		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: 0047043

Facility Name: Claremont Rehab and Living Center

Address: 150 North Weiland (Number) Buffalo Grove (City) 60089 (Zip Code)

County: Lake

Telephone Number: (847) 465-0200 **Fax #** (847) 465-0400

HFS ID Number:

Date of Initial License for Current Owners: 3/1/05

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 01/01/11 to 12/31/11 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 Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	200	Skilled (SNF)	200	73,000	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	200	TOTALS	200	73,000	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	29,945	9,121	19,219	58,285	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,945	9,121	19,219	58,285	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.84%

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 03/01/2005

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 200 and days of care provided 19,219

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 Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	411,628	39,606	18,809	470,043		470,043		470,043			1
2	Food Purchase		394,164		394,164		394,164	(40,395)	353,769			2
3	Housekeeping	241,379	45,071		286,450		286,450		286,450			3
4	Laundry	55,404	28,688		84,092		84,092		84,092			4
5	Heat and Other Utilities			253,569	253,569		253,569	2,059	255,628			5
6	Maintenance	161,010	88,310	156,626	405,946		405,946	8,421	414,367			6
7	Other (specify):*											7
8	**TOTAL General Services**	869,421	595,839	429,004	1,894,264		1,894,264	(29,915)	1,864,349			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	3,592,195	287,000	660,324	4,539,519		4,539,519	6,911	4,546,430			10
10a	Therapy	1,118,325	6,317	265,925	1,390,567		1,390,567		1,390,567			10a
11	Activities	261,248	20,055	261	281,564		281,564		281,564			11
12	Social Services	97,753		96,570	194,323		194,323		194,323			12
13	CNA Training											13
14	Program Transportation							13,542	13,542			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	5,069,521	313,372	1,059,080	6,441,973		6,441,973	20,453	6,462,426			16
	C. General Administration											
17	Administrative	101,290		751,109	852,399		852,399	(731,820)	120,579			17
18	Directors Fees											18
19	Professional Services			127,738	127,738		127,738	17,029	144,767			19
20	Dues, Fees, Subscriptions & Promotions			65,994	65,994		65,994	(2,910)	63,084			20
21	Clerical & General Office Expenses	415,110	89,834	478,712	983,656		983,656	150,386	1,134,042			21
22	Employee Benefits & Payroll Taxes			1,103,093	1,103,093		1,103,093	40,395	1,143,488			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,524	16,524		16,524	429	16,953			24
25	Other Admin. Staff Transportation			17,599	17,599		17,599	(12,707)	4,892			25
26	Insurance-Prop.Liab.Malpractice			589,493	589,493		589,493	641	590,134			26
27	Other (specify):* Home Office Benefits							44,593	44,593			27
28	**TOTAL General Administration**	516,400	89,834	3,150,262	3,756,496		3,756,496	(493,963)	3,262,532			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,455,342	999,045	4,638,346	12,092,733		12,092,733	(503,426)	11,589,307			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 Rehab and Living Center #0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			141,688	141,688		141,688	(4,403)	137,285			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			68,323	68,323		68,323	(2,180)	66,143			32
33	Real Estate Taxes							273,030	273,030			33
34	Rent-Facility & Grounds			1,592,881	1,592,881		1,592,881	(265,755)	1,327,126			34
35	Rent-Equipment & Vehicles			90,447	90,447		90,447	2,853	93,300			35
36	Other (specify):*											36
37	TOTAL Ownership			1,893,339	1,893,339		1,893,339	3,545	1,896,884			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		934,077	168,610	1,102,687		1,102,687		1,102,687			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):* Non-Allow Costs			259,509	259,509		259,509	(259,509)				43
44	TOTAL Special Cost Centers		934,077	537,619	1,471,696		1,471,696	(259,509)	1,212,187			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,455,342	1,933,122	7,069,304	15,457,768		15,457,768	(759,390)	14,698,378			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 Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(13,320)	30		9
10	Interest and Other Investment Income	(4,519)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,570)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,070)	43		18
19	Entertainment	(5,996)	43		19
20	Contributions	(30,785)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(96,000)	43		24
25	Fund Raising, Advertising and Promotional	(48,588)	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	(85,073)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (287,921)		$	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)	(471,469)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (471,469)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (759,390)		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 Rehab and Living Center

ID# 0047043

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	Cable	(6,204)	43	2
3	To offset misc. income	(941)	21	3
4	To disallow non-allowable legal fees	(3,458)	19	4
5	To disallow lobbying expense	(3,904)	20	5
6	Disallow xray expense	(44,222)	43	6
7	Disallow laboratory fees	(24,074)	43	7
8				8
9	Employee Meal Reclass	(40,395)	2	9
10	Employee Meal Reclass	40,395	22	10
11				11
12				12
13	Real Estate Taxes Included in Rent	266,119	33	13
14	Real Estate Taxes Included in Rent	(266,119)	34	14
15	To Reverse A/P Legal Accrual	(2,270)	19	15
16	Reclass Patient Transport	13,542	14	16
17	Reclass Patient Transport	(13,542)	25	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**	(85,073)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(40,395)	0	0	0	0	0	0	0	0	0	0	(40,395)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,059	0	0	0	0	0	0	0	0	2,059	5
6	Maintenance	0	0	8,185	236	0	0	0	0	0	0	0	8,421	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(40,395)	0	10,244	236	0	0	0	0	0	0	0	(29,915)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	6,911	0	0	0	0	0	0	0	6,911	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	13,542	0	0	0	0	0	0	0	0	0	0	13,542	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	13,542	0	0	6,911	0	0	0	0	0	0	0	20,453	16
	C. General Administration													
17	Administrative	0	0	(731,820)	0	0	0	0	0	0	0	0	(731,820)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,728)	250	22,507	0	0	0	0	0	0	0	0	17,029	19
20	Fees, Subscriptions & Promotions	(3,904)	0	966	28	0	0	0	0	0	0	0	(2,910)	20
21	Clerical & General Office Expenses	(941)	0	137,030	14,297	0	0	0	0	0	0	0	150,386	21
22	Employee Benefits & Payroll Taxes	40,395	0	0	0	0	0	0	0	0	0	0	40,395	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	246	183	0	0	0	0	0	0	0	429	24
25	Other Admin. Staff Transportation	(13,542)	0	574	261	0	0	0	0	0	0	0	(12,707)	25
26	Insurance-Prop.Liab.Malpractice	0	0	641	0	0	0	0	0	0	0	0	641	26
27	Other (specify):*	0	0	43,718	875	0	0	0	0	0	0	0	44,593	27
28	TOTAL General Administration	16,281	250	(526,138)	15,644	0	0	0	0	0	0	0	(493,963)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(10,573)	250	(515,894)	22,791	0	0	0	0	0	0	0	(503,426)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(13,320)	0	8,772	145	0	0	0	0	0	0	0	(4,403)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,519)	0	2,216	123	0	0	0	0	0	0	0	(2,180)	32
33	Real Estate Taxes	266,119	0	6,911	0	0	0	0	0	0	0	0	273,030	33
34	Rent-Facility & Grounds	(266,119)	0	364	0	0	0	0	0	0	0	0	(265,755)	34
35	Rent-Equipment & Vehicles	0	0	2,853	0	0	0	0	0	0	0	0	2,853	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(17,839)	0	21,116	268	0	0	0	0	0	0	0	3,545	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(74,500)	0	0	0	0	0	0	0	0	0	0	(259,509)	43
44	**TOTAL Special Cost Centers**	(74,500)	0	0	0	0	0	0	0	0	0	0	(259,509)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(102,912)	250	(494,778)	23,059	0	0	0	0	0	0	0	(759,390)	45

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Pg6 Supp		See Pg6 Supp		See Pg6 Supp		

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)	
1	V	19	Professional Fees	$	Claremont Extended Healthcare Realty, LLC	100.00%	$ 250	$ 250	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 250	$ * 250	14

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

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	$ 2,059	$ 2,059	15
16	V	6	Repairs and Maintenance		NuCare Management Company	80.00%	8,185	8,185	16
17	V	17	Management Fees	751,109	NuCare Management Company	80.00%	12,899	(738,210)	17
18	V	19	Professional Fees		NuCare Management Company	80.00%	22,507	22,507	18
19	V	20	Dues, Subscriptions		NuCare Management Company	80.00%	966	966	19
20	V	21	Office Expense		NuCare Management Company	80.00%	137,030	137,030	20
21	V	24	Education and Seminars		NuCare Management Company	80.00%	246	246	21
22	V	25	Other Admin Transportation		NuCare Management Company	80.00%	574	574	22
23	V	26	Insurance		NuCare Management Company	80.00%	641	641	23
24	V	27	Employee Benefits		NuCare Management Company	80.00%	43,402	43,402	24
25	V	30	Depreciation Expense		NuCare Management Company	80.00%	7,402	7,402	25
26	V	32	Interest & Amortization		NuCare Management Company	80.00%	2,216	2,216	26
27	V	33	Real Estate Taxes		NuCare Management Company	80.00%	6,911	6,911	27
28	V	34	Facility Rent		NuCare Management Company	80.00%	364	364	28
29	V	35	Equipment Rental		NuCare Management Company	80.00%	2,853	2,853	29
30	V	30	Depreciation Expense		NuCare Management Company	80.00%	1,370	1,370	30
31	V	17	Administrative		NuCare Management Company	80.00%	6,390	6,390	31
32	V								32
33	V	27	Employee Benefits		NuCare Management Company	80.00%	316	316	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 751,109			$ 256,331	$ * (494,778)	39

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

23059

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginnir 01/01/11 Ending: 12/31/11

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		$ 236	$ 236	15
16	V	10	Nursing and Medical Records	$	Cinical Consulting Services, LLC		6,911	6,911	16
17	V								17
18	V	20	Dues, Subscriptions		Cinical Consulting Services, LLC		28	28	18
19	V	21	Office Expense		Cinical Consulting Services, LLC		14,297	14,297	19
20	V	24	Education and Seminars		Cinical Consulting Services, LLC		183	183	20
21	V	25	Other Admin Transportation		Cinical Consulting Services, LLC		261	261	21
22	V	27	Employee Benefits		Cinical Consulting Services, LLC		875	875	22
23	V	30	Depreciation Expense		Cinical Consulting Services, LLC		108	108	23
24	V	32	Interest & Amortization		Cinical Consulting Services, LLC		123	123	24
25	V	30	Depreciation Expense		Cinical Consulting Services, LLC		37	37	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			$			$ 23,059	$ * 23,059	39

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

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Ross Bottner	4	Bronzeville Park	Chicago	Nucare Services	Lincolnwood	Bookeeping Mgmt	1
2	Nancy Bottner	1	California Gardens Corp.	Chicago	7527 N. Lincoln Ave, L	Lincolnwood	Building Rental	2
3	Jonah Bruck	4	Claremont Rehab. & Living	Buffalo Grove	Diamond Insurance	Northbrook	Work Comp Ins.	3
4	Jo Bruck	1	Claremont - Hanover Park	Hanover Park	Seasons Hospice	Park Ridge	Hospice	4
5	Barry Carr	4	Claridge Imperial, LTD.	Chicago	JLR Management	Lincolnwood	Management Co.	5
6	Randi S. Carr	4	Forest Villa	Niles	KFT Services, LLC	Lincolnwood	Management Co.	6
7	Ryan A. Carr	1	Jackson Corp	Chicago	Drake Louis Enterpris	Lincolnwood	Management Co.	7
8	Jared S. Carr	1	Monroe Pavillion	Chicago	JEM Rehab Serv.	Chicago	Psych Services	8
9	David Hartman	40	Renaissance at 87th Street	Chicago	DBD Rehab Serv.	Chicago	Psych Services	9
10	Robert Hartman Dynasty Trust	9.5	Renaissance at Hillside	Hillside	Clinical Consulting Ser	Lincolnwood	Clinical Consult	10
11	Robert Hartman Family Trust	9.5	Renaissance at Midway	Chicago	Quest Services Corp	Lincolnwood	Marketing	11
12	Robert and Debra Hartman Family Found	6.75	Renaissance at South Shore	Chicago				12
13	Robert Hartman	4.25	Renaissance Park South	Chicago				13
14	Gerry Jenich	4	Renaissance East	Mesa, Arizona				14
15	Dawn Jenich	1	Renaissance West	Mesa, Arizona				15
16	Leonard Weiss	4	Renaissance Village IL	Mesa, Arizona				16
17	Jessica Weiss	1	Renaissance Village AL	Mesa, Arizona				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

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	David Hartman	Member	Administrative	40.00	56,370	0.67	0.02	Mgmt Fee	$ 60,000	17(7)	1
2	Gerry Jenich	Member	Owner		193,610	1.28	0.03	Salary	6,390	17(7)	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 66,390		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 Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$	73,000	$ 2,059	1
2	6	Repairs and Maintenance	Bed days available	1,283,340	14	143,887		73,000	8,185	2
3	17	Management Fees	Bed days available	1,283,340	14	226,766	226,766	73,000	12,899	3
4	19	Professional Fees	Bed days available	1,283,340	14	395,673		73,000	22,507	4
5	20	Dues, Subscriptions	Bed days available	1,283,340	14	16,986		73,000	966	5
6	21	Office Expense	Bed days available	1,283,340	14	2,408,992	2,104,186	73,000	137,030	6
7	24	Education and Seminars	Bed days available	1,283,340	14	4,332		73,000	246	7
8	25	Other Admin Transportation	Bed days available	1,283,340	14	10,088		73,000	574	8
9	26	Insurance	Bed days available	1,283,340	14	11,273		73,000	641	9
10	27	Employee Benefits	Bed days available	1,283,340	14	763,008		73,000	43,402	10
11	30	Depreciation Expense	Bed days available	1,283,340	14	130,120		73,000	7,402	11
12	32	Interest & Amortization	Bed days available	1,283,340	14	38,953		73,000	2,216	12
13	33	Real Estate Taxes	Bed days available	1,283,340	14	121,491		73,000	6,911	13
14	34	Facility Rent	Bed days available	1,283,340	14	6,400		73,000	364	14
15	35	Equipment Rental	Bed days available	1,283,340	14	50,154		73,000	2,853	15
16	30	Depreciation Expense	Direct Allocation		1	1,370			1,370	16
17	17	Administrative	Hours		4	50,000	50,000		6,390	17
18	27	Employee Benefits	Hours		4	2,471	2,471		316	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,418,156	$ 2,383,423		$ 256,331	25

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$	73,000	$ 236	1
2	10	Nursing and Medical Records	Bed days available	1,283,340	14	$ 121,500	$ 121,500	73,000	6,911	2
3										3
4	20	Dues, Subscriptions	Bed days available	1,283,340	14	500		73,000	28	4
5	21	Office Expense	Bed days available	1,283,340	14	251,339	235,467	73,000	14,297	5
6	24	Education and Seminars	Bed days available	1,283,340	14	3,225		73,000	183	6
7	25	Other Admin Transportation	Bed days available	1,283,340	14	4,586		73,000	261	7
8	27	Employee Benefits	Bed days available	1,283,340	14	15,390		73,000	875	8
9	30	Depreciation Expense	Bed days available	1,283,340	14	1,896		73,000	108	9
10	32	Interest & Amortization	Bed days available	1,283,340	14	2,164		73,000	123	10
11		Depreciation Expense	Direct Allocation		1	37			37	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					$ 404,784	$ 356,967		$ 23,059	25

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		X	Line of Credit	Interest Only	2/1/10	2,000,000	1,976,491	3/1/11	0.0325	58,287	6
7	Bank of America		X	Line of Credit	Interest Only	2/1/10	500,000	281,243	3/1/11	0.0325	10,036	7
8												8
9	TOTAL Facility Related						$ 2,500,000	$ 2,257,734			$ 68,323	9
	B. Non-Facility Related*											
10								Interest Income Offset			(4,519)	10
11								Management Company allocation			2,339	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,180)	14
15	TOTALS (line 9+line14)						$ 2,500,000	$ 2,257,734			$ 66,143	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 Rehab and Living Center # 0047043 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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	$ 266,119	2
3. Under or (over) accrual (line 2 minus line 1).		$ 266,119	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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
Allocation from Management Company		6,911	
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.		$ 273,030	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	232,336	8
	2007	234,552	9
	2008	246,103	10
	2009	257,582	11
	2010	266,119	12

Based on Prior Year amounts

	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 Rehab and Living Center COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0047043

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.	15-33-404-140	Nursing Home	$ 266,119.03	$ 266,119.03
2.	10-27-319-028-0000	Management Company	$ 81,875.48	$ 6,911.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 347,994.51	$ 273,030.03

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 Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 86,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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: N/A
(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	Allocation from management company - NuCare			$ 8,191	1
2	Allocation from management company - CCS			455	2
3	TOTALS			$ 8,646	3

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		2005		$ 99,133	$	25	$ 2,832	$ 2,832	$ 23,012	4
5											5
6											6
7	HO Allocation - NuCare		2004		73,720		35	2,106	2,106	17,114	7
8	HO Allocation - CCS		2004		4,096		35	117	117	951	8
	Improvement Type**										
9	Data cables & jacks			2005	8,647		20	432	432	2,808	9
10	Electrical work			2005	4,050		20	203	203	1,319	10
11	Landscape architecture			2005	4,500		20	225	225	1,463	11
12	Alarm for door			2005	1,550		20	79	79	511	12
13	Flooring			2005	55,880		20	2,794	2,794	18,161	13
14	Heater			2005	1,578		20	78	78	507	14
15	Sewerline			2005	4,000		20	200	200	1,300	15
16	Nursing Station countertop and cabinet			2005	13,000		20	650	650	4,225	16
17	Draperies			2005	5,013		20	251	251	1,631	17
18	Modulator and DTV box			2005	750		20	37	37	241	18
19	Wireless TV satellite dish			2005	1,137		20	57	57	370	19
20	Concrete by parlor exit			2005	1,575		20	79	79	513	20
21	Microboard			2005	5,110		20	256	256	1,664	21
22	Electrical work			2005	1,720		20	86	86	559	22
23	Chair Rail			2006	4,293		20	215	215	1,073	23
24	Dining Room Remodel			2006	3,875		20	194	194	969	24
25	Door Repairs			2006	4,440		20	222	222	1,110	25
26	Electrical Work			2006	19,035		20	952	952	4,759	26
27	Elevator			2006	1,800		20	90	90	450	27
28	Fireproof Basement			2006	2,620		20	131	131	656	28
29	Flooring			2006	41,808		20	2,090	2,090	10,452	29
30	Kitchen Remodel			2006	23,800		20	1,190	1,190	5,950	30
31	Landscaping			2006	16,528		20	826	826	4,132	31
32	Play Area			2006	6,718		20	336	336	1,680	32
33	Remodel Dialysis Unit			2006	3,800		20	190	190	950	33
34	Remodel Resident Rooms			2006	22,640		20	1,132	1,132	5,660	34
35	Roof			2006	1,750		20	88	88	438	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 Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Motor	2006	$ 2,080	$	20	$ 104	$ 104	$ 520	37
38	Thermostat	2006	18,900		20	945	945	4,726	38
39	Wall Mural & Wallpaper	2006	5,860		20	293	293	1,466	39
40	Water Heater	2006	30,639		20	1,532	1,532	7,660	40
41	Window Treatments	2006	10,774		20	539	539	2,693	41
42	Compressor	2006	15,410		20	771	771	3,852	42
43	Therpy Rm - Plumbing, tile, & Paint	2007	17,096		20	855	855	3,847	43
44	Showers Demolish, Rebuild, Tiles	2007	22,654		20	1,133	1,133	5,097	44
45	Employee Lounge - Drywall & Paint	2007	8,200		20	410	410	1,845	45
46	Thermostats installed	2007	3,000		20	150	150	675	46
47	Therpy Rm - Cabinets installed	2007	4,300		20	215	215	968	47
48	Elevator Panels and repairs	2007	9,800		20	490	490	2,205	48
49	Thermostats installed	2007	3,975		20	199	199	894	49
50	Therpy Rm - Wall	2007	2,700		20	135	135	608	50
51	Window Installed	2007	15,484		20	774	774	3,484	51
52	Shower Tiles	2007	7,330		20	367	367	1,649	52
53	Door Installed	2007	12,420		20	621	621	2,795	53
54	Built-in Med Rec Shelves	2007	2,702		20	135	135	608	54
55	Door Installed	2007	3,355		20	168	168	755	55
56	Remove/Install Heating Elements	2007	8,100		20	405	405	1,823	56
57	Kitchen - Cooler Repaired & Tile Installed	2007	7,685		20	384	384	1,729	57
58	Elevator Valve	2007	2,800		20	140	140	630	58
59	Built-in Med Rec Shelves	2007	2,878		20	144	144	647	59
60	Motorized Hot/Cold Water Unit	2007	10,050		20	503	503	2,261	60
61	Generator and Water Heater	2007	3,314		20	166	166	746	61
62	Dish Washer Water Heater Booster	2007	3,635		20	182	182	818	62
63	2nd Flr Nurses Stat - Carpeting, Lights	2007	5,411		20	271	271	1,217	63
64	Alarm System Testing	2007	2,878		20	144	144	648	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 681,996	$		$ 30,309	$ 30,309	$ 171,491	70

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

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 681,996	$		$ 30,309	$ 30,309	$ 171,491	1
2	3 Hot/Clod Water Units	2008	9,500		20	475	475	1,663	2
3	Heating Units Fixed	2008	3,550		20	178	178	621	3
4	Patio & Landscaping	2008	31,693		20	1,585	1,585	5,546	4
5	Tube	2008	4,654		20	233	233	814	5
6	Kitchen Heating Tab & Dinning Blinds	2008	5,300		20	265	265	928	6
7	Doors Replaced & Fixed	2008	21,041		20	1,052	1,052	3,682	7
8	Painting & Wallpaper on 3rd floor	2008	38,894		20	1,945	1,945	6,806	8
9	Bathrooms - Toilets, Showers, Tile, etc	2008	62,000		20	3,100	3,100	15,525	9
10	Elevator Control Panel	2008	9,463		20	473	473	1,656	10
11	Shower Remodel - Remove walls, install heating units, etc	2009	10,071		20	504	504	1,259	11
12	Dinning Room - Replace carpet, wall coverings, etc	2009	85,987		20	4,299	4,299	10,748	12
13	Window Coverings	2009	3,651		20	183	183	456	13
14	Electrical repairs and Digital Thermostats	2009	18,756		20	938	938	2,344	14
15	Resident Room Reno. - Door Closers, Wall Base, Crown Mod.	2009	47,644		20	2,382	2,382	5,956	15
16	Landscaping and Signage	2009	25,617		20	1,281	1,281	3,202	16
17	Laundry Duct Work	2009	23,482		20	1,174	1,174	2,935	17
18	Roof Repair	2009	2,500		20	125	125	313	18
19	Computer Cabling Installed	2009	3,075		20	154	154	384	19
20									20
21	Magnetic Door Holders	2010	2,701		20	135	135	203	21
22	Fire Dampers in Ductwork	2010	7,614		20	381	381	571	22
23	Patio Door and Retaining Wall	2010	4,595		20	230	230	345	23
24	Cabinets Built-In Patient Rooms	2010	19,280		20	964	964	1,446	24
25	Flex Air Base Station Repeater	2010	3,234		20	162	162	243	25
26	Furnish & install - Hot Water Supply to Laundry	2010	2,615		20	131	131	196	26
27	New Paging System & Camera System	2010	23,818		20	1,191	1,191	1,786	27
28									28
29	Beauty Salon Renovations	2011	6,056		20	151	151	151	29
30	Building Masonry Sign	2011	13,832		20	346	346	346	30
31	Carpeting- Nursing Station	2011	4,422		20	111	111	111	31
32	Heating A/C	2011	3,848		20	96	96	96	32
33	Shower Renovations	2011	7,000		20	175	175	175	33
34	TOTAL (lines 1 thru 33)		$ 1,187,889	$		$ 54,725	$ 54,725	$ 241,999	34

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

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,187,889	$		$ 54,725	$ 54,725	$ 241,999	1
2	Exit Sign Flourescent Light	2011	2,386		20	60	60	60	2
3	Repair Parking Lot Asphalt	2011	2,750		20	69	69	69	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,193,025	$		$ 54,853	$ 54,853	$ 242,127	34

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

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,193,025	$		$ 54,853	$ 54,853	$ 242,127	1
2	2011 Allocation from management company:								2
3	Alarm System	2003	666		20	33	33	271	3
4	Buildout of Offices	2004	53,160		20	677	677	5,221	4
5	Security & Fire Alarm System	2004	1,546		20	77	77	580	5
6	Data Cables, Lights & Heat Exchanger	2005	802		20	40	40	275	6
7	Fire Alarm System	2005	7,093		20	458	458	2,889	7
8	Cooling Unit	2006	1,087		20	54	54	292	8
9	Asphalt & Carpet	2008	1,146		20	57	57	187	9
10	Landscaping, 2nd Floor Reconst. (including Phone, Sprinklers,	2009	18,454		20	923	923	2,408	10
11	Alarm Systems, Kitchen Remodel, Wallcovings, etc..)								11
12	HVAC, Paint/Wallpaper, Electrical, Sprinkler, & Generator Repair	2010	2,836		20	142	142	214	12
13	Hot water Heater	2011	153		20	7	7	7	13
14									14
15									15
16									16
17	Current Year Booked Depreciation (B&F and MME)	2011		141,688			(141,688)		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	TOTAL (lines 1 thru 33)		$ 1,279,968	$ 141,688		$ 57,321	$ (84,367)	$ 254,471	34

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

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 982,231	$	$ 70,208	$ 70,208	10	$ 289,883	71
72	Current Year Purchases	93,148		4,657	4,657	10	4,657	72
73	Fully Depreciated Assets							73
74	Allocation from management company	67,393		4,124	4,124	3-10	34,963	74
75	TOTALS	$ 1,142,772	$	$ 78,989	$ 78,989		$ 329,503	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Bus	2006	$ 4,365	$	$ 873	$ 873	5	$ 4,802	76
77	Allocation from management company			504		101	101		143	77
78										78
79										79
80	TOTALS			$ 4,869	$	$ 974	$ 974		$ 4,945	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)	$ 2,436,255	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 141,688	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 137,285	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,403)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 588,917	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.

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Claremont Extended Healthcare, LLC

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. [X] 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:	1994	200		$ 1,326,762			3
4	Additions							4
5								5
6		Allocation from Management Company			364			6
7	TOTAL		200		$ 1,327,126 **			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 .

9. Option to Buy: [X] YES [ ] NO Terms: $550,000 option can be exercised a *

10. Effective dates of current rental agreement:
Beginning 3/1/05
Ending 3/28/2011

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$ 1,592,881
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: $ 67,518 Description: Copier-680; Med eqpt-19,584; Beds-38,123; Storage-2,678; Parking-3,600; 2,853 Mgmt Alloc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patients	2008 Ford, E350	$ 812.50	$ 9,750	17
18	Administration	2010 Acrua, RDX	540.00	6,480	18
19	Administration	2009 Infiniti, M45	796.00	9,552	19
20					20
21	TOTAL		$ 2,148.50	$ 25,782	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 Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$ 408,352	1,166	$ 83,983	$	1,166	$ 492,335	1
2	Licensed Speech and Language Development Therapist	L10A C3	hrs	162,906	326	23,482		326	186,388	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A C2 & 3	hrs	547,067	1,628	117,199	6,317	1,628	670,583	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39 C2	# of prescrpts				934,077		934,077	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Schedule 16A	Var.			3,939	209,871		3,939	209,871	13
14	TOTAL			$ 1,118,325	7,060	$ 434,535	$ 940,394	7,060	$ 2,493,254	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.

Claremont Extended Healthcare, LLC D/B/A Claremont Rehab and Living Center
PROVIDER #0047043
1/1/11 - 12/31/11

Schedule 16A

XIV. SPECIAL SERVICES (Direct Cost) Line 14						
	Schedule V	Outside Practitioner				
Service	Line & Col. Ref.	Units	Costs	Supplies		Ref
Respiratory Therapy	L10A C3	635	41261		*	From Pg 16.1
Ambulance	L39 C3		3388			From Pg 16.2
Hemodialysis	L39 C3	3304	165222		**	From Pg 16.2
		3939	209871	0		

* Used $65 a unit, which is from Pg 20.2.
** Used $50 a unit, which consistent to PY.

STATE OF ILLINOIS

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (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	$ 3,000	$ 3,750	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 354,034)	3,726,139	3,726,139	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	143,375	143,375	6
7	Other Prepaid Expenses	46,274	46,274	7
8	Accounts Receivable (owners or related parties)	2,428	2,428	8
9	Other(specify): See attached Sch 17A	(195)	649,805	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,921,021	$ 4,571,771	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		8,646	13
14	Buildings, at Historical Cost		176,949	14
15	Leasehold Improvements, at Historical Cost	1,007,875	1,103,019	15
16	Equipment, at Historical Cost	967,959	1,147,641	16
17	Accumulated Depreciation (book methods)	(534,153)	(588,917)	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)**	$ 1,441,681	$ 1,847,338	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,362,702	$ 6,419,109	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,202,181	$ 1,202,181	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,303	2,303	28
29	Short-Term Notes Payable	2,257,734	2,257,734	29
30	Accrued Salaries Payable	646,065	646,065	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,887	10,887	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Sch 17A	70,208	777,409	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,189,378	$ 4,896,579	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,189,378	$ 4,896,579	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,173,324	$ 1,522,530	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,362,702	$ 6,419,109	48

*(See instructions.)

Claremont Extended Healthcare, LLC D/B/A Claremont Rehab and Living Center
PROVIDER #0047043
1/1/11 - 12/31/11

Schedule 17A

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.
A. Current Assets

Other Current Assets (specify):	Operating	After Consolidation
Due from claremont Realty	-	650,000
Cash-Petty	2,150	2,150
Cash-Resident Trust	(2,419)	(2,419)
Accrued Management Fees-Nucare	86,076	86,076
Accrued Management Fees-Quest	(71,699)	(71,699)
Accrued Management Fees-CCS	(9,038)	(9,038)
Due to Others	(5,265)	(5,265)
Total Line 9 - Other Current Assets (specify):	**(195)**	**649,805**

C. Current Liabilities

Other Current Liabilities (specify):	Operating	After Consolidation
Accrued Expenses		655,377
Nucare Services Corp		51,824
Cash in Bank - BoA	523,204	523,204
Due from Claremont Realty	(655,377)	(655,377)
Accrued Accounts Payable	295,616	295,616
Accrued Utilities	11,558	11,558
Due Employees - Old Payroll Checks	4,923	4,923
Accrued Deductions - Wage Assignments	(1,113)	(1,113)
Due to Bronzeville Park Expense	(77)	(77)
Due to Cal Gardens Expense	5,642	5,642
Due to Forest Villa Expense	(583)	(583)
Due to Imperial Grove Expense	(77)	(77)
Due to Ivy Apartments Expense	(77)	(77)
Due to Jackson Square Expense	(77)	(77)
Due to Monroe Pavilion Expense	(77)	(77)
Due to Renaissance at Hillside Expense	(77)	(77)
Due to Renaissance at Midway Expense	(77)	(77)
Due to Renaissance at South Shore Expense	(77)	(77)
Due to Renaissance at 87th Street Expense	(77)	(77)
Due to Renaissance Park South Expense	(77)	(77)
Due to Quest Services Expense	113,740	113,740
Due to Clinical Consulting Expense	53,165	53,165
Due to Nucare Services Corp Expense	(561,342)	(561,342)
Due to Claremont of Hanover Park expense	(18,576)	(18,576)
Due Nuvision Holdings Expense	221,762	221,762
Due to Prior Owners	78,359	78,359
	70,208	**777,409**

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,458,972	1
2	Restatements (describe):		2
3	**Prior period adjustments**	(171,821)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,287,151	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(113,827)	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)**	$ (113,827)	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)**	$ 1,173,324	24 *

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

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,706,140	1
2	Discounts and Allowances for all Levels	(2,030,007)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,676,133	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,756,078	6
7	Oxygen	38,344	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,794,422	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	15,269	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,298,818	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	149,881	19
20	Radiology and X-Ray	88,553	20
21	Other Medical Services	312,288	21
22	Laundry	3,117	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,867,926	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,519	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,519	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	941	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 941	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,343,941	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,894,264	31
32	Health Care	6,441,973	32
33	General Administration	3,756,496	33
	B. Capital Expense		
34	Ownership	1,893,339	34
	C. Ancillary Expense		
35	Special Cost Centers	1,362,196	35
36	Provider Participation Fee	109,500	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,457,768	40
41	**Income before Income Taxes (line 30 minus line 40)****	(113,827)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (113,827)	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 Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	1,752	2,080	$ 98,168	$ 47.20	1
2	Assistant Director of Nursing	5,384	6,520	214,864	32.95	2
3	Registered Nurses	35,139	39,440	1,118,215	28.35	3
4	Licensed Practical Nurses	21,147	23,352	520,613	22.29	4
5	CNAs & Orderlies	81,177	92,271	1,004,729	10.89	5
6	CNA Trainees	26,186	26,838	285,459	10.64	6
7	Licensed Therapist	31,636	36,619	1,118,325	30.54	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,032	2,200	40,076	18.22	9
10	Activity Assistants	16,443	18,293	221,172	12.09	10
11	Social Service Workers	3,525	4,466	97,753	21.89	11
12	Dietician	3,329	4,100	118,604	28.93	12
13	Food Service Supervisor					13
14	Head Cook	4,202	4,910	68,688	13.99	14
15	Cook Helpers/Assistants	23,088	24,907	224,336	9.01	15
16	Dishwashers					16
17	Maintenance Workers	5,317	5,717	161,010	28.16	17
18	Housekeepers	24,310	27,427	241,379	8.80	18
19	Laundry	5,583	6,482	55,404	8.55	19
20	Administrator	2,456	2,781	101,290	36.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,290	19,194	415,110	21.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,656	1,760	37,866	21.51	28
29	Resident Services Coordinator	6,725	7,728	242,529	31.38	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,514	2,715	69,751	25.69	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	320,890	359,798	$ 6,455,342 *	$ 17.94	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	410	$ 18,809	L1,C3	35
36	Medical Director	Monthly	36,000	L9,C3	36
37	Medical Records Consultant	Monthly	4,800	L10, C3	37
38	Nurse Consultant	465	25,465	L10, C3	38
39	Pharmacist Consultant	220	12,447	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	5	261	L11, C3	44
45	Social Service Consultant	21	1,233	L12,C3	45
46	Other(specify) Medical Consultant	Monthly	44,500	L10,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,120	$ 143,514		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,091	$ 166,934	L10,C3	50
51	Licensed Practical Nurses	2,062	86,609	L10,C3	51
52	Certified Nurse Assistants/Aides	14,421	317,253	L10,C3	52
53	TOTAL (lines 50 - 52)	19,574	$ 570,796		53

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rupal Mistry	Administrator	0%	$ 101,290
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 101,290

B. Administrative - Other

Description	Amount
Management Fees (Adjusted in Col. 7)	$ 751,109
TOTAL (agree to Schedule V, line 17, col. 3)	$ 751,109
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RSM/McGladrey & Pullen	Accounting	$ 14,222
Frost,Ruttenburg & Rothblatt	Accounting	5,800
A/P Accrual -	Accounting	7,500
Klein Dub & Holleb, Ltd	Legal	21,422
Much Shelist	Legal	42,089
POLSINELLI SHUGHART	Legal	371
Stone,Mcguire&Siegel	Legal	17,656
Stone,Pogrund & Korey Llc	Legal	8,613
Ashman & Stein	Legal	58
Chuhak & Tecson, Pc	Legal	5,644
A/P Accrual -	Legal	2,270
Personal Planners, Inc	Unemployment Consult.	2,094
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 127,738

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 161,155
Unemployment Compensation Insurance	14,146
FICA Taxes	577,386
Employee Health Insurance	288,191
Employee Meals	40,395
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	22,256
Life Insurance	18,987
401 (K)	10,831
Employee Physicals	4,160
Employee Awards	0
Uniform Exp	5,981
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,143,488

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	$ 995
Advertising: Employee Recruitment	17,434
Health Care Worker Background Check	
(Indicate # of checks performed 1050)	10,500
Patient Background Checks 217	5,184
Misc. Licenses & Inspections	17,668
IHCA Dues	11,040
Misc. Dues & Subscriptions	3,173
Less: Lobbying portion of IHCA dues	(3,904)
Allocation of management company	994
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 63,084

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	16,524
Allocation from management company	429
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,953

**See instructions.

Claremont Rehab and Living Center
Provider #: 0047043
1/1/2011 to 12/31/2011

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	127,738
Plus: Home Office Allocation	22,757
Less: Non-Allowable Legal	(5,728)
Total (agree to Schedule V, line 19, column 8)	144,767

Facility Name & ID Number Claremont Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Rehab and Living Center # 0047043 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. **IHCA $11,040 (Lobby offset of $)**

(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? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **2,606** 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 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. $ **109,500**
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. $ **40,395** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **40,395**

(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? **N/A**
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? **No**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **No**
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 service
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees