		FOR BHF USE					

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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: 0044750

Facility Name: Community Nursing & Rehabilitation Center, LLC

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

County: DuPage

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	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 Community Nursing & Rehabilitation Center, LLC # 0044750 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	153	Skilled (SNF)	153	55,845	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	153	TOTALS	153	55,845	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	29,744	4,559	11,110	45,413	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,744	4,559	11,110	45,413	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.32%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

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

F. Does the facility maintain a daily midnight census? 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 04/01/2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 153 and days of care provided 9,294

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: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 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	365,106	53,094	7,490	425,690		425,690		425,690			1
2	Food Purchase		272,531		272,531		272,531	(20,366)	252,165			2
3	Housekeeping	235,012	6,212		241,224		241,224		241,224			3
4	Laundry	49,768	19,375		69,143		69,143		69,143			4
5	Heat and Other Utilities			216,440	216,440		216,440		216,440			5
6	Maintenance	63,047	35,226	115,333	213,606		213,606	13,142	226,748			6
7	Other (specify):*											7
8	TOTAL General Services	712,933	386,438	339,263	1,438,634		1,438,634	(7,224)	1,431,410			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	3,203,278	265,319	555	3,469,152		3,469,152	1,050	3,470,202			10
10a	Therapy			1,248,288	1,248,288		1,248,288		1,248,288			10a
11	Activities	147,607	4,175	4,218	156,000		156,000		156,000			11
12	Social Services	78,722		750	79,472		79,472		79,472			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,429,607	269,494	1,275,411	4,974,512		4,974,512	1,050	4,975,562			16
	C. General Administration											
17	Administrative	158,916		750,000	908,916		908,916		908,916			17
18	Directors Fees											18
19	Professional Services			181,652	181,652		181,652	11,965	193,617			19
20	Dues, Fees, Subscriptions & Promotions			45,261	45,261		45,261	250	45,511			20
21	Clerical & General Office Expenses	164,688	44,676	81,671	291,035		291,035	(38,176)	252,859			21
22	Employee Benefits & Payroll Taxes			832,756	832,756		832,756	15,190	847,946			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,324	7,324		7,324	(3,797)	3,527			24
25	Other Admin. Staff Transportation			13,921	13,921		13,921		13,921			25
26	Insurance-Prop.Liab.Malpractice			117,485	117,485		117,485	16,587	134,072			26
27	Other (specify):*											27
28	TOTAL General Administration	323,604	44,676	2,030,070	2,398,350		2,398,350	2,019	2,400,369			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,466,144	700,608	3,644,744	8,811,496		8,811,496	(4,155)	8,807,341			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 Community Nursing & Rehabilitation Center, LLC #0044750 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			156,904	156,904		156,904	279,630	436,534			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,824	44,824		44,824	411,518	456,342			32
33	Real Estate Taxes							99,446	99,446			33
34	Rent-Facility & Grounds			738,025	738,025		738,025	(738,025)				34
35	Rent-Equipment & Vehicles			67,473	67,473		67,473	(103)	67,370			35
36	Other (specify):* Mortgage Insurance							34,744	34,744			36
37	TOTAL Ownership			1,007,226	1,007,226		1,007,226	87,210	1,094,436			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		556,793	142,311	699,104		699,104		699,104			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			194,339	194,339		194,339		194,339			42
43	Other (specify):* Non-Allow Costs	109,297		226,501	335,798		335,798	(335,798)				43
44	TOTAL Special Cost Centers	109,297	556,793	563,151	1,229,241		1,229,241	(335,798)	893,443			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,575,441	1,257,401	5,215,121	11,047,963		11,047,963	(252,743)	10,795,220			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 Community Nursing & Rehabilitation Center, LLC # 0044750 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	(1,878)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,812)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	135,114	30		9
10	Interest and Other Investment Income	(2,496)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(358)	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				18
19	Entertainment				19
20	Contributions	(800)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,398)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(127,305)	43		24
25	Fund Raising, Advertising and Promotional	(18,026)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(10,112)	43		28
29	Other-Attach Schedule See Pg 5A	(189,350)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (224,421)		$	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)	(28,322)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (28,322)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (252,743)		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

Community Nursing & Rehabilitation Center, LLC

ID# 0044750

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (6,775)	43	1
2	Café Income	(3,298)	2	2
3	NH X Ray	(54,440)	43	3
4	Travel & Seminar	(3,797)	24	4
5	Admissions & Marketing	(109,297)	43	5
6	Cable TV	(8,685)	43	6
7	Repairs & Maintenance - Other	10,614	6	7
8	Office Supplies	(13,672)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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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**	(189,350)		49

Facility Name & ID Number Community Nursing & Rehabilitation Center, LLC # 0044750 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
Mark and Chana Weldler	29.50	Pine Acres Rehab & Living Center, LLC	DeKalb	Community Nursing	Naperville	
Steve and Bluma Jeremias	29.50			& Rehab Realty,LLC		Real Estate
Malka Mermelstein	.50	The Springs at Crystal Lake, LLC	Crystal Lake			
Herman Mermelstein	.50			Pine Acres Realty, LL	DeKalb	Real Estate
Joseph Neumann	30.00					
Hirsch Wolf	10.00			TS Realty, LLC	Crystal Lake	Real Estate

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	6	Building - Repairs & Mtce	$	Community Nursing & Rehab Realty, LLC		$	$	1
2	V	21	Bank Fees		Community Nursing & Rehab Realty, LLC		146	146	2
3	V	26	Insurance		Community Nursing & Rehab Realty, LLC		16,587	16,587	3
4	V	30	Depreciation		Community Nursing & Rehab Realty, LLC		144,515	144,515	4
5	V	32	Interest		Community Nursing & Rehab Realty, LLC		414,015	414,015	5
6	V	33	Real Estate Tax		Community Nursing & Rehab Realty, LLC		99,446	99,446	6
7	V	20	Licenses		Community Nursing & Rehab Realty, LLC		250	250	7
8	V	34	Building Rent	738,025	Community Nursing & Rehab Realty, LLC			(738,025)	8
9	V	36	Mortgage Insurance		Community Nursing & Rehab Realty, LLC		34,744	34,744	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 738,025			$ 709,703	$ * (28,322)	14

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

Facility Name & ID Number Community Nursing & Rehabilitation Cente # 0044750 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	Steve Jeremias	COO	Administrative	29.50	60,000	35	70.00	Guar Pymnts	$ 375,000	L17, C3	1
2	Mark Weldler	CFO	Finance	29.50	60,000	35	70.00	Guar Pymnts	375,000	L17, C3	2
3											3
4											4
5					* Steve Jeremias and Mark Weldler each received $60,000 from Pine Acres.						5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 750,000		13

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

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

Facility Name & ID Number Community Nursing & Rehabilitation Center, LLC # 0044750 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 [ ] NO [X]

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

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

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

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 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** 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	Chase - Subaru Motors		X	Facility Vehicle	$633.16	03/3/11	$ 35,281	$ 30,302	03/3/16	0.0290	$ 719	1
2	Ally Vehicle Finance		X	Facility Vehicle	$789.28	10/1/11	43,628	41,609	10/1/16	0.0324	348	2
3	Cambridge Reality		X	Mortgage	$43,339.00	03/20/08	7,267,500	6,909,345	02/20/48	0.0595	414,015	3
4	MaxxSource		X	Facility Equipment	$600.00	06/15/11	12,000	10,200	02/15/13			4
5	Marlin - Dish Machine & Booster		X	Facility Equipment	$247.10	04/15/11	13,954	12,533	04/15/16	0.0625	556	5
	Working Capital											
6												6
7	Brickyard Bank		X	Working Capital	Varies	5/21/10	950,000		5/21/11	0.0750	32,928	7
8	Lake Forest Bank		X	Working Capital	Varies	9/15/11	1,000,000	235,483	9/1/12	0.0550	10,273	8
9	TOTAL Facility Related				$45,608.54		$ 9,322,363	$ 7,239,472			$ 458,839	9
	B. Non-Facility Related*											
10												10
11								Less: Interest Income Offset			(2,497)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,497)	14
15	TOTALS (line 9+line14)						$ 9,322,363	$ 7,239,472			$ 456,342	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 34,744 **Line #** 36

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

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

Facility Name & ID Number Community Nursing & Rehabilitation Center, LLC # 0044750 **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.**		$ 93,000	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	$ 95,046	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,046	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 97,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 99,446	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	114,973	8
	2007	118,575	9
	2008	111,973	10
	2009	92,745	11
	2010	95,046	12

Real estate tax accrual based on 102% of prior years tax bill

	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 Community Nursing & Rehabilitation Center, LLC COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0044750

CONTACT PERSON REGARDING THIS REPORT Mark Weldler

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

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

Enter the tax index number and real estate tax assessed for 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.	07-12-403-042	Nursing Home	$ 95,046.00	$ 95,046.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 95,046.00	$ 95,046.00

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Community Nursing & Rehabilitation Center, LLC # 0044750 Report Period Beginning: 01/01/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 62,087 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).

None

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: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Use	164,335	2000	$ 453,622	1
2					2
3	TOTALS	164,335		$ 453,622	3

Facility Name & ID Number Community Nursing & Rehabilitation Center, LLC # 0044750 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	153		2000	1986	$ 4,184,589	$	40	$ 104,615	$ 104,615	$ 1,229,232	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CABLE			2000	4,305	108	40	108		1,269	9
10	ELEVATOR DOOR			2000	4,389	110	40	110		1,283	10
11	PARKING LOT			2000	38,200	955	40	955		11,142	11
12	LANDSCAPING			2000	8,736	218	40	218		2,525	12
13	SIGN			2000	4,541	114	40	114		1,320	13
14	ARCHITECT FEES			2000	3,060	77	40	77		902	14
15	DOOR LOCK			2000	2,248	56	40	56		649	15
16	CLOSETS			2000	7,729	193	40	193		2,203	16
17	COVE BASE			2000	4,459	111	40	111		1,249	17
18	HANDRAILS AND KICKPLATES			2000	15,146	379	40	379		4,264	18
19	LIGHTING			2000	65,796	1,645	40	1,645		18,506	19
20	TILE			2000	2,317	58	40	58		652	20
21	FLOORING			2000	16,378	409	40	409		4,552	21
22	EXIT DOORS			2000	1,598	40	40	40		450	22
23	WINDOW AND CUBICLE TREATMENTS			2000	34,021	851	40	851		9,574	23
24	LIGHTING			2000	1,729	43	40	43		484	24
25	CARPETING			2000	27,139	678	40	678		7,628	25
26	FIRE PANEL			2000	4,500	113	40	113		1,271	26
27	NURSE'S STATION			2000	8,913	223	40	223		2,490	27
28	DOOR HANDLES			2000	1,644	41	40	41		458	28
29	CUBICLE TRACK			2000	915	23	40	23		255	29
30	MOTOR			2000	13,276	332	40	332		3,818	30
31	STOVE HOODS			2000	1,429	36	40	36		399	31
32	COVER BASE - RESIDENTS' ROOMS			2001	865	87	10	3	(84)	865	32
33	CERAMIC TILES			2001	10,930	1,093	10	91	(1,002)	10,930	33
34	CEILING & LIGHTING			2001	9,063	906	10	178	(728)	9,063	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 Community Nursing & Rehabilitation Center, LLC # 0044750 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	RENOVATIONS - THERAPY ROOM	2001	$ 10,558	$ 1,056	10	$ 85	$ (971)	$ 10,558	37
38	TILE & COVE BASE - BASEMENT	2001	2,327	233	10		(233)	2,327	38
39	SHAMPOO STATION	2001	5,431	543	10	46	(497)	5,431	39
40	COVE BASE - SECOND FLOOR	2001	1,699	170	10	13	(157)	1,699	40
41	WALLPAPER/COVEBASE/CARPETING/LIGHTING	2001	1,403	140	10	14	(126)	1,403	41
42	ABS PUMP	2001	11,908	1,191	10	97	(1,094)	11,908	42
43	CARPETING	2001	14,572	1,457	10	123	(1,334)	14,572	43
44	FLOORING	2001	1,320	132	10	11	(121)	1,320	44
45	2ND FLOOR RENOVATIONS	2001	38,875	3,888	10	967	(2,921)	38,875	45
46	AVERY	2001	2,419	242	10	60	(182)	2,419	46
47	KITCHEN - COOLING AIR UNIT	2001	2,275	228	10	33	(195)	2,275	47
48	WALLCOVERINGS	2001	12,289	1,229	10		(1,229)	12,289	48
49	SIGNAGE/ELECTRIC BALLAST (ADMISSIONS OFFICE)	2001	3,131	313	10	105	(208)	3,131	49
50	ROOM CURTAIN DIVIDER	2001	2,003	200	10	69	(131)	2,003	50
51	HANDRAILS & BUMPER GUARDS	2001	17,855	1,786	10	591	(1,195)	17,855	51
52	FIRE ALARM TRANSFORMER	2001	1,715	172	10	53	(119)	1,715	52
53	TEMP CONTROL ON AIR HANDLER	2001	9,519	952	10	316	(636)	9,519	53
54	COVEBASE/LANDSCAPING/LIGHTING/FLOORING	2001	2,642	264	10	90	(174)	2,642	54
55	LIGHTING - CORRIDORS & RESIDENT ROOMS	2001	20,544	2,054	10	860	(1,194)	20,544	55
56	NEW BEARING & SHAFT	2001	1,402	140	10	72	(68)	1,402	56
57	DIALYSIS ROOM RENOVATIONS	2001	23,351	2,335	10	2,141	(194)	23,351	57
58	ASPHALT SEALCOATING & STRIPING	2001	1,405	141	10	89	(52)	1,405	58
59	KITCHEN TILE	2001	930	93	10	70	(23)	930	59
60	SEPTIC TANK PUMPS	2001	13,862	1,386	10	1,041	(345)	13,862	60
61	CARPETING	2001	5,729	573	10	238	(335)	5,729	61
62	PAINTING & WALLPAPER	2001	20,440	2,044	10		(2,044)	20,440	62
63	PAINTING & WALLPAPER	2001	11,875	1,188	10	292	(896)	11,875	63
64	PAINTING & WALLPAPER	2001	4,500	450	10	187	(263)	4,500	64
65	NEW DOORS	2002	1,731	173	10	173		1,644	65
66	MURAL FOR SECOND FLOOR DINING ROOM	2002	7,000	700	10	700		6,650	66
67	NEW TROUGH IN LAUNDRY ROOM	2002	6,300	630	10	630		5,985	67
68	WINDOW MOLDINGS	2002	210	21	10	21		200	68
69	NEW THRESHHOLDS	2002	205	21	10	21		199	69
70	TOTAL (lines 4 thru 69)		$ 4,739,340	$ 35,044		$ 120,908	$ 85,864	$ 1,588,090	70

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

Facility Name & ID Number Community Nursing & Rehabilitation Center, LLC # 0044750 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		$ 4,739,340	$ 35,044		$ 120,908	$ 85,864	$ 1,588,090	1
2	NEW PVC PIPING IN KITCHEN	2002	1,320	132	10	132		1,254	2
3	UPGRADE BACKFLOW SYSTEM	2002	1,695	170	10	170		1,615	3
4	ALARM FOR RAMP EXIT	2002	1,443	144	10	144		1,368	4
5	FLOORING IN ELEVATOR	2002	856	86	10	86		817	5
6	CORNER GUARDS/WATER SOFTENER	2002	1,328	133	10	133		1,263	6
7	NEW DRAINAGE PIPES - DISPOSAL	2002	9,985	999	10	999		9,490	7
8	CORNER GUARDS	2003	276	28	10	28		252	8
9	UPGRADE DIALYSIS ROOM	2003	28,103	2,810	10	2,810		25,290	9
10	NEW AWNINGS FOR PATIO	2003	3,940	394	10	394		3,546	10
11	INSTALL GREASE TRAP IN KITCHEN	2003	3,250	325	10	325		2,925	11
12	NEW COIL FOR AIR HANDLER	2003	3,493	349	10	349		3,141	12
13	INSTALL LASER EYE ON ELEVATOR	2003	1,590	159	10	159		1,431	13
14	UPGRADE DIALYSIS ROOM	2004	30,778	3,078	10	3,078		24,624	14
15	NEW ROOF	2004	8,600	860	10	860		6,880	15
16	REMODEL VESTIBULE, NEW FLOORING	2004	10,044	1,004	10	1,004		8,032	16
17	INSTALL NEW SMOKE DETECTORS	2004	4,911	491	10	491		3,928	17
18	NEW OXYGEN ROOM	2004	5,688	569	10	569		4,552	18
19	NEW ELEVATOR TANK, PUMP AND MOTOR	2004	11,960	1,196	10	1,196		9,568	19
20	ROOF REPLACEMENT	2005	5,800	580	10	580		3,770	20
21	WIRE GLASS FOR RECEPTION WINDOW	2005	1,348	135	10	135		880	21
22	NEW CEMENT WALKWAYS	2005	2,400	240	10	240		1,560	22
23	NEW WALL HUNG SINK	2006	3,410	341	10	341		1,704	23
24	MOTOR FOR A/C	2006	664	66	10	66		330	24
25	NEW PUMP SYSTEM	2006	5,108	511	10	511		2,554	25
26	NEW HOT WATER HEATER	2006	7,998	800	10	800		4,000	26
27	SOLID STATE STARTER	2006	3,900	390	10	390		1,950	27
28	PUMP	2006	1,553	155	10	155		774	28
29	NEW FIRE ALARM	2006	6,800	680	10	680		3,400	29
30	NEW PUMP FOR BASEMENT A/C	2006	988	99	10	99		494	30
31	PAVE PARKING LOT	2006	3,500	350	10	350		1,750	31
32	NEW TIME CLOCK	2006	4,345	435	10	435		2,174	32
33	REPLACE HVAC ROOF TOP UNIT	2007	3,511	351	10	351		1,580	33
34	TOTAL (lines 1 thru 33)		$ 4,919,925	$ 53,104		$ 138,968	$ 85,864	$ 1,724,986	34

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

Facility Name & ID Number Community Nursing & Rehabilitation Center, LLC # 0044750 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		$ 4,919,925	$ 53,104		$ 138,968	$ 85,864	$ 1,724,986	1
2	BALANCE OF TIME CLOCK	2007	4,345	434	10	434		1,953	2
3	HOT WATER HEATER	2007	9,212	921	10	921		4,145	3
4	SECURITY CAMERAS	2008	5,458	546	10	546		1,911	4
5	RELOCATE GAS LINE	2008	21,900	2,190	10	2,190		7,665	5
6	FRONT & BACK LANDSCAPING	2008	33,000	3,300	10	3,300		11,550	6
7									7
8	Architect Services	2009	29,257	2,926	10	2,926		7,314	8
9	Roof	2009	230,100	23,010	10	23,010		57,525	9
10	Construction Period Interest	2009	32,240	3,224	10	3,224		8,060	10
11	1st floor resident room baths - remove existing vinyl floor,								11
12	floor prep, installation of sheet vinyl, ceramic tile	2009	22,546	2,255	10	2,255		5,636	12
13	1st floor dining room - remove existing cove base and sheet								13
14	vinyl, floor prep, pvt install, pvt wallcovering	2009	32,001	3,200	10	3,200		8,000	14
15	Activity room - wall covering, remove cove base, install pvt &								15
16	cove base, cornices, custom built in computer work station,								16
17	remove existing ceiling tile, furnish & install new acoustic								17
18	ceiling tile, furnish & install new can lights	2009	20,443	2,044	10	2,044		5,111	18
19	Shower room - install 4 shower stalls, remove existing cove								19
20	base & sheet vinyl, install new ceramic tile	2009	43,873	4,387	10	4,387		10,969	20
21	Basement corridor - cove base, flooring, paint doors & frames,								21
22	wallpaper purchase & installation	2009	46,436	4,644	10	4,644		11,609	22
23	Therapy room - wallcovering, remove existing cove base and								23
24	vct installation of pvt, glue down carpet, remove cinder-								24
25	block wall and office separating OT & PT rooms, demo of								25
26	old and installation of new acoustical ceiling	2009	30,482	3,048	10	3,048		7,620	26
27	Foyer - remove old flooring, install new ceramic flooring &								27
28	pedimat, wallcovering	2009	12,181	1,218	10	1,218		3,045	28
29	Lobby - remove old cove base and flooring, install new ceramic								29
30	tile and cove base, wallcovering, built in reception desk,								30
31	remove mirror, door, frame & glass. Install new moldings,								31
32	remove existing receptionist wall and rebuild wall, re-								32
33	install door 3 feet from current location	2009	34,706	3,471	10	3,471		8,676	33
34	TOTAL (lines 1 thru 33)		$ 5,528,105	$ 113,922		$ 199,786	$ 85,864	$ 1,885,776	34

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

Facility Name & ID Number Community Nursing & Rehabilitation Center, LLC # 0044750 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		$ 5,528,105	$ 113,922		$ 199,786	$ 85,864	$ 1,885,776	1
2	Building Facade & Renovation								2
3	- General requirements	2009	19,795	1,980	10	1,980		4,949	3
4	- Permits	2009	5,000	500	10	500		1,250	4
5	- Excavation and site demolition	2009	22,626	2,263	10	2,263		5,656	5
6	- Asphalt Patching	2009	5,928	593	10	593		1,482	6
7	- Mansard and patio canopy demolition	2009	9,300	930	10	930		2,325	7
8	- Concrete work	2009	23,807	2,381	10	2,381		5,951	8
9	- Brick pavers	2009	13,440	1,344	10	1,344		3,360	9
10	- Masonry columns & Screen wall	2009	16,190	1,619	10	1,619		4,048	10
11	- Steel	2009	9,700	970	10	970		2,425	11
12	- Wood fencing	2009	1,580	158	10	158		395	12
13	- Pylon Sign	2009	8,000	800	10	800		2,000	13
14	- Room framing and sheathing	2009	81,769	8,177	10	8,177		20,442	14
15	- Cut and patch existing roofing for new construction	2009	17,310	1,731	10	1,731		4,328	15
16	- Roofing and sheetmetal	2009	40,835	4,084	10	4,084		10,209	16
17	- Electrical	2009	4,150	415	10	415		1,038	17
18	- Dry fire sprinkler system	2009	7,000	700	10	700		1,750	18
19	- Duct demolition	2009	2,160	216	10	216		540	19
20	- Homosote sheathing	2009	7,549	755	10	755		1,887	20
21	- Eifs	2009	13,350	1,335	10	1,335		3,338	21
22	- Fypon Moldings	2009	6,790	679	10	679		1,698	22
23	- Painting	2009	3,400	340	10	340		850	23
24	- Main extrance roof tower	2009	47,588	4,759	10	4,759		11,897	24
25	- Asphalt sidewalk on north side of bldg	2009	4,920	492	10	492		1,230	25
26	- Landscaping	2009	18,000	1,800	10	1,800		4,500	26
27	- Landscape demo	2009	5,566	557	10	557		1,391	27
28	- Insurance	2009	3,562	356	10	356		890	28
29	- General contractor fee	2009	13,685	1,369	10	1,369		3,421	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,941,105	$ 155,222		$ 241,086	$ 85,864	$ 1,989,026	34

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

Facility Name & ID Number Community Nursing & Rehabilitation Center, LLC # 0044750 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 12D, Carried Forward		$ 5,941,105	$ 155,222		$ 241,086	$ 85,864	$ 1,989,026	1
2	1st floor elevator lobby - remove old flooring and install new								2
3	pvt tile, wallcovering	2009	2,699	270	10	270		675	3
4	1st floor corridor - corner guard, remove old and install new								4
5	wood look pvt flooring and carpet, wallcovering	2009	55,531	5,553	10	5,553		13,883	5
6	1st floor wallcovering and paint	2009	38,491	3,849	10	3,849		9,623	6
7	2nd floor shower rooms - remove existing ceramic tile, furnish								7
8	and install new ceramic tile	2009	7,067	707	10	707		1,766	8
9	1st floor resident rooms - cove base, built in double wardrobe,								9
10	remove old wallpaper and glue, paint ceilings, walls, doors								10
11	and radiators, custom built in wardrobes, cornices and								11
12	cubicle curtains	2009	159,255	15,926	10	15,926		39,815	12
13									13
14									14
15	Landmark-building façade renovation	2009	9,419	942	10	942		2,355	15
16	Satellite TV-Installation and wiring	2009	9,000	900	10	900		2,250	16
17	Architect Fees	2009	713	71	10	71		179	17
18	Sprinkler System	2009	134,000	13,400	10	13,400		33,500	18
19	Window Treatments	2009	44,355	4,436	10	4,436		11,089	19
20	Alzheimers Nurses Station Remodel	2009	18,328	1,833	10	1,833		4,582	20
21	Adjust for accounts payable invoice	2009	(23,592)						21
22									22
23	Pump Motor	2010	7,004	700	10	700		1,050	23
24	Telephone Paging System	2010	7,047	176	40	176		264	24
25	Wanderguard	2010	12,289	308	40	308		462	25
26	2nd Fllor Common Area Flooring	2010	6,860	686	10	686		1,029	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,429,571	$ 204,977		$ 290,841	$ 85,864	$ 2,111,548	34

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

Facility Name & ID Number Community Nursing & Rehabilitation Center, LLC # 0044750 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 12E, Carried Forward		$ 6,429,571	$ 204,977		$ 290,841	$ 85,864	$ 2,111,548	1
2	Compressor Replacement	2011	9,763	488	10	488		488	2
3	Sprinkler system	2011	9,933	248	20	248		248	3
4	Patio	2011	3,708	93	20	93		93	4
5	Business office thermostat	2011	5,988	599	5	599		599	5
6	Transformer	2011	13,500	338	20	338		338	6
7	Rehab corridor(Flooring, wallcovering)	2011	40,509	2,894	7	2,894		2,894	7
8	Rehab corridor(Handrails, Door & Frame)	2011	43,724	1,093	20	1,093		1,093	8
9	Nursing home (Relaminate)	2011	13,483	674	10	674		674	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	Adjust book depreciation to financial statements			(97,141)			97,141		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,570,179	$ 114,263		$ 297,268	$ 183,005	$ 2,117,975	34

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

Facility Name & ID Number Community Nursing & Rehabilitation Center, LLC # 0044750 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	$ 1,240,145	$ 20,328	$ 120,489	$ 100,161	10-40	$ 1,225,942	71
72	Current Year Purchases	145,624	14,672	10,836	(3,836)	03-07	10,836	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,385,769	$ 35,000	$ 131,325	$ 96,325		$ 1,236,778	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	GMC Truck	2011	$ 43,628	$ 4,063	$ 4,363	$ 300	5	$ 4,363	76
77	Facility	Subaru	2011	35,781	3,578	3,578		5	3,578	77
78										78
79										79
80	TOTALS			$ 79,409	$ 7,641	$ 7,941	$ 300		$ 7,941	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)	$ 8,488,979	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 156,904	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 436,534	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 279,630	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,362,694	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 Community Nursing & Rehabilitation Center, LLC # 0044750 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: 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 [X] NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

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 [X] NO

16. Rental Amount for movable equipment: $ 60,565 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	2004 Toyota Avalon	$ 619.00	$ 6,805	17
18					18
19					19
20					20
21	TOTAL		$ 619.00	$ 6,805	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.

Community Nursing & Rehabiliitation Center, LLC
Provider #: 0044750
12/31/2011 Schedule 14A

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

Description	Amount
Non-Medical Equipment	33,866
Nursing Equipment	1,596
Copiers	22,615
Water Cooler	2,179
Maintenance Equipment	309
TOTAL	60,565

Facility Name & ID Number Community Nursing & Rehabilitation Center, LLC # 0044750 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 Community Nursing & Rehabilitation Center, LLC # 0044750 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	10A(3)	hrs	$	6,848	$ 493,031	$	6,848	$ 493,031	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,249	161,929		2,249	161,929	2
3	Licensed Recreational Therapist	10A(3)	hrs							3
4	Licensed Physical Therapist		hrs		8,241	593,328		8,241	593,328	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				547,579		547,579	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					9,214		9,214	12
13	Other (specify): Dialysis Services	39(3)				142,311			142,311	13
14	TOTAL			$	17,338	$ 1,390,599	$ 556,793	17,338	$ 1,947,392	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.

Facility Name & ID Number Community Nursing & Rehabilitation Center, LLC # 0044750 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	$ 2,567	$ 22,860	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (143,964))	3,247,281	3,247,281	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	127,131	143,916	6
7	Other Prepaid Expenses	12,000	12,000	7
8	Accounts Receivable (owners or related parties)	542,036	513,207	8
9	Other(specify): See Schedule 17A	203,913	604,496	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,134,928	$ 4,543,760	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		453,622	13
14	Buildings, at Historical Cost		4,184,589	14
15	Leasehold Improvements, at Historical Cost	1,470,471	2,385,590	15
16	Equipment, at Historical Cost	1,402,361	1,465,178	16
17	Accumulated Depreciation (book methods)	(1,744,797)	(3,362,694)	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): Mortgage Costs, Net		160,862	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,128,035	$ 5,287,147	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,262,963	$ 9,830,907	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,125,018	$ 1,290,756	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	24,500	136,481	29
30	Accrued Salaries Payable	222,280	222,280	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,476	24,476	31
32	Accrued Real Estate Taxes(Sch.IX-B)		97,400	32
33	Accrued Interest Payable	2,107	36,366	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	985,269	985,269	36
37	Due To/From Insurance	215,586	215,586	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,599,236	$ 3,008,614	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	305,627	305,627	39
40	Mortgage Payable		6,797,364	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Resident Refunds	6,315	6,315	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 311,942	$ 7,109,306	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,911,178	$ 10,117,920	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,351,785	$ (287,013)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,262,963	$ 9,830,907	48

*(See instructions.)

Community Nursing & Rehabilitation Center, LLC
Provider # 0044750
1/1/11-12/31/11 Schedule 17A

Other Current Asset

Line 9	**Operating**	**After Consolidation**
NH Escrow-MIP	-	28,344
NH Escrow-Insurance	-	53,660
NH Escrow-Real Estate	-	104,783
NH Escrow-Replacement	-	213,796
NH Escrow-Due to/from Administrator	203,913	203,913
Total	203,913	604,496

Other Current Liabilities

Line 36	**Operating**	**After Consolidation**
Provider Tax Payable	110,571	110,571
Accrued Management Fees	450,000	450,000
Accrued Assessment Fee	(219)	(219)
Insurance Payable	127,131	127,131
Due to State	202,037	202,037
Resident Credit Balances	74,712	74,712
Due To/From Pine Acres Rehab	21,037	21,037
Total	985,269	985,269

Facility Name & ID Number Community Nursing & Rehabilitation Center, LLC # 0044750 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**	$ 999,650	1
2	Restatements (describe):	(133,445)	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 866,205	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,485,580	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)**	$ 1,485,580	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,351,785	24 *

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

Facility Name & ID Number Community Nursing & Rehabilitation Center, LLC # 0044750 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

	1 Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,060,194	1
2	Discounts and Allowances for all Levels	(1,724,551)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,335,643	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,375,851	6
7	Oxygen	19,189	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,395,040	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	3,298	12
13	Barber and Beauty Care	4,122	13
14	Non-Patient Meals	1,878	14
15	Telephone, Television and Radio	6,812	15
16	Rental of Facility Space		16
17	Sale of Drugs	541,894	17
18	Sale of Supplies to Non-Patients	510	18
19	Laboratory	79,281	19
20	Radiology and X-Ray	55,053	20
21	Other Medical Services	69,312	21
22	Laundry	1,664	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 763,824	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,300	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,300	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue	36,736	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 36,736	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,533,543	30

	2 Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,438,634	31
32	Health Care	4,974,512	32
33	General Administration	2,398,350	33
	B. Capital Expense		
34	Ownership	1,007,226	34
	C. Ancillary Expense		
35	Special Cost Centers	1,034,902	35
36	Provider Participation Fee	194,339	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,047,963	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,485,580	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,485,580	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.**
Provider 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 Community Nursing & Rehabilitation Center, LLC # 0044750 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	1,880	2,080	$ 97,316	$ 46.79	1
2	Assistant Director of Nursing	2,958	3,173	135,601	42.73	2
3	Registered Nurses	26,283	28,600	903,134	31.58	3
4	Licensed Practical Nurses	17,831	19,262	396,759	20.60	4
5	CNAs & Orderlies	98,085	105,051	1,325,320	12.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,001	2,160	43,557	20.17	9
10	Activity Assistants	10,526	11,311	104,050	9.20	10
11	Social Service Workers	2,834	2,997	78,722	26.27	11
12	Dietician					12
13	Food Service Supervisor	5,059	5,638	100,366	17.80	13
14	Head Cook	11,178	12,139	135,880	11.19	14
15	Cook Helpers/Assistants	13,202	13,943	128,860	9.24	15
16	Dishwashers					16
17	Maintenance Workers	3,433	3,729	63,047	16.91	17
18	Housekeepers	22,481	24,676	235,012	9.52	18
19	Laundry	4,917	5,383	49,768	9.25	19
20	Administrator	1,528	1,744	158,916	91.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,910	7,572	164,688	21.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,860	3,231	30,818	9.54	31
32	Other Health Ca SCH20A	15,040	16,182	314,330	19.42	32
33	Other(specify) Marketing	2,934	3,200	109,297	34.16	33
34	TOTAL (lines 1 - 33)	251,941	272,073	$ 4,575,441 *	$ 16.82	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	176	$ 7,490	1(3)	35
36	Medical Director	Monthly	21,600	9(3)	36
37	Medical Records Consultant	27	555	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	896	11(3)	44
45	Social Service Consultant	13	750	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	232	$ 31,291		49

C. CONTRACT NURSES

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

Community Nursing & Rehabilitation Center, LLC
Provider # 0044750
1/1/11-12/31/11

Schedule 20A

Staffing & Salary

Description	Hours Worked	Hours Paid	Amount
MDS Coordinator	3319	3499	139,839
Restorative Aides	11432	12355	165,111
Treatment Nurse	289	328	9,380
	15,040	**16,182**	**314,330**

Facility Name & ID Number Community Nursing & Rehabilitation Center, LLC # 0044750 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Larry Banks	Adminstrator	0	$ 158,916
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 158,916

B. Administrative - Other

Description	Amount
Steve Jeremias-COO	$ 375,000
Mark Weldler-CFO	375,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 750,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
McGladrey & Pullen, LLP	Accounting	$ 61,418
Polaris-IT Source Tech audit	IT Services	1,656
MDI Achieve	Computer Consultant	23,124
Innovative LTC Solutions	Computer Services	14,861
Allscripts	Data Processing	2,969
Meyer Magence	Legal	63
Paylocity	Payroll Fees	8,858
Personnel Planners	Unemployment Consultant	3,494
Career Services	HR Services	99
SAS Architecture	Architect	525
See Schedule 21A	See Schedule 21A	64,586
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 181,652

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 213,940
Unemployment Compensation Insurance	
FICA Taxes	410,306
Employee Health Insurance	189,309
Employee Meals	15,190
Illinois Municipal Retirement Fund (IMRF)*	
Flowers	496
Uniform Expense	739
Other Employee Benefits	17,966
TOTAL (agree to Schedule V, line 22, col.8)	$ 847,946

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	$ 1,990
Advertising: Employee Recruitment	1,183
Health Care Worker Background Check	
(Indicate # of checks performed 453)	5,440
Patient Background Checks 0	
IL Council LTC Dues	16,991
Recruitment Expense	10,000
Miscellaneous Dues & Subscriptions	3,007
See Schedule 21B	6,900
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 45,511

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,527
See Schedule 21C	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,527

**See instructions.

Community Nursing & Rehabilitation Center, LLC
Provider # 0044750
1/1/11-12/31/11 Schedule 21A

C. Professional Services

Vendor	Type	Amount	
Stone Pogrund & Korey	Legal	8,140	
Much Shelist	Legal	1,808	
Marliyn P Dunn	Legal	1,191	
Foote, Meyers, Mielke & Flowers	Legal	2,706	
Holland & Knight, LLP	Legal	7,232	
Ashman & Stein	Legal	4,855	
Tex Collect	Legal - Collections	2,026	
Medifax	Software Maintenance	1,016	
Singer Networks	Hardware Maintenance	32,129	
Information Controls, Inc.	Computer Services	1,514	
Ivans	Computer Services	1,217	
Vivian Mccain	Computer Services	752	
To Page 21C		64,586	
From Sch V L19 C3			181,652
	Add: Achieve Accreditation Reclass		14,260
	Add: Ivans Reclass		103
	Add: Much Shelist invoice reported on Pine Acres		314
	Less: Nonallowable legal expense		(2,712)
To Sch V L19 C8			193,617

Community Nursing & Rehabilitation Center, LLC
Provider # 0044750
1/1/11-12/31/11 Schedule 21B

Dues, Fees, Subscriptions and Promotions

Description	Amount
Dupage County Health	850
Illinois Secretary of State	250
IIT Source Tech	1,640
JCHO	3,560
Miscellaneous License	350
Real Estate Entity Allocation	250
	6,900

Community Nursing & Rehabilitation Center, LLC
Provider # 0044750
1/1/11-12/31/11 Schedule 21C

Seminar Expense

Persons Attending	Title	Date Attended	Location	Title Sponsor	Cost
Steve Jeremias	COO	11/8/2011	Skokie, IL	ICLTC	105.00
Steve Jeremias	COO	1/19/2011	Skokie, IL	IHCA	105.00
Sherri Walton Peterson	Act	5/11/2011	DeKalb, IL	NIAIP	33.00
Steve Jeremias	COO	6/16/2011	Skokie, IL	Illinois Concil on LTC	105.00
Karen Denecke	Office	7/6/2011	Skokie, IL	Illinois Concil on LTC	105.00
Myrna Speck	Office	7/6/2011	Skokie, IL	Illinois Concil on LTC	105.00
Debbie Hedlund	A/R	7/6/2011	Skokie, IL	Illinois Concil on LTC	105.00
Sheri Clayton	Office	7/6/2011	Skokie, IL	Illinois Concil on LTC	105.00
Christine Yonan	Act	7/8/2011	Rockford, IL	Comprehensive Therapeutics	195.00
Gina Wolbert	Act	7/8/2011	Rockford, IL	Comprehensive Therapeutics	
Steve Jeremias	COO	7/28/2011	Skokie, IL	Illinois Concil on LTC	105.00
Larry Banks	Admin	8/11/2011	Chicago Illinois	Polaris	99.00
Mark Weldler	CFO	8/11/2011	Chicago Illinois	Polaris	99.00
Louisa Beltran	DON	8/16/2011	In house	Polaris	159.00
Grace Hamid	Adon	8/16/2011	In house	Polaris	
Kim Bojanowski	Adon	8/16/2011	In house	Polaris	
Sherri Walton Peterson	Act	8/16/2011	In house	Polaris	
Louisa Beltran	DON	8/18/2011	Rosemeont, IL	MDI	600.00
Grace Hamid	Adon	8/18/2011	Rosemeont, IL	MDI	
Cristina Alagaban	MDS	8/18/2011	Rosemeont, IL	MDI	
Sherri Walton Peterson	Activ	8/18/2011	Rosemeont, IL	MDI	
Shannon McCain	SS	8/18/2011	Rosemeont, IL	MDI	
Lynne Croce	SS	8/18/2011	Rosemeont, IL	MDI	
Raul Gachez	Dietary	8/18/2011	Rosemeont, IL	MDI	
Kim Bojanowski	Adon	8/18/2011	Rosemeont, IL	MDI	
Larry Banks	Admin	8/18/2011	Rosemeont, IL	MDI	
Cristina Alagaban	MDS	9/7/2011	Woodridge, IL	AANAC	550.00
Sherri Walton Peterson	Act	9/8/2011	Joliet, IL	Pat Griffith	130.00
Karen Denecke	Office	9/23/2011	Oak Brook, IL	National Seminars Training	199.00
Lynne Croce	ASON	10/13/2011	Chicago, IL	Cross Country Education	159.00
Shannon McCain	SS	10/13/2011	Chicago, IL	Cross Country Education	159.00
Steve Jeremias	COO	10/28/2011	Skokie, IL	Illinois Concil on LTC	105.00
Erona Shehaj	RN	11/1/11	Joliet, IL	Wound Care Educational Institute	200.00
					3,527.00

Facility Name & ID Number Community Nursing & Rehabilitation Center, LLC # 0044750 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 Community Nursing & Rehabilitation Center, LLC # 0044750 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. **Illinois Council -LTC - $16, 991**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **3-7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,486** Line **10(2)**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **194,339**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **15,190** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,878**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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