008	860	37	20	43	6	140	22
23	Landscaping, 2nd Floor Reconst. (including Phone, Sprinklers,			2009	13,841	1,893	20	692	(1,201)	1,806	23
24	Alarm Systems, Kitchen Remodel, Wallcovings, etc..)										24
25	HVAC, Paint/Wallpaper, Electrical, Sprinkler, & Generator Repair			2010	2,127	92	20	106	14	160	25
26	Hot water Heater			2011	115	5	20	5		5	26
27											27
28	2011 Allocation from CCS:										28
29	Installation of Security Equipment			2004	61		20	3	3	23	29
30	Fire Alarm & Sprinkler System Installation			2005	280	2	20	18	16	114	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 17,733,405	$ 4,865		$ 443,431	$ 438,566	$ 463,051	70

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

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$	$	$	$		$	71
72	Current Year Purchases	230,609	41,062	41,062		5	41,062	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt. Co.	1,301,274	1,527	128,165	126,638	7	151,295	74
75	TOTALS	$ 1,531,883	$ 42,589	$ 169,227	$ 126,638		$ 192,357	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	Allocated from NuCare Management Company			378	16	76	60		107	77
78										78
79										79
80	TOTALS			$ 378	$ 16	$ 76	$ 60		$ 107	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 20,796,150	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 47,470	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 612,734	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 565,264	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 655,515	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

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

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

Church Street Station Skilled Nursing
0049957
12/31/11
Schedule 13A

	Category of Equipment	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Component Life	Accumulated Depreciation
1	Allocated from NuCare Management Company	50,544	1,527	3,093	1,566	7	26,222
2	Allocated from RE Entity	1,250,730		125,073	125,073	7	125,073
	Totals	1,301,274	1,527	128,166	126,639		151,295

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Home Office Allocation				273			6
7	TOTAL				$ 273 **			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: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 71,472 Description: Med Equip $23,258; Bed Rental $45,049; Copy Machine $1,025; Mgmt Alloc $2,140
(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	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* 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.

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	$ 355,967	2,973	$ 214,050	$	2,973	$ 570,017	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs	71,190	447	32,207		447	103,397	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs	480,854	4,301	309,652		4,301	790,506	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				933,884		933,884	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	10A(2,3)			63	4,518	1,463	63	5,981	12
13	Other (specify): See Sch 16A	39(3)					12,928		12,928	13
14	TOTAL			$ 908,011	7,784	$ 560,427	$ 948,275	7,784	$ 2,416,713	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.

Church Street Station Skilled Nursing Facility
Provider Number - 0049957
FYE: 12/31/11

Schedule 16A

XIV. SPECIAL SERVICES (Direct Cost) Line 14

	Schedule V	Outside Practitioner		
Service	Line & Col. Ref	Units	Costs	Supplies
Oxygen	10A(2)			11,940
Ambulance	39(3)			988
		0	0	12,928

STATE OF ILLINOIS

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (last day of reporting year)

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	$ (484,893)	$ (482,091)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (36,847))	2,712,070	3,298,034	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	60,216	482,591	6
7	Other Prepaid Expenses	20,850	25,501	7
8	Accounts Receivable (owners or related parties)	683	683	8
9	Other(specify): See Sch 17A	(395,023)	(290,910)	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,913,903	$ 3,033,808	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,530,484	13
14	Buildings, at Historical Cost		17,637,129	14
15	Leasehold Improvements, at Historical Cost	58,030	96,276	15
16	Equipment, at Historical Cost	497,722	1,532,261	16
17	Accumulated Depreciation (book methods)	(47,470)	(655,515)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 508,282	$ 20,140,635	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,422,185	$ 23,174,443	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 833,534	$ 833,534	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	247,900	247,900	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,252	32,252	31
32	Accrued Real Estate Taxes(Sch.IX-B)		495,250	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	2,449,189	2,211,997	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,562,875	$ 3,820,933	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		18,527,721	40
41	Bonds Payable		407,018	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)**	$	$ 18,934,739	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,562,875	$ 22,755,672	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,140,690)	$ 418,771	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,422,185	$ 23,174,443	48

*(See instructions.)

Church Street Station Skilled Nursing
FYE: 12/31/11
Medicaid Cost Report Workpapers

Schedule 17A

	Operating	After Consolidation
Line 9		
Escrow - Replacement Reserve	-	(104,113)
Accrued Management Fees - Nucare	359,568	359,568
Accrued Management Fees - Quest	30,844	30,844
Acrued management Fees - CCS	4,611	4,611
Total to L 9	**395,023**	**290,910**
	-	-
Line 36		
Closing Costs	-	(14,994)
Deferred Loan Costs	-	(417,028)
Accumulated Amortization - Closing	-	375
Accumulated Amort - Loan Costs - HUD	-	10,426
Accrued Interest	-	100,000
Due to Claremont	-	84,029
Accrued Accounts Payable	455,864	455,864
Accrued Utilities	47,123	47,123
Accrued Deductions - Wage Assignments	852	852
Due to Shareholders (S/H Loans)	1,000,000	1,000,000
Due to Claremont Expense	18,576	18,576
Due to Renaissance at Hillside Expenses	(750)	(750)
Due to Renaissance at 87th Street Expense	1,082	1,082
Due to Quest Services Expense	(3,560)	(3,560)
Due to Clinical Consulting Expense	(55,000)	(55,000)
Due to NuCare Services Corp Expense	672,169	672,169
Due to Church Street Property	(84,029)	(84,029)
Due NuVision Holdings Expense	(28,138)	(28,138)
Due Ren Hlthcare	425,000	425,000
Total to L 36	**2,449,189**	**2,211,997**
	-	-

Facility Name & ID Number CLAREMONT - HANOVER PARK **#** 0049957 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 89,390	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 89,390	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,230,080)	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)**	$ (1,230,080)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,140,690)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	1 Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,642,283	1
2	Discounts and Allowances for all Levels	(1,339,770)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,302,513	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,032,775	6
7	Oxygen	38,099	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,070,874	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	13,509	13
14	Non-Patient Meals	13,291	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,796,461	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	54,494	19
20	Radiology and X-Ray	109,029	20
21	Other Medical Services	162,463	21
22	Laundry	193	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,149,440	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	257	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 257	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income and Jury Duty	967	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 967	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,524,051	30

	2 Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,407,079	31
32	Health Care	4,211,507	32
33	General Administration	1,829,480	33
	B. Capital Expense		
34	Ownership	2,023,802	34
	C. Ancillary Expense		
35	Special Cost Centers	1,199,103	35
36	Provider Participation Fee	83,160	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,754,131	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,230,080)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,230,080)	43

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

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

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,966	2,106	$ 89,178	$ 42.34	1
2	Assistant Director of Nursing	4,658	4,848	170,200	35.11	2
3	Registered Nurses	27,140	27,983	794,632	28.40	3
4	Licensed Practical Nurses	13,757	14,225	336,102	23.63	4
5	CNAs & Orderlies	43,614	45,011	524,451	11.65	5
6	CNA Trainees					6
7	Licensed Therapist	25,557	27,593	908,011	32.91	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,696	1,800	31,885	17.71	9
10	Activity Assistants	3,328	3,408	36,529	10.72	10
11	Social Service Workers	3,160	3,717	87,435	23.52	11
12	Dietician	2,086	2,245	58,483	26.05	12
13	Food Service Supervisor					13
14	Head Cook	8,156	8,450	142,374	16.85	14
15	Cook Helpers/Assistants	11,964	12,250	116,949	9.55	15
16	Dishwashers					16
17	Maintenance Workers	3,106	3,233	90,181	27.89	17
18	Housekeepers	10,551	10,860	108,380	9.98	18
19	Laundry	1,365	1,459	14,650	10.04	19
20	Administrator	2,734	2,929	127,744	43.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,104	12,356	256,285	20.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	4,959	5,167	155,864	30.17	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	600	608	19,906	32.74	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	182,501	190,248	$ 4,069,239 *	$ 21.39	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	344	$ 19,459	1(3)	35
36	Medical Director	Monthly	8,000	9(3)	36
37	Medical Records Consultant	Monthly	13,934	10(3)	37
38	Nurse Consultant	59	3,245	10(3)	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	47	2,697	11(3)	44
45	Social Service Consultant	19	1,117	12(2)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	469	$ 48,452		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,301	$ 124,229	10(3)	50
51	Licensed Practical Nurses	768	32,237	10(3)	51
52	Certified Nurse Assistants/Aides	950	20,889	10(3)	52
53	TOTAL (lines 50 - 52)	4,019	$ 177,355		53

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lisa Ulm	Administrator	0	$ 127,744
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 127,744

B. Administrative - Other

Description	Amount
General and Administrative - Management Service	$ 470,024
(Eliminated on Sch V Col 7)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 470,024

C. Professional Services

Vendor/Payee	Type	Amount
McGladrey & Pullen, LLP	Accounting	$ 27,275
CDW COMPUTER CENTERS, INC	Computer Consulting	3,631
COMPUTER PROGRAM FOR THE	Computer Consulting	514
EITECHS CORPORATION	Computer Consulting	6,818
GIFTRAP CORPORATION	Computer Consulting	4,090
HEALTH DATA SYSTEMS INC	Computer Consulting	679
IT'S NEVER2 LATE	Computer Consulting	910
MDI ACHIEVE, INC	Computer Consulting	14,407
MEDIFAX	Computer Consulting	282
OPTIMA HEALTHCARE SOLUTIC	Computer Consulting	1,710
PSD SOLUTIONS	Computer Consulting	16,885
See Sch 21A		81,640
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 158,841

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,707
Unemployment Compensation Insurance	
FICA Taxes	388,241
Employee Health Insurance	116,978
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	20,140
Employee Retirement	1,676
Employee Uniforms	19,679
Allocated from Mgmt. Co.	33,209
TOTAL (agree to Schedule V, line 22, col.8)	$ 666,630

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

Description	Line #	Amount
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,945
Advertising: Employee Recruitment	294
Health Care Worker Background Check	
(Indicate # of checks performed 271)	3,250
Patient Background Checks 271	3,250
Miscellaneous Licenses & Fees	6,232
Miscellaneous Dues & Subscriptions	3,120
Allocated from Mgmt. Co.	746
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,837

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	9,733
Allocated from Mgmt. Co.	323
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,056

**See instructions.

Church Street Station Skilled Nursing
FYE: 12/31/11
Medicaid Cost Report Workpapers

Schedule 21A

AVENUE WEB MEDIA	Internet Expenses	150
BUSINESS CARD	Internet Expenses	772
COMCAST CABLE	Internet Expenses	2,071
CITRX LICENSE/CITI BUSINESS CARD	Internet Expenses	267
EFAX	Internet Expenses	368
IT IN MOTION	Internet Expenses	1,500
IT'S NEVER2 LATE	Internet Expenses	1,458
PAETEC	Internet Expenses	11,760
Personal Planners, Inc	UC Tax Consulting	288
DOCUMENTATION SOLUTIONS	ICD Consulting	5,748
CHARLES H OLEY & ASSOCIATES	Financial Consultant	2,650
CONFETTI GOURMET CATERING	Dietary Consultant	8,428
DIGITAL TAKE	Consulting	2,834
Much Shelist	Legal	19,235
Polsinelli Shughart	Legal	9,491
Stone, McGuire & Siegel	Legal	14,162
Stone Pogrund & Korey, LLC	Legal	400
Ashman & Stein	Legal	58
		81,640
Total Line 19 Col 3		158,841
Non-allowable legal		(5,700)
Allocated from NuCare Management		
	Legal	5,228
	Accounting	1,194
	Comuter	10,458
		16,880
Church Street Station Properties		
	Legal	2,631
	Accounting	20,200
		22,831
Total Line 19 Col 8		192,852

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CLAREMONT - HANOVER PARK # 0049957 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **9,539** Line **10(3)**

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

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
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 Departmen
during this cost report period. $ **83,160**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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? **No** Indicate the amount. $ **N/A**

(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 fo
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 othe
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **Yes**

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