FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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 01/01/2015 to 12/31/2015 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) RSM US 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: 01/01/2015 Ending: 12/31/2015

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	21,612	4,343	9,844	35,799	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,612	4,343	9,844	35,799	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.10%

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 5,154

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	447,668	57,726		505,394		505,394		505,394			1
2	Food Purchase		251,609		251,609		251,609	(20,838)	230,771			2
3	Housekeeping	212,801	34,626		247,427		247,427		247,427			3
4	Laundry	102,707	18,777		121,484		121,484		121,484			4
5	Heat and Other Utilities			209,158	209,158		209,158		209,158			5
6	Maintenance	72,577	44,536	110,131	227,244		227,244		227,244			6
7	Other (specify):*											7
8	TOTAL General Services	835,753	407,274	319,289	1,562,316		1,562,316	(20,838)	1,541,478			8
	B. Health Care and Programs											
9	Medical Director			23,900	23,900		23,900		23,900			9
10	Nursing and Medical Records	3,039,413	182,467	46,030	3,267,910		3,267,910	52,303	3,320,213			10
10a	Therapy											10a
11	Activities	144,405	3,555	4,238	152,198		152,198		152,198			11
12	Social Services	160,115		744	160,859		160,859		160,859			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,343,933	186,022	74,912	3,604,867		3,604,867	52,303	3,657,170			16
	C. General Administration											
17	Administrative	160,103		360,000	520,103		520,103		520,103			17
18	Directors Fees											18
19	Professional Services			221,700	221,700		221,700	(45,185)	176,515			19
20	Dues, Fees, Subscriptions & Promotions			39,836	39,836		39,836	(3,189)	36,647			20
21	Clerical & General Office Expenses	205,268	20,527	121,539	347,334		347,334	(20,764)	326,570			21
22	Employee Benefits & Payroll Taxes			958,882	958,882		958,882	15,672	974,554			22
23	Inservice Training & Education			890	890		890		890			23
24	Travel and Seminar			3,619	3,619		3,619		3,619			24
25	Other Admin. Staff Transportation			3,408	3,408		3,408		3,408			25
26	Insurance-Prop.Liab.Malpractice			279,567	279,567		279,567	13,321	292,888			26
27	Other (specify):*											27
28	TOTAL General Administration	365,371	20,527	1,989,441	2,375,339		2,375,339	(40,145)	2,335,194			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,545,057	613,823	2,383,642	7,542,522		7,542,522	(8,680)	7,533,842			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: 01/01/2015 Ending: 12/31/2015

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			169,802	169,802		169,802	217,507	387,309			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,467	8,467		8,467	293,942	302,409			32
33	Real Estate Taxes							103,527	103,527			33
34	Rent-Facility & Grounds			664,234	664,234		664,234	(664,234)				34
35	Rent-Equipment & Vehicles			75,142	75,142		75,142		75,142			35
36	Other (specify):* **Mortgage Insurance**							36,998	36,998			36
37	**TOTAL Ownership**			917,645	917,645		917,645	(12,260)	905,385			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	27,427	601,380	754,963	1,383,770		1,383,770		1,383,770			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			280,133	280,133		280,133		280,133			42
43	Other (specify):* **Non-Allowable Cos**	46,207		276,921	323,128		323,128	(323,128)				43
44	**TOTAL Special Cost Centers**	73,634	601,380	1,312,017	1,987,031		1,987,031	(323,128)	1,663,903			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,618,691	1,215,203	4,613,304	10,447,198		10,447,198	(344,068)	10,103,130			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: 01/01/2015 Ending: 12/31/2015

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,656)	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	65,280	30		9
10	Interest and Other Investment Income	(1,458)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(368)	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	(5,000)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,682)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(208,820)	43		24
25	Fund Raising, Advertising and Promotional	(58,071)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(12,505)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(64,527)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (293,807)		$	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)	(50,261)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (50,261)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (344,068)		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Community Nrsg & Rehab Ctr

ID# 0044750

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (5,951)	43	1
2	Café Income	(5,166)	2	2
3	NH X Ray	(17,572)	43	3
4	Miscellaneous Income	(5,756)	21	4
5	Cable TV	(14,694)	43	5
6	Non-Allowable Lobbying Expense	(14,991)	20	6
7	Vending Expense	(147)	43	7
8	Disallow additional Related Party rent	(250)	34	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**	(64,527)		49

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	19	Accounting	$	Community Nursing & Rehab Realty, LLC		$ 12,000	$ 12,000	1
2	V	20	Licenses		Community Nursing & Rehab Realty, LLC		250	250	2
3	V	26	Insurance		Community Nursing & Rehab Realty, LLC		50,319	50,319	3
4	V	30	Depreciation		Community Nursing & Rehab Realty, LLC		152,227	152,227	4
5	V	32	Interest	438	Community Nursing & Rehab Realty, LLC		295,838	295,400	5
6	V	33	Real Estate Tax		Community Nursing & Rehab Realty, LLC		103,527	103,527	6
7	V	34	Building Rent	663,984	Community Nursing & Rehab Realty, LLC			(663,984)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 664,422			$ 614,161	$ * (50,261)	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: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Steve Jeremias	Manager	Administrative	29.50	See Sch. 7A	35	70.00	Guar Pmts	$ 180,000	L17, C3	1
2	Mark Weldler	Manager	Finance	29.50	See Sch. 7A	35	70.00	Guar Pmts	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: 01/01/2015 Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3		N/A								3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
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: 01/01/2015 Ending: 12/31/2015

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	$	03/3/16	0.0290	$ 101	1
2	Ally - CNRC GMC Sierra		X	Facility Vehicle	$789.28	10/1/11	43,628	6,966	10/1/16	0.0324	386	2
3	Marlin - Dish Machine & Boost		X	Facility Equipment	$247.10	04/15/11	13,954	2,878	04/15/16	0.0625	243	3
4	2015 Subaru		X	Facility Vehicle	$651.00	04/30/15	37,666	33,104	04/30/20	0.0190	421	4
5	See Sch 9A		X	See Sch 9A	$54,499.00	See Sch 9A	7,306,521	7,105,991	See Sch 9A	See Sch 9A	299,925	5
	Working Capital											
6	Lake Forest Bank		X	Working Capital	Varies	9/15/11	1,000,000		09/01/15	0.0500	3,229	6
7												7
8												8
9	TOTAL Facility Related				$56,819.54		$ 8,437,050	$ 7,148,939			$ 304,305	9
	B. Non-Facility Related*											
10												10
11												11
12								Less: Interest Income Offset			(1,896)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,896)	14
15	TOTALS (line 9+line14)						$ 8,437,050	$ 7,148,939			$ 302,409	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 36,998** **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: Community Nrsg & Rehab Ctr
IDPH License ID Number: 0044750
Fiscal Year End: 12/31/2015

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related*		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Heartland		X	Mortgage	$52,698.00	06/27/14	$ 7,247,900	$ 7,070,202	07/01/44	0.0415	$ 295,838	1
2	Lenovo		X	Computer Equipment	$1,673.00	09/22/14	54,350	32,929	10/22/17	0.0900	3,769	2
3	Lenovo		X	Computer Equipment	$128.00	10/15/14	4,271	2,860	12/15/17	0.0900	318	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$54,499.00		$ 7,306,521	$ 7,105,991			$ 299,925	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$0.00		$ 0	$ 0			$ 0	14

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 102,500	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.)	2014	$ 102,627	2
3. Under or (over) accrual (line 2 minus line 1).		$ 127	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 103,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	**Allocated from Managment Co.**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 103,527	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	95,046	8
	2011	99,814	9
	2012	101,323	10
	2013	101,891	11
	2014	102,627	12

Real estate tax accrual based on 100.75% of 2014 tax bill
102,627 X 1.0075 = 103,397. Use 103,400.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Community Nursing & Rehabilitation Center, LLC COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0044750

CONTACT PERSON REGARDING THIS REPORT Mark Weldler

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

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-12-403-042	Nursing Home	$ 102,626.56	$ 102,626.56
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 102,626.56	$ 102,626.56

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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	$ 1,647,692	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CABLE			2000	4,305	108	40	108		1,701	9
10	ELEVATOR DOOR			2000	4,389	110	40	110		1,723	10
11	PARKING LOT			2000	38,200	955	40	955		14,962	11
12	LANDSCAPING			2000	8,736	218	40	218		3,397	12
13	SIGN			2000	4,541	114	40	114		1,776	13
14	ARCHITECT FEES			2000	3,060	77	40	77		1,210	14
15	DOOR LOCK			2000	2,248	56	40	56		873	15
16	CLOSETS			2000	7,729	193	40	193		2,975	16
17	COVE BASE			2000	4,459	111	40	111		1,693	17
18	HANDRAILS AND KICKPLATES			2000	15,146	379	40	379		5,780	18
19	LIGHTING			2000	65,796	1,645	40	1,645		25,086	19
20	TILE			2000	2,317	58	40	58		884	20
21	FLOORING			2000	16,378	409	40	409		6,188	21
22	EXIT DOORS			2000	1,598	40	40	40		610	22
23	WINDOW AND CUBICLE TREATMENTS			2000	34,021	851	40	851		12,978	23
24	LIGHTING			2000	1,729	43	40	43		656	24
25	CARPETING			2000	27,139	678	40	678		10,340	25
26	FIRE PANEL			2000	4,500	113	40	113		1,723	26
27	NURSE'S STATION			2000	8,913	223	40	223		3,382	27
28	DOOR HANDLES			2000	1,644	41	40	41		622	28
29	CUBICLE TRACK			2000	915	23	40	23		347	29
30	MOTOR			2000	13,276	332	40	332		5,146	30
31	STOVE HOODS			2000	1,429	36	40	36		543	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: 01/01/2015 Ending: 12/31/2015

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	$ 2,034,570	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: 01/01/2015 Ending: 12/31/2015

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	$ 2,034,570	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		10			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		10			3,493	12
13	INSTALL LASER EYE ON ELEVATOR	2003	1,590		10			1,590	13
14	UPGRADE DIALYSIS ROOM	2004	30,778		10			30,778	14
15	NEW ROOF	2004	8,600		10			8,600	15
16	REMODEL VESTIBULE, NEW FLOORING	2004	10,044		10			10,044	16
17	INSTALL NEW SMOKE DETECTORS	2004	4,911		10			4,911	17
18	NEW OXYGEN ROOM	2004	5,688		10			5,688	18
19	NEW ELEVATOR TANK, PUMP AND MOTOR	2004	11,960		10			11,960	19
20	ROOF REPLACEMENT	2005	5,800	290	10	290		5,800	20
21	WIRE GLASS FOR RECEPTION WINDOW	2005	1,348	63	10	63		1,348	21
22	NEW CEMENT WALKWAYS	2005	2,400	120	10	120		2,400	22
23	NEW WALL HUNG SINK	2006	3,410	341	10	341		3,068	23
24	MOTOR FOR A/C	2006	664	66	10	66		594	24
25	NEW PUMP SYSTEM	2006	5,108	511	10	511		4,598	25
26	NEW HOT WATER HEATER	2006	7,998	800	10	800		7,200	26
27	SOLID STATE STARTER	2006	3,900	390	10	390		3,510	27
28	PUMP	2006	1,553	155	10	155		1,394	28
29	NEW FIRE ALARM	2006	6,800	680	10	680		6,120	29
30	NEW PUMP FOR BASEMENT A/C	2006	988	99	10	99		890	30
31	PAVE PARKING LOT	2006	3,500	350	10	350		3,150	31
32	NEW TIME CLOCK	2006	4,345	435	10	435		3,914	32
33	REPLACE HVAC ROOF TOP UNIT	2007	3,511	351	10	351		2,984	33
34	TOTAL (lines 1 thru 33)		$ 4,919,925	$ 11,464		$ 116,079	$ 104,615	$ 2,210,800	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: 01/01/2015 Ending: 12/31/2015

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	$ 11,464		$ 116,079	$ 104,615	$ 2,210,800	1
2	BALANCE OF TIME CLOCK	2007	4,345	434	10	434		3,689	2
3	HOT WATER HEATER	2007	9,212	921	10	921		7,829	3
4	SECURITY CAMERAS	2008	5,458	546	10	546		4,095	4
5	RELOCATE GAS LINE	2008	21,900	2,190	10	2,190		16,425	5
6	FRONT & BACK LANDSCAPING	2008	33,000	3,300	10	3,300		24,750	6
7									7
8	Architect Services	2009	29,257	2,926	10	2,926		19,018	8
9	Roof	2009	230,100	23,010	10	23,010		149,565	9
10	Construction Period Interest	2009	32,240	3,224	10	3,224		20,956	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		14,655	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		20,800	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		13,287	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		28,517	20
21	Basement corridor - cove base, flooring, paint doors & frames,								21
22	wallpaper purchase & installation	2009	46,436	4,644	10	4,644		30,184	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		19,813	26
27	Foyer - remove old flooring, install new ceramic flooring &								27
28	pedimat, wallcovering	2009	12,181	1,218	10	1,218		7,917	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		22,559	33
34	TOTAL (lines 1 thru 33)		$ 5,528,105	$ 72,282		$ 176,897	$ 104,615	$ 2,614,861	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: 01/01/2015 Ending: 12/31/2015

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	$ 72,282		$ 176,897	$ 104,615	$ 2,614,861	1
2	Building Facade & Renovation								2
3	- General requirements	2009	19,795	1,981	10	1,981		12,873	3
4	- Permits	2009	5,000	500	10	500		3,250	4
5	- Excavation and site demolition	2009	22,626	2,263	10	2,263		14,708	5
6	- Asphalt Patching	2009	5,928	593	10	593		3,854	6
7	- Mansard and patio canopy demolition	2009	9,300	930	10	930		6,045	7
8	- Concrete work	2009	23,807	2,381	10	2,381		15,475	8
9	- Brick pavers	2009	13,440	1,344	10	1,344		8,736	9
10	- Masonry columns & Screen wall	2009	16,190	1,619	10	1,619		10,524	10
11	- Steel	2009	9,700	970	10	970		6,305	11
12	- Wood fencing	2009	1,580	158	10	158		1,027	12
13	- Pylon Sign	2009	8,000	800	10	800		5,200	13
14	- Room framing and sheathing	2009	81,769	8,177	10	8,177		53,150	14
15	- Cut and patch existing roofing for new construction	2009	17,310	1,731	10	1,731		11,252	15
16	- Roofing and sheetmetal	2009	40,835	4,084	10	4,084		26,545	16
17	- Electrical	2009	4,150	415	10	415		2,698	17
18	- Dry fire sprinkler system	2009	7,000	700	10	700		4,550	18
19	- Duct demolition	2009	2,160	216	10	216		1,404	19
20	- Homosote sheathing	2009	7,549	755	10	755		4,907	20
21	- Eifs	2009	13,350	1,335	10	1,335		8,678	21
22	- Fypon Moldings	2009	6,790	679	10	679		4,414	22
23	- Painting	2009	3,400	340	10	340		2,210	23
24	- Main extrance roof tower	2009	47,588	4,759	10	4,759		30,933	24
25	- Asphalt sidewalk on north side of bldg	2009	4,920	492	10	492		3,198	25
26	- Landscaping	2009	18,000	1,800	10	1,800		11,700	26
27	- Landscape demo	2009	5,566	557	10	557		3,619	27
28	- Insurance	2009	3,562	357	10	357		2,318	28
29	- General contractor fee	2009	13,685	1,369	10	1,369		8,897	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,941,105	$ 113,587		$ 218,202	$ 104,615	$ 2,883,331	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: 01/01/2015 Ending: 12/31/2015

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	$ 113,587		$ 218,202	$ 104,615	$ 2,883,331	1
2	1st floor elevator lobby - remove old flooring and install new								2
3	pvt tile, wallcovering	2009	2,699	270	10	270		1,754	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		36,095	5
6	1st floor wallcovering and paint	2009	38,491	3,849	10	3,849		25,019	6
7	2nd floor shower rooms - remove existing ceramic tile, furnish								7
8	and install new ceramic tile	2009	7,067	707	10	707		4,594	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		103,519	12
13									13
14									14
15	Landmark-building façade renovation	2009	9,419	942	10	942		6,123	15
16	Satellite TV-Installation and wiring	2009	9,000	900	10	900		5,850	16
17	Architect Fees	2009	713	71	10	71		463	17
18	Sprinkler System	2009	134,000	13,400	10	13,400		87,100	18
19	Window Treatments	2009	44,355	4,436	10	4,436		28,833	19
20	Alzheimers Nurses Station Remodel	2009	18,328	1,833	10	1,833		11,914	20
21	Adjust for accounts payable invoice	2009	(23,592)						21
22									22
23	Pump Motor	2010	7,004	700	10	700		3,850	23
24	Telephone Paging System	2010	7,047	176	40	176		968	24
25	Wanderguard	2010	12,289	308	40	308		1,694	25
26	2nd Floor Common Area Flooring	2010	6,860	686	10	686		3,773	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,429,571	$ 163,344		$ 267,959	$ 104,615	$ 3,204,879	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: 01/01/2015 Ending: 12/31/2015

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	$ 163,344		$ 267,959	$ 104,615	$ 3,204,879	1
2	Compressor Replacement	2011	9,763	976	10	976		4,392	2
3	Sprinkler system	2011	9,933	497	20	497		2,236	3
4	Patio	2011	3,708	185	20	185		833	4
5	Business office thermostat	2011	5,988	1,198	5	1,198		5,391	5
6	Transformer	2011	13,500	675	20	675		3,038	6
7	Rehab corridor(Flooring, wallcovering)	2011	40,509	5,787	7	5,787		26,042	7
8	Rehab corridor(Handrails, Door & Frame)	2011	43,724	2,186	20	2,186		9,837	8
9	Nursing home (Relaminate)	2011	13,483	1,348	10	1,348		6,066	9
10									10
11	3 Broan fans, sheet metal work - Entire Facility	2012	4,300	430	10	430		1,505	11
12	Roof Chiller - Roof of Main Building	2012	4,455	446	10	446		1,561	12
13	Automatic Door - Homeward Bound Unit	2012	4,200	420	10	420		1,470	13
14									14
15	Resurface parking lot	2013	8,033	803	10	803		2,008	15
16	Condensor fan & water heater	2013	5,932	593	10	593		1,483	16
17	Rod floor drains, install new drains	2013	3,000	300	10	300		750	17
18	Replace door	2013	3,000	300	10	300		750	18
19									19
20	Mechanical door restrictor device-Elevators	2014	2,910	291	10	291		437	20
21	Repair 5 leaks in cold water supply throughout facility	2014	4,712	471	10	471		707	21
22	Replace Wi-Fi & low voltage cabling & elec-Entire facility	2014	18,642	1,864	10	1,864		2,796	22
23	Replace concrete ramp	2014	3,900	390	10	390		585	23
24	Replace heat pump at nurses station	2014	4,195	420	10	420		629	24
25	175 KW Standby diesel generator-Entire facility	2014	72,800		40	1,820	1,820	2,730	25
26	Fire dampers-Entire facility	2014	36,960		40	924	924	1,386	26
27	Replace 25 bay windows-Homeward Bound Unit	2014	62,400		40	1,560	1,560	2,340	27
28	Recover canopy awning-Front Door	2014	16,866		40	422	422	632	28
29	Remodel Homeward Bound Unit: wall covering, wood trim,	2014	112,500		40	2,813	2,813	4,219	29
30	doors & hardware, flooring, carpentry, paint, electrical								30
31	Remodel Nurses Station - Homeward Bound Unit: wall covering,	2014	12,464		40	312	312	467	31
32	wood trim, countertop, carpentry, labor								32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,951,448	$ 182,923		$ 295,388	$ 112,465	$ 3,289,170	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: 01/01/2015 Ending: 12/31/2015

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 12F, Carried Forward		$ 6,951,448	$ 182,923		$ 295,388	$ 112,465	$ 3,289,170	1
2	Install Sewer Pit Pump - Back of building	2015	7,103	355	10	355		355	2
3	Electrical Work - Computer Room	2015	3,300	165	10	165		165	3
4	Add door to Wanderguard System - Resident Patio Smoking Door	2015	3,070	154	10	154		154	4
5	Evaporator chilled water coil pipe replacement - Entire Facility HVAC	2015	8,518	426	10	426		426	5
6									6
7	Adjust book depreciation to financial statements			(97,005)			97,005		7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,973,439	$ 87,018		$ 296,488	$ 209,470	$ 3,290,269	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: 01/01/2015 Ending: 12/31/2015

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	$ 502,136	$ 65,025	$ 73,063	$ 8,038	3-10	$ 485,991	71
72	Current Year Purchases	19,306	1,930	1,930	(0)	5	1,930	72
73	Fully Depreciated Assets	990,049					990,049	73
74								74
75	TOTALS	$ 1,511,491	$ 66,955	$ 74,992	$ 8,037		$ 1,477,969	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	$ 44,128	$ 8,826	$ 8,826	$	5	$ 39,717	76
77	Facility	Subaru (Sold in April 2015)	2011	35,281	3,278	3,278		5	27,024	77
78	Facility	Subaru (Purchased in April 2015	2015	37,246	3,725	3,725		5	3,725	78
79										79
80	TOTALS			$ 116,655	$ 15,829	$ 15,829	$		$ 70,466	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)	$ 9,055,207	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 169,802	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 387,309	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 217,507	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,838,705	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	CIP	$ 71,459	92
93			93
94			94
95		$ 71,459	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: 01/01/2015 Ending: 12/31/2015

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 75,142 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	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name: **Community Nrsg & Rehab Ctr**
IDPH License ID Number: **0044750**
Fiscal Year End: **12/31/2015**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	23,359
Office Equipment	1,636
Maintenance Equipment	996
Copier	49,151
Total - Line 16	**75,142**

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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	$	4,288	$ 308,759	$	4,288	$ 308,759	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,298	93,455		1,298	93,455	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		3,996	287,743		3,996	287,743	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				563,567		563,567	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Resp Ther/Oxygen	39(1)(2)	763	27,427			37,813	763	65,240	12
13	Other (specify): Dialysis Services	39(3)				65,006			65,006	13
14	TOTAL			$ 27,427	9,582	$ 754,963	$ 601,380	10,345	$ 1,383,770	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.

STATE OF ILLINOIS

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (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	38,640	38,640	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 364,410)	1,819,750	1,819,750	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	233,846	259,874	6
7	Other Prepaid Expenses	646	646	7
8	Accounts Receivable (owners or related parties)	708,483	664,607	8
9	Other(specify): See Schedule 17A	101,288	481,552	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,902,853	$ 3,265,269	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	1,559,742	2,788,850	15
16	Equipment, at Historical Cost	559,034	1,628,146	16
17	Accumulated Depreciation (book methods)	(1,385,401)	(4,838,705)	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	71,459	71,459	22
23	Other(specify): Mortgage Costs, Net		56,829	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 804,834	$ 4,344,790	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,707,687	$ 7,610,059	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 901,695	$ 941,013	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	35,789	35,789	29
30	Accrued Salaries Payable	62,432	62,432	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,339	6,339	31
32	Accrued Real Estate Taxes(Sch.IX-B)		103,400	32
33	Accrued Interest Payable		24,451	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	918,729	918,729	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,924,984	$ 2,092,153	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	42,948	42,948	39
40	Mortgage Payable		7,070,202	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)**	$ 42,948	$ 7,113,150	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,967,932	$ 9,205,303	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,739,755	$ (1,595,244)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,707,687	$ 7,610,059	48

*(See instructions.)

Facility Name: **Community Nrsg & Rehab Ctr**
IDPH License ID Number: **0044750**
Fiscal Year End: **12/31/2015**

Schedule 17A

XV. Balance Sheet
Line 9 Other Current (specify):

Acct #	Description	Operating	After Consolidation
11500.000	Rent Receivable	-	503
14100.000	Escrow - MIP	-	17,677
14200.000	Escrow - Insurance	-	6,376
14300.000	Escrow - Real Estate Taxes	-	41,721
14400.000	Escrow - Replacement Reserve	-	313,987
20810.000	Resident Refunds	9,623	9,623
21510.000	Due To/from AdminAstar	91,665	91,665
	Total - Line 9	**101,288**	**481,552**

Line 36 Other Current Liabilities (specify):

Acct #	Description	Operating	After Consolidation
20230.000	Accrued Management Fees	165,000	165,000
20260.000	Accrued Rent	503	503
20430.000	Accrued Assessment Fee	(221)	(221)
20435.000	Accrued Assessment Fee #2	28,359	28,359
20570.000	Insurance Payable	326,013	326,013
20800.000	Due To State	197,039	197,039
20815.000	Resident Credit Balances	171,691	171,691
20820.000	Due To /From Insurance (BC-BS Etc	1,198	1,198
20830.000	Due To/from BC-BS	36,047	36,047
20840.000	Due To/from Hospice	7,761	7,761
20905.000	Due To/from Pine Acres	(189,506)	(189,506)
20910.000	Due To/from The Springs	(24,519)	(24,519)
21505.000	Resident Deposits	249	249

25145.000	Note Payable - State	199,115	199,115
	Total - Line 36	**918,729**	**918,729**

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,314,598	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,314,598	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(761,838)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	187,000	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) **Rounding**	(5)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (574,843)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,739,755	24 *

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

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 8,661,175	1
2	Discounts and Allowances for all Levels	(1,621,980)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,039,195	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,921,951	6
7	Oxygen	23,175	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,945,126	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	4,479	12
13	Barber and Beauty Care	3,677	13
14	Non-Patient Meals	687	14
15	Telephone, Television and Radio	2,656	15
16	Rental of Facility Space		16
17	Sale of Drugs	525,744	17
18	Sale of Supplies to Non-Patients	627	18
19	Laboratory	116,619	19
20	Radiology and X-Ray	19,567	20
21	Other Medical Services	9,091	21
22	Laundry	4,662	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 687,809	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,458	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,458	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Sch 19A	11,772	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,772	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,685,360	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,562,316	31
32	Health Care	3,604,867	32
33	General Administration	2,375,339	33
	B. Capital Expense		
34	Ownership	917,645	34
	C. Ancillary Expense		
35	Special Cost Centers	1,706,898	35
36	Provider Participation Fee	280,133	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,447,198	40
41	**Income before Income Taxes (line 30 minus line 40)****	(761,838)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (761,838)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,866,597	44
45	Private Pay - Net Inpatient Revenue	1,187,413	45
46	Medicare - Net Inpatient Revenue	1,403,631	46
47	Other-(specify) Managed Care	107,494	47
48	Other-(specify) Hospice	474,060	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,039,195	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.**

^ - This entity is a cash basis taxpayer

Facility Name: **Community Nrsg & Rehab Ctr**
IDPH License ID Number: **0044750**
Fiscal Year End: **12/31/2015**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

Acct #	Description	Operating
59751.000	Gain / Loss On Sale Of Assets	5,873
59811.000	Prior Year Adjustments	143
59911.000	Misc. Income	5,756
	Total - Line 28	**11,772**

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,880	2,080	$ 133,799	$ 64.33	1
2	Assistant Director of Nursing	3,896	4,168	172,489	41.38	2
3	Registered Nurses	23,828	25,296	737,742	29.16	3
4	Licensed Practical Nurses	16,933	18,008	445,422	24.73	4
5	CNAs & Orderlies	81,500	88,294	1,229,580	13.93	5
6	CNA Trainees					6
7	Licensed Therapist	763	779	27,427	35.21	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,776	2,080	46,852	22.53	9
10	Activity Assistants	8,142	8,581	97,553	11.37	10
11	Social Service Workers	3,556	3,904	160,115	41.01	11
12	Dietician	1,644	1,758	47,466	27.00	12
13	Food Service Supervisor	3,874	4,229	85,549	20.23	13
14	Head Cook	7,737	8,433	109,267	12.96	14
15	Cook Helpers/Assistants	18,010	19,460	205,386	10.55	15
16	Dishwashers					16
17	Maintenance Workers	4,017	4,429	72,577	16.39	17
18	Housekeepers	17,240	19,055	212,801	11.17	18
19	Laundry	10,015	10,549	102,707	9.74	19
20	Administrator	1,392	1,472	160,103	108.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,127	8,779	205,268	23.38	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	1,748	1,887	28,870	15.30	31
32	Other Health C: SCH20A	8,507	9,068	291,511	32.15	32
33	Other(specify) Mktg & Hosp Liai	3,690	4,114	46,207	11.23	33
34	TOTAL (lines 1 - 33)	228,275	246,423	$ 4,618,691 *	$ 18.74	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	23,900	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	800	10(3,7)	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	20	1,120	11(3)	44
45	Social Service Consultant	12	744	12(3)	45
46	Other(specify) Pumlonary Cons	65	19,500	10(3)	46
47	Infectious Disease Consultant	Monthly	22,914	10(3)	47
48	Psych Consultant	Monthly	2,816	10(3)	48
49	TOTAL (lines 35 - 48)	97	$ 71,794		49

C. CONTRACT NURSES

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

Facility Name: **Community Nrsg & Rehab Ctr**
IDPH License ID Number: **0044750**
Fiscal Year End: **12/31/2015**

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Restorative Nurses	2,944	3,126	69,693	$ 22.29
MDS Coordinator	353	361	26,007	$ 72.04
Treatment Nurse	2,776	2,941	87,256	$ 29.67
Case Manager & Trans Care Coordinator	2,434	2,640	108,555	$ 41.12
Total - Line 32 Other Health Care (specify):	**8,507**	**9,068**	**291,511**	**$ 32.15**

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Larry Banks	Administrator	0	$ 160,103
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 160,103

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	$ 48,501
AHACPA	Accounting	300
Paylocity	Payroll Services	11,256
CLIA Acredditation	Accreditation	1,384
MDI Achieve	Computer Consultant	38,058
Innovative LTC Solutions	Software Company	5,318
Allscripts	Data Processing	3,752
Matrixcare	Billing Consultant	14,245
Personnel Planners	U/E Consultant	1,619
Medifax - EDI	Software Maintenance	924
See Schedule 21C	See Schedule 21C	96,343
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 221,700

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 307,599
Unemployment Compensation Insurance	
FICA Taxes	388,034
Employee Health Insurance	233,763
Employee Meals	15,672
Illinois Municipal Retirement Fund (IMRF)*	
Flowers	55
Other Employee Benefits	29,431
TOTAL (agree to Schedule V, line 22, col.8)	$ 974,554

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	$ 3,980
Advertising: Employee Recruitment	327
Health Care Worker Background Check	
(Indicate # of checks performed 17)	238
Patient Background Checks 251	3,292
IL Council LTC Dues	25,124
Miscellaneous Dues & Subscriptions	18,677
Less: Lobbying Expense	(14,991)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,647

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,619
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,619

**See instructions.

Facility Name: **Community Nrsg & Rehab Ctr**
IDPH License ID Number: **0044750**
Fiscal Year End: **12/31/2015**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Fr. Pg 21 Sect C		125,357
Ashman & Stein	USA Sattelite Release	1,059
Meyers & Flowers LLC	Collection	4,623
Much Shelist Attorneys At Law	General Counseling	16,128
Polsinelli	Bank Loan Renewal	7,079
ABILITY Netwok Inc.	Medicare Billing Software	4,034
CDW	Computer Services	8,493
Nestel	Computer Services	485
Ziprecruiter.Com	Computer Services	910
AT&T	Internet Services	998
Neebo Systems Inc	Insurance Verification Software	430
QA Reader	Incident Reporting Software	3,672
Singer Networks LLC	Service and Equipment	40,009
Telemedicine Solutions LLC	Computer Software	8,424
	Total (agree to Schedule V, line 19, column 3)	221,700
Allocated from Real Estate Entity	Accounting Fees	12,000
Reclass to the appropriate account		(51,503)
Less: Non-Allowable Legal Fees		(5,682)
	Total (agree to Schedule V, line 19, column 8)	176,515

Facility Name & ID Number Community Nrsg & Rehab Ctr # 0044750 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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 - $25,124**

(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 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **915** 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. $ **280,133**
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. $ **15,672** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **5,166**

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

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.