		FOR BHF USE					

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

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 Nrsg & Rehab Ctr

Address: 1136 North Mill St (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: 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 Community Nrsg & Rehab Ctr # 0044750 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	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	28,423	4,875	10,368	43,666	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,423	4,875	10,368	43,666	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.19%

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 8,871

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 Community Nrsg & Rehab Ctr # 0044750 **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				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	455,460	77,801		533,261		533,261		533,261			1
2	Food Purchase		269,954		269,954		269,954	(21,944)	248,010			2
3	Housekeeping	196,689	12,596		209,285		209,285		209,285			3
4	Laundry	87,597	19,064		106,661		106,661		106,661			4
5	Heat and Other Utilities			213,004	213,004		213,004		213,004			5
6	Maintenance	70,071	50,144	92,590	212,805		212,805		212,805			6
7	Other (specify):*											7
8	**TOTAL General Services**	809,817	429,559	305,594	1,544,970		1,544,970	(21,944)	1,523,026			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	3,205,801	263,176	78,191	3,547,168		3,547,168	1,020	3,548,188			10
10a	Therapy											10a
11	Activities	147,093	3,925	4,321	155,339		155,339		155,339			11
12	Social Services	164,984		732	165,716		165,716		165,716			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,517,878	267,101	104,844	3,889,823		3,889,823	1,020	3,890,843			16
	C. General Administration											
17	Administrative	174,967		360,000	534,967		534,967		534,967			17
18	Directors Fees											18
19	Professional Services			169,591	169,591		169,591	9,033	178,624			19
20	Dues, Fees, Subscriptions & Promotions			47,192	47,192		47,192	(4,880)	42,312			20
21	Clerical & General Office Expenses	196,154	27,250	110,595	333,999		333,999	(26,788)	307,211			21
22	Employee Benefits & Payroll Taxes			923,130	923,130		923,130	15,813	938,943			22
23	Inservice Training & Education			758	758		758		758			23
24	Travel and Seminar			6,376	6,376		6,376	(2,001)	4,375			24
25	Other Admin. Staff Transportation			16,676	16,676		16,676		16,676			25
26	Insurance-Prop.Liab.Malpractice			149,301	149,301		149,301	14,948	164,249			26
27	Other (specify):*											27
28	**TOTAL General Administration**	371,121	27,250	1,783,619	2,181,990		2,181,990	6,125	2,188,115			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,698,816	723,910	2,194,057	7,616,783		7,616,783	(14,799)	7,601,984			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 Nrsg & Rehab Ctr #0044750 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			156,943	156,943		156,943	199,907	356,850			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,943	2,943		2,943	343,806	346,749			32
33	Real Estate Taxes							99,323	99,323			33
34	Rent-Facility & Grounds			738,025	738,025		738,025	(738,025)				34
35	Rent-Equipment & Vehicles			84,312	84,312		84,312		84,312			35
36	Other (specify):* Mortgage Insurance							33,614	33,614			36
37	**TOTAL Ownership**			982,223	982,223		982,223	(61,375)	920,848			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	6,926	644,531	1,410,753	2,062,210		2,062,210		2,062,210			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			293,195	293,195		293,195		293,195			42
43	Other (specify):* Non-Allowable Cos	51,385		404,236	455,621		455,621	(455,621)				43
44	**TOTAL Special Cost Centers**	58,311	644,531	2,108,184	2,811,026		2,811,026	(455,621)	2,355,405			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,757,127	1,368,441	5,284,464	11,410,032		11,410,032	(531,795)	10,878,237			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 Nrsg & Rehab Ctr # 0044750 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,184)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,182)	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	53,079	30		9
10	Interest and Other Investment Income	(56,732)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(630)	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	(24,268)	43		18
19	Entertainment				19
20	Contributions	(500)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,867)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(240,000)	43		24
25	Fund Raising, Advertising and Promotional	(67,884)	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	(145,403)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (499,571)		$	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)	(32,224)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (32,224)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (531,795)		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 Nrsg & Rehab Ctr

ID# 0044750

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (6,592)	43	1
2	Café Income	(4,947)	2	2
3	NH X Ray	(103,470)	43	3
4	Miscellaneous Income	(10,986)	21	4
5	Cable TV	(12,277)	43	5
6	Chamber of Commerce	(795)	20	6
7	Non-Allowable Lobbying Expense	(4,335)	20	7
8	Travel & Seminar	(2,001)	24	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**	(145,403)		49

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 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
Mark Weldler	29.50	Pine Acres Rehab & Living Center, LLC	DeKalb	Community Nursing	Naperville	
Steve Jeremias	29.50			& Rehab Realty,LLC		Real Estate
Malka Mermelstein	.50	The Springs at Crystal Lake, LLC	Crystal Lake			
Herman Mermelstein Decl of Trust 27-610789	.50			Pine Acres Realty, LL	DeKalb	Real Estate
Estate of Hirsch Wolf	40					
				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			$			$	$	1
2	V	19	Acctg & Professional Fees		Community Nursing & Rehab Realty, LLC		10,300	10,300	2
3	V	26	Insurance		Community Nursing & Rehab Realty, LLC		48,562	48,562	3
4	V	30	Depreciation		Community Nursing & Rehab Realty, LLC		146,828	146,828	4
5	V	32	Interest	110	Community Nursing & Rehab Realty, LLC		400,648	400,538	5
6	V	33	Real Estate Tax		Community Nursing & Rehab Realty, LLC		99,323	99,323	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								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 738,135			$ 705,911	$ * (32,224)	14

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

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Steve Jeremias	COO	Administrative	29.50	See SCH 7A	35	70.00	Guar Pymnts	180,000	L17, C3	1
2	Mark Weldler	CFO	Finance	29.50	See SCH 7A	35	70.00	Guar Pymnts	180,000	L17, C3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 360,000		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 Nrsg & Rehab Ctr # 0044750 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 [ ] 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				N/A		$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 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	Chase - Subaru Motors		X	Facility Vehicle	$633.16	03/3/11	$ 35,281	$ 16,484	03/3/16	0.0290	$ 589	1
2	Ally Vehicle Finance		X	Facility Vehicle	$789.28	10/1/11	43,628	24,847	10/1/16	0.0324	955	2
3	Cambridge Reality		X	Mortgage	$43,339.00	03/20/08	7,267,500	6,678,531	02/20/48	0.0595	400,648	3
4	Marlin - Dish Machine & Booster		X	Facility Equipment	$247.10	04/15/11	13,954	7,897	04/15/16	0.0625	575	4
5												5
	Working Capital											
6	Lake Forest Bank		X	Working Capital	Varies	9/15/11	1,000,000		9/1/12	0.0550	824	6
7												7
8												8
9	TOTAL Facility Related				$45,008.54		$ 8,360,363	$ 6,727,759			$ 403,591	9
	B. Non-Facility Related*											
10								Less: Interest Income Offset			(56,842)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (56,842)	14
15	TOTALS (line 9+line14)						$ 8,360,363	$ 6,727,759			$ 346,749	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 33,614 **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 Nrsg & Rehab Ctr # 0044750 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.**	$ 104,900	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2012	$ 101,323	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,577)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 102,900	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.		$ 99,323	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	111,973	8
	2009	92,745	9
	2010	95,046	10
	2011	99,814	11
	2012	101,323	12

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

	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 Community Nrsg & Rehab Ctr 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 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.	07-12-403-042	Nursing Home	$ 101,323.00	$ 101,323.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 101,323.00	$ 101,323.00

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 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 Community Nrsg & Rehab Ctr # 0044750 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Nrsg & Rehab Ctr # 0044750 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	153		2000	1986	$ 4,184,589	$	40	$ 104,615	$ 104,615	$ 1,438,462	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CABLE			2000	4,305	108	40	108		1,485	9
10	ELEVATOR DOOR			2000	4,389	110	40	110		1,503	10
11	PARKING LOT			2000	38,200	955	40	955		13,052	11
12	LANDSCAPING			2000	8,736	218	40	218		2,961	12
13	SIGN			2000	4,541	114	40	114		1,548	13
14	ARCHITECT FEES			2000	3,060	77	40	77		1,056	14
15	DOOR LOCK			2000	2,248	56	40	56		761	15
16	CLOSETS			2000	7,729	193	40	193		2,589	16
17	COVE BASE			2000	4,459	111	40	111		1,471	17
18	HANDRAILS AND KICKPLATES			2000	15,146	379	40	379		5,022	18
19	LIGHTING			2000	65,796	1,645	40	1,645		21,796	19
20	TILE			2000	2,317	58	40	58		768	20
21	FLOORING			2000	16,378	409	40	409		5,370	21
22	EXIT DOORS			2000	1,598	40	40	40		530	22
23	WINDOW AND CUBICLE TREATMENTS			2000	34,021	851	40	851		11,276	23
24	LIGHTING			2000	1,729	43	40	43		570	24
25	CARPETING			2000	27,139	678	40	678		8,984	25
26	FIRE PANEL			2000	4,500	113	40	113		1,497	26
27	NURSE'S STATION			2000	8,913	223	40	223		2,936	27
28	DOOR HANDLES			2000	1,644	41	40	41		540	28
29	CUBICLE TRACK			2000	915	23	40	23		301	29
30	MOTOR			2000	13,276	332	40	332		4,482	30
31	STOVE HOODS			2000	1,429	36	40	36		471	31
32	COVER BASE - RESIDENTS' ROOMS			2001	865		10			865	32
33	CERAMIC TILES			2001	10,930		10			10,930	33
34	CEILING & LIGHTING			2001	9,063		10			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 Nrsg & Rehab Ctr # 0044750 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	RENOVATIONS - THERAPY ROOM	2001	$ 10,558	$	10	$	$	$ 10,558	37
38	TILE & COVE BASE - BASEMENT	2001	2,327		10			2,327	38
39	SHAMPOO STATION	2001	5,431		10			5,431	39
40	COVE BASE - SECOND FLOOR	2001	1,699		10			1,699	40
41	WALLPAPER/COVEBASE/CARPETING/LIGHTING	2001	1,403		10			1,403	41
42	ABS PUMP	2001	11,908		10			11,908	42
43	CARPETING	2001	14,572		10			14,572	43
44	FLOORING	2001	1,320		10			1,320	44
45	2ND FLOOR RENOVATIONS	2001	38,875		10			38,875	45
46	AVERY	2001	2,419		10			2,419	46
47	KITCHEN - COOLING AIR UNIT	2001	2,275		10			2,275	47
48	WALLCOVERINGS	2001	12,289		10			12,289	48
49	SIGNAGE/ELECTRIC BALLAST (ADMISSIONS OFFICE)	2001	3,131		10			3,131	49
50	ROOM CURTAIN DIVIDER	2001	2,003		10			2,003	50
51	HANDRAILS & BUMPER GUARDS	2001	17,855		10			17,855	51
52	FIRE ALARM TRANSFORMER	2001	1,715		10			1,715	52
53	TEMP CONTROL ON AIR HANDLER	2001	9,519		10			9,519	53
54	COVEBASE/LANDSCAPING/LIGHTING/FLOORING	2001	2,642		10			2,642	54
55	LIGHTING - CORRIDORS & RESIDENT ROOMS	2001	20,544		10			20,544	55
56	NEW BEARING & SHAFT	2001	1,402		10			1,402	56
57	DIALYSIS ROOM RENOVATIONS	2001	23,351		10			23,351	57
58	ASPHALT SEALCOATING & STRIPING	2001	1,405		10			1,405	58
59	KITCHEN TILE	2001	930		10			930	59
60	SEPTIC TANK PUMPS	2001	13,862		10			13,862	60
61	CARPETING	2001	5,729		10			5,729	61
62	PAINTING & WALLPAPER	2001	20,440		10			20,440	62
63	PAINTING & WALLPAPER	2001	11,875		10			11,875	63
64	PAINTING & WALLPAPER	2001	4,500		10			4,500	64
65	NEW DOORS	2002	1,731		10			1,731	65
66	MURAL FOR SECOND FLOOR DINING ROOM	2002	7,000		10			7,000	66
67	NEW TROUGH IN LAUNDRY ROOM	2002	6,300		10			6,300	67
68	WINDOW MOLDINGS	2002	210		10			210	68
69	NEW THRESHHOLDS	2002	205		10			205	69
70	TOTAL (lines 4 thru 69)		$ 4,739,340	$ 6,813		$ 111,428	$ 104,615	$ 1,811,714	70

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

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 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	
1	Totals from Page 12A, Carried Forward		$ 4,739,340	$ 6,813		$ 111,428	$ 104,615	$ 1,811,714	1
2	NEW PVC PIPING IN KITCHEN	2002	1,320		10			1,320	2
3	UPGRADE BACKFLOW SYSTEM	2002	1,695		10			1,695	3
4	ALARM FOR RAMP EXIT	2002	1,443		10			1,443	4
5	FLOORING IN ELEVATOR	2002	856		10			856	5
6	CORNER GUARDS/WATER SOFTENER	2002	1,328		10			1,328	6
7	NEW DRAINAGE PIPES - DISPOSAL	2002	9,985		10			9,985	7
8	CORNER GUARDS	2003	276		10			276	8
9	UPGRADE DIALYSIS ROOM	2003	28,103	3	10	3		28,103	9
10	NEW AWNINGS FOR PATIO	2003	3,940		10			3,940	10
11	INSTALL GREASE TRAP IN KITCHEN	2003	3,250		10			3,250	11
12	NEW COIL FOR AIR HANDLER	2003	3,493	3	10	3		3,493	12
13	INSTALL LASER EYE ON ELEVATOR	2003	1,590		10			1,590	13
14	UPGRADE DIALYSIS ROOM	2004	30,778	3,076	10	3,076		30,778	14
15	NEW ROOF	2004	8,600	860	10	860		8,600	15
16	REMODEL VESTIBULE, NEW FLOORING	2004	10,044	1,004	10	1,004		10,040	16
17	INSTALL NEW SMOKE DETECTORS	2004	4,911	491	10	491		4,910	17
18	NEW OXYGEN ROOM	2004	5,688	567	10	567		5,688	18
19	NEW ELEVATOR TANK, PUMP AND MOTOR	2004	11,960	1,196	10	1,196		11,960	19
20	ROOF REPLACEMENT	2005	5,800	580	10	580		4,930	20
21	WIRE GLASS FOR RECEPTION WINDOW	2005	1,348	135	10	135		1,150	21
22	NEW CEMENT WALKWAYS	2005	2,400	240	10	240		2,040	22
23	NEW WALL HUNG SINK	2006	3,410	341	10	341		2,386	23
24	MOTOR FOR A/C	2006	664	66	10	66		462	24
25	NEW PUMP SYSTEM	2006	5,108	511	10	511		3,576	25
26	NEW HOT WATER HEATER	2006	7,998	800	10	800		5,600	26
27	SOLID STATE STARTER	2006	3,900	390	10	390		2,730	27
28	PUMP	2006	1,553	155	10	155		1,084	28
29	NEW FIRE ALARM	2006	6,800	680	10	680		4,760	29
30	NEW PUMP FOR BASEMENT A/C	2006	988	99	10	99		692	30
31	PAVE PARKING LOT	2006	3,500	350	10	350		2,450	31
32	NEW TIME CLOCK	2006	4,345	435	10	435		3,044	32
33	REPLACE HVAC ROOF TOP UNIT	2007	3,511	351	10	351		2,282	33
34	TOTAL (lines 1 thru 33)		$ 4,919,925	$ 19,146		$ 123,761	$ 104,615	$ 1,978,155	34

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

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 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	
1	Totals from Page 12B, Carried Forward		$ 4,919,925	$ 19,146		$ 123,761	$ 104,615	$ 1,978,155	1
2	BALANCE OF TIME CLOCK	2007	4,345	434	10	434		2,821	2
3	HOT WATER HEATER	2007	9,212	921	10	921		5,987	3
4	SECURITY CAMERAS	2008	5,458	546	10	546		3,003	4
5	RELOCATE GAS LINE	2008	21,900	2,190	10	2,190		12,045	5
6	FRONT & BACK LANDSCAPING	2008	33,000	3,300	10	3,300		18,150	6
7									7
8	Architect Services	2009	29,257	2,926	10	2,926		13,166	8
9	Roof	2009	230,100	23,010	10	23,010		103,545	9
10	Construction Period Interest	2009	32,240	3,224	10	3,224		14,508	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		10,146	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		14,400	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		9,199	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		19,743	20
21	Basement corridor - cove base, flooring, paint doors & frames,								21
22	wallpaper purchase & installation	2009	46,436	4,644	10	4,644		20,897	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		13,716	26
27	Foyer - remove old flooring, install new ceramic flooring &								27
28	pedimat, wallcovering	2009	12,181	1,218	10	1,218		5,481	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		15,618	33
34	TOTAL (lines 1 thru 33)		$ 5,528,105	$ 79,964		$ 184,579	$ 104,615	$ 2,260,581	34

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

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 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	
1	Totals from Page 12C, Carried Forward		$ 5,528,105	$ 79,964		$ 184,579	$ 104,615	$ 2,260,581	1
2	Building Facade & Renovation								2
3	- General requirements	2009	19,795	1,981	10	1,981		8,911	3
4	- Permits	2009	5,000	500	10	500		2,250	4
5	- Excavation and site demolition	2009	22,626	2,263	10	2,263		10,182	5
6	- Asphalt Patching	2009	5,928	593	10	593		2,668	6
7	- Mansard and patio canopy demolition	2009	9,300	930	10	930		4,185	7
8	- Concrete work	2009	23,807	2,381	10	2,381		10,713	8
9	- Brick pavers	2009	13,440	1,344	10	1,344		6,048	9
10	- Masonry columns & Screen wall	2009	16,190	1,619	10	1,619		7,286	10
11	- Steel	2009	9,700	970	10	970		4,365	11
12	- Wood fencing	2009	1,580	158	10	158		711	12
13	- Pylon Sign	2009	8,000	800	10	800		3,600	13
14	- Room framing and sheathing	2009	81,769	8,177	10	8,177		36,796	14
15	- Cut and patch existing roofing for new construction	2009	17,310	1,731	10	1,731		7,790	15
16	- Roofing and sheetmetal	2009	40,835	4,084	10	4,084		18,377	16
17	- Electrical	2009	4,150	415	10	415		1,868	17
18	- Dry fire sprinkler system	2009	7,000	700	10	700		3,150	18
19	- Duct demolition	2009	2,160	216	10	216		972	19
20	- Homosote sheathing	2009	7,549	755	10	755		3,397	20
21	- Eifs	2009	13,350	1,335	10	1,335		6,008	21
22	- Fypon Moldings	2009	6,790	679	10	679		3,056	22
23	- Painting	2009	3,400	340	10	340		1,530	23
24	- Main extrance roof tower	2009	47,588	4,759	10	4,759		21,415	24
25	- Asphalt sidewalk on north side of bldg	2009	4,920	492	10	492		2,214	25
26	- Landscaping	2009	18,000	1,800	10	1,800		8,100	26
27	- Landscape demo	2009	5,566	557	10	557		2,505	27
28	- Insurance	2009	3,562	357	10	357		1,604	28
29	- General contractor fee	2009	13,685	1,369	10	1,369		6,159	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,941,105	$ 121,269		$ 225,884	$ 104,615	$ 2,446,441	34

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

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 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	
1	Totals from Page 12D, Carried Forward		$ 5,941,105	$ 121,269		$ 225,884	$ 104,615	$ 2,446,441	1
2	1st floor elevator lobby - remove old flooring and install new								2
3	pvt tile, wallcovering	2009	2,699	270	10	270		1,214	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		24,989	5
6	1st floor wallcovering and paint	2009	38,491	3,849	10	3,849		17,321	6
7	2nd floor shower rooms - remove existing ceramic tile, furnish								7
8	and install new ceramic tile	2009	7,067	707	10	707		3,180	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		71,667	12
13									13
14									14
15	Landmark-building façade renovation	2009	9,419	942	10	942		4,239	15
16	Satellite TV-Installation and wiring	2009	9,000	900	10	900		4,050	16
17	Architect Fees	2009	713	71	10	71		321	17
18	Sprinkler System	2009	134,000	13,400	10	13,400		60,300	18
19	Window Treatments	2009	44,355	4,436	10	4,436		19,961	19
20	Alzheimers Nurses Station Remodel	2009	18,328	1,833	10	1,833		8,248	20
21	Adjust for accounts payable invoice	2009	(23,592)						21
22									22
23	Pump Motor	2010	7,004	700	10	700		2,450	23
24	Telephone Paging System	2010	7,047	176	40	176		616	24
25	Wanderguard	2010	12,289	308	40	308		1,078	25
26	2nd Floor Common Area Flooring	2010	6,860	686	10	686		2,401	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,429,571	$ 171,026		$ 275,641	$ 104,615	$ 2,668,475	34

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

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 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	
1	Totals from Page 12E, Carried Forward		$ 6,429,571	$ 171,026		$ 275,641	$ 104,615	$ 2,668,475	1
2	Compressor Replacement	2011	9,763	976	10	976		2,440	2
3	Sprinkler system	2011	9,933	497	20	497		1,242	3
4	Patio	2011	3,708	185	20	185		463	4
5	Business office thermostat	2011	5,988	1,198	5	1,198		2,995	5
6	Transformer	2011	13,500	675	20	675		1,688	6
7	Rehab corridor(Flooring, wallcovering)	2011	40,509	5,787	7	5,787		14,468	7
8	Rehab corridor(Handrails, Door & Frame)	2011	43,724	2,186	20	2,186		5,465	8
9	Nursing home (Relaminate)	2011	13,483	1,348	10	1,348		3,370	9
10									10
11	3 Broan fans, sheet metal work - Entire Facility	2012	4,300	430	10	430		645	11
12	Roof Chiller - Roof of Main Building	2012	4,455	446	10	446		669	12
13	Automatic Door - Homeward Bound Unit	2012	4,200	420	10	420		630	13
14									14
15	Resurface parking lot	2013	8,033	402	10	402		402	15
16	Condensor fan & water heater	2013	5,932	297	10	297		297	16
17	Rod floor drains, install new drains	2013	3,000	150	10	150		150	17
18	Replace door	2013	3,000	150	10	150		150	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			(96,971)			96,971		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,603,099	$ 89,200		$ 290,786	$ 201,586	$ 2,703,549	34

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

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 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	$ 414,252	$ 50,712	$ 49,033	$ (1,679)	3-40	$ 344,520	71
72	Current Year Purchases	14,992	1,499	1,499		10	1,499	72
73	Fully Depreciated Assets	990,049					990,049	73
74								74
75	TOTALS	$ 1,419,293	$ 52,211	$ 50,532	$ (1,679)		$ 1,336,068	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	$ 8,976	$ 8,976	$	5	$ 22,065	76
77	Facility	Subaru	2011	32,781	6,556	6,556		5	16,690	77
78										78
79										79
80	TOTALS			$ 76,409	$ 15,532	$ 15,532	$		$ 38,755	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)	$ 8,552,423	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 156,943	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 356,850	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 199,907	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,078,372	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	Construction in Progress	$ 6,884	92
93			93
94			94
95		$ 6,884	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 Nrsg & Rehab Ctr # 0044750 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 [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.	/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: $ 81,256 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	2009 Toyota Avalon	$	$ 3,056	17
18					18
19					19
20					20
21	TOTAL		$	$ 3,056	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
12/31/2013

Schedule 14A

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

Description	Amount
Non-Medical Equipment	15,904
Copiers	28,360
Water Cooler	1,885
Maintenance Equipment	35,107
TOTAL	81,256

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 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 Community Nrsg & Rehab Ctr # 0044750 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	$	7,447	$ 536,169	$	7,447	$ 536,169	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,608	187,775		2,608	187,775	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		7,773	559,667		7,773	559,667	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				631,409		631,409	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Resp Therapy/Oxygen	39(1)(2)	279	6,926			13,122	279	20,048	12
13	Other (specify): Dialysis Services	39(3)				127,142			127,142	13
14	TOTAL			$ 6,926	17,828	$ 1,410,753	$ 644,531	18,107	$ 2,062,210	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 Nrsg & Rehab Ctr **#** 0044750 **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	$ 200	$ 200	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 373,452)	2,737,466	2,737,466	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	216,435	231,347	6
7	Other Prepaid Expenses		25,919	7
8	Accounts Receivable (owners or related parties)	507,677	452,929	8
9	Other(specify): See Schedule 17A	227,905	615,753	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,689,683	$ 4,063,614	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	1,503,391	2,418,510	15
16	Equipment, at Historical Cost	464,872	1,495,702	16
17	Accumulated Depreciation (book methods)	(1,081,285)	(4,078,372)	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 (spe CIP	6,884	6,884	22
23	Other(specify): Mortgage Costs, Net		151,548	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 893,862	$ 4,632,483	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,583,545	$ 8,696,097	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,101,534	$ 1,114,308	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	18,555	144,652	29
30	Accrued Salaries Payable	80,458	80,458	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,892	10,892	31
32	Accrued Real Estate Taxes(Sch.IX-B)		102,900	32
33	Accrued Interest Payable	80	33,194	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,068,722	1,068,722	36
37	Due To/From Insurance	12,596	12,596	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,292,837	$ 2,567,722	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	30,673	30,673	39
40	Mortgage Payable		6,552,434	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 30,673	$ 6,583,107	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,323,510	$ 9,150,829	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,260,035	$ (454,732)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,583,545	$ 8,696,097	48

***(See instructions.)**

Community Nursing & Rehabilitation Center, LLC
Provider # 0044750
1/1/13-12/31/13

Schedule 17A

Other Current Asset

Line 9	**Operating**	**After Consolidation**
NH Escrow-MIP		33,495
NH Escrow-Insurance		44,486
NH Escrow-Real Estate		145,086
NH Escrow-Replacement		164,781
NH Escrow-Due to/from AdminiStar	225,127	225,127
Resident Refund	2,778	2,778
Total	227,905	615,753

Other Current Liabilities

Line 36	**Operating**	**After Consolidation**
Accrued Management Fees	(270,000)	(270,000)
Accrued Assessment Fee	(52,267)	(52,267)
Insurance Payable	(202,667)	(202,667)
Due to State	(254,659)	(254,659)
Resident Credit Balances	(27,244)	(27,244)
Due To/From BC-BS	(341,044)	(341,044)
Due To/From Hospice	(26,665)	(26,665)
Due To/From Pine Acres	85,890	85,890
Due To/From The Springs	19,934	19,934
Total	(1,068,722)	(1,068,722)

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 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**	$ 2,288,724	1	
2	Restatements (describe):		2	
3	**Prior Period Adjustment**	(50,002)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,238,722	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	21,313	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)**	$ 21,313	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)**	$ 2,260,035	24	*

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

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 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	$ 9,648,698	1
2	Discounts and Allowances for all Levels	(1,963,783)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,684,915	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,785,580	6
7	Oxygen	10,855	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,796,435	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	4,947	12
13	Barber and Beauty Care	4,842	13
14	Non-Patient Meals	1,184	14
15	Telephone, Television and Radio	7,182	15
16	Rental of Facility Space		16
17	Sale of Drugs	599,786	17
18	Sale of Supplies to Non-Patients	5,480	18
19	Laboratory	146,555	19
20	Radiology and X-Ray	103,110	20
21	Other Medical Services	5,070	21
22	Laundry	4,011	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 882,167	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	56,842	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 56,842	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue (Misc Income)	10,986	28
28a	Medical Supplies		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,986	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,431,345	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,544,970	31
32	Health Care	3,889,823	32
33	General Administration	2,181,990	33
	B. Capital Expense		
34	Ownership	982,223	34
	C. Ancillary Expense		
35	Special Cost Centers	2,517,831	35
36	Provider Participation Fee	293,195	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,410,032	40
41	**Income before Income Taxes (line 30 minus line 40)****	21,313	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 21,313	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,774,263	44
45	Private Pay - Net Inpatient Revenue	1,997,688	45
46	Medicare - Net Inpatient Revenue	1,123,903	46
47	Other-(specify) Managed Care	131,240	47
48	Other-(specify) Hospice	657,821	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,684,915	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.**

^ - Provider is a cash basis taxpayer.

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 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	1,781	2,062	$ 90,236	$ 43.76	1
2	Assistant Director of Nursing	653	701	27,988	39.93	2
3	Registered Nurses	25,486	26,822	876,752	32.69	3
4	Licensed Practical Nurses	16,139	17,094	308,030	18.02	4
5	CNAs & Orderlies	92,269	98,809	1,338,049	13.54	5
6	CNA Trainees					6
7	Licensed Therapist	279	279	6,926	24.82	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,900	2,080	43,903	21.11	9
10	Activity Assistants	8,615	9,278	103,190	11.12	10
11	Social Service Workers	3,792	4,160	84,643	20.35	11
12	Dietician	1,787	1,933	49,833	25.78	12
13	Food Service Supervisor	4,785	5,311	81,812	15.40	13
14	Head Cook	11,383	12,399	157,423	12.70	14
15	Cook Helpers/Assistants	15,842	16,595	166,392	10.03	15
16	Dishwashers					16
17	Maintenance Workers	4,064	4,441	70,071	15.78	17
18	Housekeepers	17,377	18,963	196,689	10.37	18
19	Laundry	7,711	8,152	87,597	10.75	19
20	Administrator	1,384	1,432	174,967	122.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,432	9,029	196,154	21.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,703	1,919	31,891	16.62	31
32	Other Health Ca SCH20A	16,237	17,431	532,855	30.57	32
33	Other(specify) Marketing & Hosp	3,688	4,093	131,726	32.18	33
34	TOTAL (lines 1 - 33)	245,307	262,983	$ 4,757,127 *	$ 18.09	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		$		35
36	Medical Director	Monthly	21,600	9(3)	36
37	Medical Records Consultant	17	1,020	10(7)	37
38	Nurse Consultant	Monthly	69,917	10(3,7)	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	13	1,875	10(3,7)	42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	896	11(3)	44
45	Social Service Consultant	12	732	12(3)	45
46	Other(specify)				46
47	Medicaid Consultant	Monthly	6,200	10(3)	47
48	Psych Consultant	Monthly	199	10(3)	48
49	TOTAL (lines 35 - 48)	58	$ 102,439		49

C. CONTRACT NURSES

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

Community Nursing & Rehabilitation Center, LLC
Provider # 0044750
1/1/13-12/31/13

Schedule 20A

Staffing & Salary

Description	Hours Worked	Hours Paid	Amount
MDS Coordinator	3,633	3,931	124,209
Restorative Aides	5,792	6,169	116,506
Treatment Nurse	1,944	2,080	56,086
Program Development Consultant	739	739	27,245
Case Manager	2,289	2,435	141,722
Transitional Care Coordinator	1,840	2,077	67,087
	16,237	**17,431**	**532,855**

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Larry Banks	Adminstrator	0	$ 174,967
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 174,967

B. Administrative - Other

Description	Amount
Steve Jeremias-COO	$ 180,000
Mark Weldler-CFO	180,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 360,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
McGladrey LLP	Accounting	$ 36,907
Corporate Cost Solutions	Workman's Comp	
MDI Achieve	Computer Consultant	23,124
Innovative LTC Solutions	Computer Services	3,232
Allscripts	Data Processing	3,141
Meyer Magence	Legal	
Paylocity	Payroll Fees	9,973
Personnel Planners	Unemployment Consultant	1,894
Medifax - EDI	Software Maintenance	
See Schedule 21C	Legal	40,571
See Schedule 21C	Computer	50,749
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 169,591

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 210,833
Unemployment Compensation Insurance	
FICA Taxes	454,003
Employee Health Insurance	230,388
Employee Meals	15,813
Illinois Municipal Retirement Fund (IMRF)*	
Flowers	470
Other Employee Benefits	27,436
TOTAL (agree to Schedule V, line 22, col.8)	$ 938,943

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	667
Health Care Worker Background Check	
(Indicate # of checks performed 13)	182
Patient Background Checks 219	4,207
IL Council LTC Dues	18,957
Recruitment Expense	19,500
Miscellaneous Dues & Subscriptions	1,939
Less: Chamber of Commerce	(795)
Less: Lobbying Expense	(4,335)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,312

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,375
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,375

**See instructions.

Community Nursing & Rehabilitation Center, LLC
Provider # 0044750
1/1/13-12/31/13

Schedule 21C

C. Professional Services

Vendor	Type	Amount
Ashman & Stein	Legal	15,177
Duane Morris LLP	Legal	7,901
Gutman & Associates , LLC	Legal	775
Meyers & Flowers LLC.	Legal	569
Much Shelist	Legal	8,121
Ashman & Stein	Legal	1,376
Duane Morris	Legal	528
AP12-04 - Holland & Knight	Legal	6,126
Ability Network Inc.	Computer Service	1,007
American Express	Computer Service	1,310
AT&T	Computer Service	280
HCA	Computer Service	3,000
Information Controls, Inc.	Computer Service	3,613
Ivans	Billing Service	936
Medfax-EDI	Computer Service	1,100
Nebo Systems Inc	BC BS Claims System	392
Relias Learning, LLC	Computer Service	9,967
Singer Networks LLC	Computer Service	21,470
Social Media Beast	Computer Service	7,675
To Page 21C	**Total**	**91,320**

From Sch V L19 C3	169,591
Add: Achieve Accreditation	7,600
Add: RE Entity Prof Fees	10,300
Less: Nonallowable legal expense	(8,867)
To Sch V L19 C8	**178,624**

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 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 Community Nrsg & Rehab Ctr # 0044750 **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? **Yes**
If YES, give association name and amount. **Illinois Council -LTC - $12,701**

(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? **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. $ **1,817** 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. $ **293,195**
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. $ **15,813** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,184**

(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? **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.