FOR BHF USE

LL1

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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0049957

Facility Name: Claremont - Hanover Park

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/13 to 12/31/13 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) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	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	1,152	3,214	27,686	32,052	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,152	3,214	27,686	32,052	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.54%

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 1/11/11

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/11/11 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 150 and days of care provided 23,696

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: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	383,440	26,014	53,567	463,021		463,021		463,021			1
2	Food Purchase		256,861		256,861		256,861	(68)	256,793			2
3	Housekeeping	119,919	50,906		170,825		170,825		170,825			3
4	Laundry	57,962	38,711		96,673		96,673	(1,863)	94,810			4
5	Heat and Other Utilities			451,826	451,826		451,826	1,689	453,515			5
6	Maintenance	83,581	47,754	109,335	240,670		240,670	4,637	245,307			6
7	Other (specify):*											7
8	**TOTAL General Services**	644,902	420,246	614,728	1,679,876		1,679,876	4,395	1,684,271			8
	B. Health Care and Programs											
9	Medical Director			15,550	15,550		15,550		15,550			9
10	Nursing and Medical Records	3,144,616	295,384	151,958	3,591,958		3,591,958	22,208	3,614,166			10
10a	Therapy											10a
11	Activities	137,791	9,337		147,128		147,128	630	147,758			11
12	Social Services	107,516		8,936	116,452		116,452		116,452			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,389,923	304,721	176,444	3,871,088		3,871,088	22,838	3,893,926			16
	C. General Administration											
17	Administrative	185,575		828,201	1,013,776		1,013,776	(789,260)	224,516			17
18	Directors Fees											18
19	Professional Services			196,379	196,379		196,379	(47,039)	149,340			19
20	Dues, Fees, Subscriptions & Promotions			29,027	29,027		29,027	1,343	30,370			20
21	Clerical & General Office Expenses	301,606	49,836	272,726	624,168		624,168	127,467	751,635			21
22	Employee Benefits & Payroll Taxes			675,706	675,706		675,706		675,706			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,715	3,715		3,715	675	4,390			24
25	Other Admin. Staff Transportation			1,716	1,716		1,716	1,285	3,001			25
26	Insurance-Prop.Liab.Malpractice							112,256	112,256			26
27	Other (specify):* **Home Office Benefit**							32,424	32,424			27
28	**TOTAL General Administration**	487,181	49,836	2,007,470	2,544,487		2,544,487	(560,849)	1,983,638			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,522,006	774,803	2,798,642	8,095,451		8,095,451	(533,616)	7,561,835			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Claremont - Hanover Park #0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

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			92,737	92,737		92,737	593,772	686,509			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			145,140	145,140		145,140	1,119,163	1,264,303			32
33	Real Estate Taxes							145,215	145,215			33
34	Rent-Facility & Grounds			2,400,000	2,400,000		2,400,000	(2,399,697)	303			34
35	Rent-Equipment & Vehicles			110,818	110,818		110,818	3,939	114,757			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,748,695	2,748,695		2,748,695	(537,608)	2,211,087			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,007,242	2,712,406	3,719,648		3,719,648	(11,733)	3,707,915			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			128,221	128,221		128,221		128,221			42
43	Other (specify):* **Non-Allowable Cos**			454,511	454,511		454,511	(454,511)				43
44	**TOTAL Special Cost Centers**		1,007,242	3,295,138	4,302,380		4,302,380	(466,244)	3,836,136			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,522,006	1,782,045	8,842,475	15,146,526		15,146,526	(1,537,468)	13,609,058			45

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

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	(68)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,009)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(1,863)	4		8
9	Non-Straightline Depreciation	20,940	30		9
10	Interest and Other Investment Income	(104,452)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(915)	43		18
19	Entertainment	(488)	43		19
20	Contributions	(12,700)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	16,450	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(152,600)	43		24
25	Fund Raising, Advertising and Promotional	(76,697)	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	(265,298)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (579,700)		$	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)	(957,768)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (957,768)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,537,468)		37

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

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

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

Claremont - Hanover Park

ID# 0049957

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	TIF Revenue	$ (55,817)	43	1
2	X-Rays - Part A	(99,649)	43	2
3	Labs - Part A	(109,453)	43	3
4	Misc. Income	(379)	21	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				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**	(265,298)		49

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$	Church Street Station Properties, LLC	100.00%	$ 950	$ 950	1
2	V	20	Dues, Fees, Subs. & Promotions		Church Street Station Properties, LLC	100.00%			2
3	V	26	Insurance		Church Street Station Properties, LLC	100.00%	111,386	111,386	3
4	V	30	Depreciation		Church Street Station Properties, LLC	100.00%	564,542	564,542	4
5	V	32	Amortization		Church Street Station Properties, LLC	100.00%	10,801	10,801	5
6	V	32	Interest	156	Church Street Station Properties, LLC	100.00%	1,211,801	1,211,645	6
7	V	33	Real Estate Taxes		Church Street Station Properties, LLC	100.00%	71,506	71,506	7
8	V	34	Rent	2,400,000	Church Street Station Properties, LLC	100.00%		(2,400,000)	8
9	V	43	TIF Revenue		Church Street Station Properties, LLC	100.00%	55,817	55,817	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,400,156			$ 2,026,803	$ * (373,353)	14

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

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Services Corp.	70.00%	$ 1,689	$ 1,689	15
16	V	6	Repairs and Maintenance		NuCare Services Corp.	70.00%	4,638	4,638	16
17	V	10	Clinical Salaries		NuCare Services Corp.	70.00%	4,159	4,159	17
18	V	11	Activities Salaries		NuCare Services Corp.	70.00%	630	630	18
19	V	17	Management Fees	828,201	NuCare Services Corp.	70.00%	26,056	(802,145)	19
20	V	19	Professional Fees		NuCare Services Corp.	70.00%	5,078	5,078	20
21	V	20	Dues, Subscriptions		NuCare Services Corp.	70.00%	1,093	1,093	21
22	V	21	Office Expense		NuCare Services Corp.	70.00%	158,779	158,779	22
23	V	24	Education and Seminars		NuCare Services Corp.	70.00%	675	675	23
24	V	25	Other Admin Transportation		NuCare Services Corp.	70.00%	1,285	1,285	24
25	V	26	Insurance		NuCare Services Corp.	70.00%	1,120	1,120	25
26	V	27	Employee Benefits		NuCare Services Corp.	70.00%	32,424	32,424	26
27	V	30	Depreciation Expense		NuCare Services Corp.	70.00%	9,346	9,346	27
28	V	32	Interest & Amortization		NuCare Services Corp.	70.00%	1,169	1,169	28
29	V	33	Real Estate Taxes		NuCare Services Corp.	70.00%	4,192	4,192	29
30	V	34	Facility Rent		NuCare Services Corp.	70.00%	303	303	30
31	V	35	Auto Lease		NuCare Services Corp.	70.00%	2,426	2,426	31
32	V	35	Equipment Rental		NuCare Services Corp.	70.00%	1,513	1,513	32
33	V	30	Depreciation Expense		NuCare Services Corp.	70.00%	(1,056)	(1,056)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 828,201			$ 255,519	$ * (572,682)	39

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

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	39	DME and Medical Supplies	$ 101,362	Integra Healthcare Equipment	100.00%	$ 96,916	$ (4,446)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								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			$ 101,362			$ 96,916	$ * (4,446)	39

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

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	39	Respirator	$ 36,300	Integra Respiratory Service	79.93%	$ 29,013	$ (7,287)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								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			$ 36,300			$ 29,013	$ * (7,287)	39

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

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Hartman Family Trust	40	Bronzeville Park	Chicago	Nucare Services	Lincolnwood	Bookeeping Mgmt	1
2	Rajchenbach Family Trust	25.5	California Gardens Corp.	Chicago	7527 N. Lincoln Ave, L	Lincolnwood	Building Rental	2
3	David Hartman	24.5	Claremont Rehab. & Living	Buffalo Grove	Diamond Insurance	Northbrook	Work Comp Ins.	3
4	Gerald Jenich	10	Claremont - Hanover Park	Hanover Park	Mapleleaf Insurance	Grand Cayman	Liability/Work Com	4
5			Claridge Imperial, LTD.	Chicago	Seasons Hospice	Park Ridge	Hospice	5
6			Jackson Corp	Chicago	JLR Financial Svcs. C	Lincolnwood	Management Co.	6
7			Monroe Pavillion	Chicago	KFT Services, LLC	Lincolnwood	Management Co.	7
8			Renaissance at 87th Street	Chicago	Drake Louis Enterpris	Lincolnwood	Management Co.	8
9			Renaissance at Midway	Chicago	Integra Healthcare Eq	Elmhurst	DME & Med. Suppl	9
10			Renaissance at South Shore	Chicago	Lifeline Ambulance, L	Chicago	Ambulance	10
11			Renaissance Park South	Chicago				11
12			Aria Post Acute Care	Hillside				12
13			Seven Oaks	Glendale, WI	Symphony Healthcare	Morton Grove	Sub Lessor	13
14			Renaissance East	Mesa, Arizona	Symphony M.L., LLC	Morton Grove	Main Lessor	14
15			Renaissance West	Mesa, Arizona	Symphony HMG, LLC	Morton Grove	Sub Lessor	15
16			Renaissance Village IL	Mesa, Arizona	Symphony Financial S	Morton Grove	Mgmt Co.	16
17			Renaissance Village AL	Mesa, Arizona				17
18								18
19								19
20			Symphony Aspen Ridge, LLC D/B/A Symphony	Decatur				20
21			Symphony Countryside, LLC D/B/A Countrysid	Aurora				21
22			Symphony Crestwood, LLC D/B/A Symphony o	Crestwood				22
23			Symphony Deerbrook, LLC D/B/A Symphony o	Joliet				23
24			Symphony Maple Crest, LLC D/B/A Maple Cres	Belvidere				24
25			Symphony Maple Ridge, LLC D/B/A Symphony	Lincoln				25
26			Symphony McKinley, LLC D/B/A McKinley Co	Decatur				26
27			Symphony Northwoods, LLC D/B/A Northwood	Belvidere				27
28								28
29								29
30								30

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Services Corp.
Street Address: 7257 North Lincoln Avenue
City / State / Zip Code: Lincolnwood, IL 60645
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	1,205,960	13	$ 37,199		54,750	$ 1,689	1
2	6	Repairs and Maintenance	Bed days available	1,205,960	13	102,157	12,620	54,750	4,638	2
3	10	Clinical Salaries	Bed days available	1,205,960	13	91,606	91,606	54,750	4,159	3
4	11	Activities Salaries	Bed days available	1,205,960	13	13,872	13,872	54,750	630	4
5	17	Management Fees	Bed days available	1,205,960	13	573,931	573,931	54,750	26,056	5
6	19	Professional Fees	Bed days available	1,205,960	13	111,853		54,750	5,078	6
7	20	Dues, Subscriptions	Bed days available	1,205,960	13	24,065		54,750	1,093	7
8	21	Office Expense	Bed days available	1,205,960	13	3,497,400	3,139,005	54,750	158,780	8
9	24	Education and Seminars	Bed days available	1,205,960	13	14,876		54,750	675	9
10	25	Other Admin Transportation	Bed days available	1,205,960	13	28,298		54,750	1,285	10
11	26	Insurance	Bed days available	1,205,960	13	24,669		54,750	1,120	11
12	27	Employee Benefits	Bed days available	1,205,960	13	714,188		54,750	32,424	12
13	30	Depreciation Expense	Bed days available	1,205,960	13	205,852		54,750	9,346	13
14	32	Interest & Amortization	Bed days available	1,205,960	13	25,740		54,750	1,169	14
15	33	Real Estate Taxes	Bed days available	1,205,960	13	92,330		54,750	4,192	15
16	34	Facility Rent	Bed days available	1,205,960	13	6,664		54,750	303	16
17	35	Auto Lease	Bed days available	1,205,960	13	53,447		54,750	2,426	17
18	35	Equipment Rental	Bed days available	1,205,960	13	33,335		54,750	1,513	18
19	30	Depreciation Expense	Direct allocation						(1,056)	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,651,482	$ 3,831,034		$ 255,519	25

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: Integra Healthcare Equipment, LLC
Street Address: 747 Church Road
City / State / Zip Code: Elmhurst, IL 60126
Phone Number: (630) 834-3700
Fax Number: (630) 834-1500

	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	39	DME and Medical Supplies	Direct Allocation			$			$ 96,916	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 96,916	25

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: Integra Respiratory Service
Street Address: 747 Church Road
City / State / Zip Code: Elmhurst, IL 60126
Phone Number: (630) 834-3700
Fax Number: (630) 834-1500

	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	39	Respiratory	Direct Allocation			$	$		$ 29,013	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 29,013	25

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Greystone Servicing Corporation		X	Mortgage	$109,880.11		$ 18,320,600	$ 18,028,112		0.0670	$ 1,211,801	1
2	The Village of Hanover Park		X	Land	Variable	07/01/10	700,000	457,963		None		2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank and Trust Co.		X	Line of Credit	Interest Only	11/1/12	1,000,000	1,000,000	10/31/13	Variable	46,875	6
7		X								Finance Chgs	98,265	7
8												8
9	TOTAL Facility Related				$109,880.11		$ 20,020,600	$ 19,486,075			$ 1,356,941	9
	B. Non-Facility Related*											
10								Interest Income			(6,343)	10
11								Management Company Allocation			1,169	11
12								Amortization of loan costs			10,801	12
13								Offset Finance Charges			(98,265)	13
14	TOTAL Non-Facility Related						$	$			$ (92,638)	14
15	TOTALS (line 9+line14)						$ 20,020,600	$ 19,486,075			$ 1,264,303	15

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

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

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

Facility Name & ID Number Claremont - Hanover Park # 0049957 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 600,000	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.)	2012	$ 421,096	2
3. Under or (over) accrual (line 2 minus line 1).		$ (178,904)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 700,000	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.)**		$ 69,517	5
	Home Office Allocation	4,192	
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** $ 449,590 **For** 2,011 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (449,590)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 145,215	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008		8
2009		9
2010	90,714	10
2011	722,904	11
2012	421,096	12

Market Value 25,168,360 X 10%= Assessed Value 2,516,836 X State Equalization Factor 3.3 = 8,305,559

Equalized Assessed Value8,305,559X Local Tax Rate 0.0895 = 743,348. Use 700,000

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Claremont - Hanover Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049957

CONTACT PERSON REGARDING THIS REPORT Jay Flatt

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

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-36-407-021-0000	Land and Property	$ 414,067.95	$ 414,067.95
2.	06-36-309-033-0000	Land and Property	$ 7,028.44	$ 7,028.44
3.	10-27-319-028-0000	Land and Property Mgmt Co.	$ 88,815.89	$ 4,192.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 509,912.28	$ 425,288.39

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: 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	Land (Allocation)		2011	$ 1,524,000	1
2	Allocated from NuCare Services Corp.			7,264	2
3	TOTALS			$ 1,531,264	3

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocation			2011	$ 17,410,854	$	40	$ 439,469	$ 439,469	$ 1,318,407	4
5											5
6											6
7	HO Allocation - NuCare		2004		65,375		35	1,868	1,868	18,912	7
8											8
	Improvement Type**										
9	Installation of PA System and Telephone Paging System			2011	14,840		20	742	742	1,855	9
10	Fabricate and Install Syringe Disposal Cabinets to Wall			2011	10,000		20	500	500	1,250	10
11	Install and Furnish Door Control along with Back Door			2011	6,227		20	311	311	779	11
12	Boiler #1 - Fireye Flame Amplifier Module			2012	3,537		20	177	177	265	12
13	Paint 2nd Floor Hallway and 3rd floor dining room			2013	4,476		20	112	112	112	13
14	Starter for GENRAC-Install starter and rebuild starter			2013	5,112		20	128	128	128	14
15											15
16	Depreciation to tie to Financials					92,737			(92,737)		16
17											17
18											18
19											19
20											20
21	2013 Allocation from NuCare Services Corp.										21
22											22
23	Alarm System			2003	532		20	27	27	269	23
24	Buildout of Offices			2004	10,796		20	540	540	5,248	24
25	Security & Fire Alarm System			2004	5,960		20	377	377	3,189	25
26	Data Cables, Lights & Heat Exchanger			2005	640		20	32	32	283	26
27	Fire Alarm System			2005	1,299		20	65	65	617	27
28	Cooling Unit			2006	868		20	43	43	320	28
29	Asphalt & Carpet			2008	915		20	46	46	241	29
30	Landscaping, 2nd Floor Reconst. (including Phone, Sprinklers,			2009	14,729		20	736	736	3,395	30
31	Alarm Systems, Kitchen Remodel, Wallcovings, etc..)										31
32	HVAC, Paint/Wallpaper, Electrical, Sprinkler, & Generator Repair			2010	2,263		20	113	113	397	32
33	Hot Water Heater			2011	122		20	6	6	18	33
34	Paint 2nd Floor Windows			2012	136		20	7	7	12	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 17,558,681	$ 92,737		$ 445,299	$ 352,562	$ 1,355,697	70

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

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 331,577	$	$ 108,076	$ 108,076	5-10	$ 251,455	71
72	Current Year Purchases	56,724		3,633	3,633	5-10	3,633	72
73	Fully Depreciated Assets							73
74	See Schedule 13A	1,315,126		129,422	129,422		411,528	74
75	TOTALS	$ 1,703,427	$	$ 241,131	$ 241,131		$ 666,616	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	Allocated from NuCare Services Corp.			$ 396	$	$ 79	$ 79		$ 270	76
77										77
78										78
79										79
80	TOTALS			$ 396	$	$ 79	$ 79		$ 270	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 20,793,768	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 92,737	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 686,509	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 593,772	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,022,583	85	

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

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

G. Construction-in-Progress

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

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

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

Church Street Station Skilled Nursing
0049957
12/31/2013
Schedule 13A

	Category of Equipment	Cost	Current Boo Depreciation	Straight Line Depreciation	Adjustments	Component Life	Accumulated Depreciation
1	Allocated from NuCare Services Corp.	64,396		4,349	4,349	10	36,309
2	Allocated from RE Entity	1,250,730		125,073	125,073	10	375,219
	Totals	1,315,126	-	129,422	129,422	20	411,528

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Home Office Allocation				303			6
7	TOTAL				$ 303 **			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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 112,331 Description: $12,480- Copy Machine; $98,338 -Bed Rental; $1,513 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	Home Office Allocation		$	$ 2,426	17
18					18
19					19
20					20
21	TOTAL		$	$ 2,426	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	39(3)	hrs	$	13,181	$ 949,011	$	13,181	$ 949,011	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,776	199,858		2,776	199,858	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		21,117	1,520,422		21,117	1,520,422	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				985,458		985,458	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	39(3)			493	35,463		493	35,463	12
13	Other (specify): See Sch 16A	39(2)(3)				7,652	21,784		29,436	13
14	TOTAL			$	37,567	$ 2,712,406	$ 1,007,242	37,567	$ 3,719,648	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.

SPECIAL SERVICES (Ancillary Costs) - Schedule 16A

XIV. SPECIAL SERVICES (Direct Cost) Line 14

	Schedule V	Outside Practitioner		
Service	ine & Col. Re	Units	Costs	Supplies
Oxygen	39(2)			21,784
Ambulance	39(3)		7,652	
		-	**7,652**	**21,784**

STATE OF ILLINOIS

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/13 (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	$ 2,200	$ 969,318	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 197,744)	2,725,433	3,034,872	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,418	92,055	6
7	Other Prepaid Expenses	8,006	244,111	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	15,779	347,234	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,753,836	$ 4,687,590	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,531,264	13
14	Buildings, at Historical Cost		17,476,229	14
15	Leasehold Improvements, at Historical Cost	71,155	82,452	15
16	Equipment, at Historical Cost	803,690	1,703,823	16
17	Accumulated Depreciation (book methods)	(216,008)	(2,022,583)	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): See Schedule 17A		399,619	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 658,837	$ 19,170,804	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,412,673	$ 23,858,394	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 291,668	$ 291,668	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	385,206	385,206	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,541	33,541	31
32	Accrued Real Estate Taxes(Sch.IX-B)		250,410	32
33	Accrued Interest Payable	98,265	98,265	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	2,036,648	2,136,648	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,845,328	$ 3,195,738	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,000,000	1,000,000	39
40	Mortgage Payable		18,028,112	40
41	Bonds Payable		457,963	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)**	$ 1,000,000	$ 19,486,075	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,845,328	$ 22,681,813	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (432,655)	$ 1,176,581	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,412,673	$ 23,858,394	48

*(See instructions.)

Church Street Station Skilled Nursing
FYE: 12/31/13

Schedule 17A

	Operating	After Consolidation
Line 9		
Escrow - Replacement Reserve		331,455
Due from Shareholders	11,913	11,913
Due to Renaissance at Midway Expense	1,933	1,933
Due to Renaissance Park South Expense	1,933	1,933
Total to L 9	**15,779**	**347,234**
Line 23		
Closing Costs	-	14,994
Deferred Loan Costs	-	417,028
Accumulated Amortization-Closing	-	(1,125)
Accumulated Amortization-Loan Costs HUD	-	(31,278)
Total to L 23	**-**	**399,619**
Line 36		
Closing Costs		(14,994)
Deferred Loan Costs		(417,028)
Accumulated Amortization - Closing		1,125
Accumulated Amortization - Loan Costs - HUD		31,278
Accrued Interest		100,000
Accrued Accounts Payable	619,271	619,271
Professional Claims Liability	59,671	59,671
Accrued Utilities	22,456	22,456
Accrued Management Fees - Nucare	424,799	424,799
Due to NuCare Services Corp Expense	314,655	314,655
Due NuVision Holdings Expense	595,796	595,796
Total to L 36	**2,036,648**	**1,737,029**

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,898,655)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,898,653)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,465,998	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)**	$ 1,465,998	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)**	$ (432,655)	24 *

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

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,240,161	1
2	Discounts and Allowances for all Levels	(2,603,352)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,636,809	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,060,277	6
7	Oxygen	80,808	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 8,141,085	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	68	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	75	16
17	Sale of Drugs	2,211,613	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	189,784	19
20	Radiology and X-Ray	150,191	20
21	Other Medical Services	234,527	21
22	Laundry	1,863	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,788,121	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,187	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,187	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income,Jury Duty & Prior Year Adjustment	40,322	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 40,322	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,612,524	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,679,876	31
32	Health Care	3,871,088	32
33	General Administration	2,544,487	33
	B. Capital Expense		
34	Ownership	2,748,695	34
	C. Ancillary Expense		
35	Special Cost Centers	4,174,159	35
36	Provider Participation Fee	128,221	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,146,526	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,465,998	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,465,998	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 83,461	44
45	Private Pay - Net Inpatient Revenue	841,974	45
46	Medicare - Net Inpatient Revenue	4,203,271	46
47	Other-(specify) Managed Care	499,114	47
48	Other-(specify) Hospice	8,989	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,636,809	49

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

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

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

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

^ - Entity is a cash basis taxpayer.

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	1,793	2,166	$ 101,449	$ 46.84	1
2	Assistant Director of Nursing	2,534	3,033	108,946	35.92	2
3	Registered Nurses	40,850	43,626	1,284,003	29.43	3
4	Licensed Practical Nurses	21,356	23,175	557,161	24.04	4
5	CNAs & Orderlies	58,748	62,148	772,944	12.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,271	3,364	41,005	12.19	8
9	Activity Director	2,974	3,222	78,369	24.32	9
10	Activity Assistants	5,737	6,058	59,422	9.81	10
11	Social Service Workers	3,542	3,856	107,516	27.88	11
12	Dietician	2,718	3,121	93,050	29.81	12
13	Food Service Supervisor					13
14	Head Cook	7,128	7,505	138,544	18.46	14
15	Cook Helpers/Assistants	15,509	16,190	151,846	9.38	15
16	Dishwashers					16
17	Maintenance Workers	5,851	6,423	83,581	13.01	17
18	Housekeepers	11,459	12,214	119,919	9.82	18
19	Laundry	5,412	5,772	57,962	10.04	19
20	Administrator	2,120	2,240	143,303	63.97	20
21	Assistant Administrator	1,981	2,166	55,157	25.46	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,209	20,990	270,672	12.90	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	834	880	28,064	31.89	31
32	Other Health C: Care Plan Coord.	5,983	6,561	206,678	31.50	32
33	Other(specify) Skin Care Speciali	2,392	2,596	62,415	24.04	33
34	TOTAL (lines 1 - 33)	221,401	237,306	$ 4,522,006 *	$ 19.06	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	602	$ 28,300	1(3)	35
36	Medical Director	104	15,550	9(3)	36
37	Medical Records Consultant	163	24,475	10(3)	37
38	Nurse Consultant	25	1,325	10(3)	38
39	Pharmacist Consultant	Monthly	8,686	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	894	$ 78,336		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	958	$ 49,073	10(3)	50
51	Licensed Practical Nurses	1,058	46,751	10(3)	51
52	Certified Nurse Assistants/Aides	827	18,698	10(3)	52
53	TOTAL (lines 50 - 52)	2,843	$ 114,522		53

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lisa Ulm	Administrator	0	$ 130,418
Lisa Williams	Asst. Administrator	0	55,157
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 185,575

B. Administrative - Other

Description	Amount
General and Administrative - Management Service	$ 828,201
(Eliminated on Sch. V, Col. 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 828,201
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
McGladrey LLP	Accounting	$ 30,377
Ability Network, Inc.	Computer Consulting	96
Business Card	Computer Consulting	862
CDW Government	Computer Consulting	159
EFAX Corporate	Computer Consulting	5,421
E-Health Data Solutions	Computer Consulting	4,545
HDSI Health Data System	Computer Consulting	4,049
IT'S NEVER2 LATE	Computer Consulting	2,125
IVANS, INC.	Computer Consulting	1,100
Maren Schwartz	Computer Consulting	334
MDI ACHIEVE, INC	Computer Consulting	7,826
See Sch. 21C	See Sch. 21C	139,485
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 196,379

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 165,513
Unemployment Compensation Insurance	74,879
FICA Taxes	344,183
Employee Health Insurance	66,645
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	17,946
Employee Retirement	6,136
Employee Uniforms	404
TOTAL (agree to Schedule V, line 22, col.8)	$ 675,706

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	50
Health Care Worker Background Check	3,248
(Indicate # of checks performed 310)	
Patient Background Checks 310	3,248
Miscellaneous Licenses & Fees	16,216
Miscellaneous Dues & Subscriptions	1,690
Newspaper Subscription	2,585
Allocated from Real Estate Entity	250
Allocated from NuCare Services Corp.	1,093
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,370

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,715
Allocated from NuCare Services Corp.	675
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,390

**See instructions.

Church Street Station Skilled Nursing
FYE: 12/31/13

Schedule 21C

MEDIFAX	Computer Consulting	1,429
Providence Management & Development	Computer Consulting	11,714
Providigm LLC	Computer Consulting	899
PSD Soulutions	Computer Consulting	2,105
Transworld Systems	Computer Consulting	575
Computer Services Accrual	Computer Consulting	10,000
AVENUE WEB MEDIA	Internet Expenses	30
COMCAST CABLE	Internet Expenses	2,814
Illinois Health Information Exchange	Internet Expenses	240
Officite Business Card	Internet Expenses	7,161
PAETEC	Internet Expenses	11,760
Tik Tek IT Soultions	Internet Expenses	168
Personal Planners, Inc	UC Tax Consulting	1,425
ACHIEVE ACCREDITATION	JCAHO Consultation	10,916
Risk Management Services LLC	Risk Managemnet	2,500
Service Trac Inc.	Sales Consulting	243
Suburban Lung Associates	General Consulting	9
PINNACLE QUALITY INSIGHT	QA Consulting	1,950
Professional Fees Accrual	Accrual	5,000
Much Shelist	Legal	549
Legal Cash	Legal	(14,150)
Stone, McGuire & Siegel	Legal	13,512
Allen A. Lefkovitz & Associates	Legal	69,517
Ashman & Stein	Legal	1,419
Legal Accrual	Legal	(2,300)
Subtotal		139,485
Total Line 19 Col 3		196,379
Out of period legal/Accruals		1,447
Reclass legal to real estate taxes		(69,517)
Allocated from NuCare Management	Accounting	5,078
		5,078

Church Street Station Properties	Accounting	950
Total Line 19 Col 8		134,337

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3											N/A		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Claremont - Hanover Park # 0049957 Report Period Beginning: 01/01/13 Ending: 12/31/13

XX. GENERAL INFORMATION:

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

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

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **225** 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. $ **128,221**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **68**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.