

			FOR OHF USE			

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**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

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.

<p><b>I. IDPH Facility ID Number:</b> <u>0044750</u></p> <p><b>Facility Name:</b> <u>Community Nursing &amp; Rehabilitation Center</u></p> <p><b>Address:</b> <u>1136 North Mill Street</u> <u>Naperville</u> <u>60563</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Dupage</u></p> <p><b>Telephone Number:</b> <u>( 630 ) 355-3300</u> <b>Fax #</b> <u>( 630 ) 355-1417</u></p> <p><b>IDPA ID Number:</b> <u>3643458778001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>04/01/2000</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;"><b>IRS Exemption Code</b> _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact</b>  <b>Name:</b> <u>Christine Hanove</u> <b>Telephone Number:</b> <u>(312) 634-4581</u>  <b>Please send copies of desk review and audit adjustments to address on this page</b></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/05</u> to <u>12/31/05</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; border: none;"><b>Officer or Administrator of Provider</b></td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) _____</td> </tr> <tr> <td style="border: none;"><b>Paid Preparer</b></td> <td style="border: none;">(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name &amp; Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p align="center"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630     </p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	<b>Paid Preparer</b>	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center

# 0044750 Report Period Beginning: 01/01/05 Ending: 12/31/05

**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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	48	Skilled (SNF)	48	17,520	1
2		Skilled Pediatric (SNF/PED)			2
3	105	Intermediate (ICF)	105	38,325	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF	6,128		5,556	11,684	8
9	SNF/PED					9
10	ICF	26,903	9,302	1,633	37,838	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,031	9,302	7,189	49,522	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.68%

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  NO  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

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  Date 04/01/2000 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 48 and days of care provided 5,556

Medicare Intermediary AdminaStar Federal

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year YES  NO

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Community Nursing &amp; Rehabilitation Center # 0044750 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
	Operating Expenses	Salary/Wage 1	Supplies 2	Other 3					Total 4	9
<b>A. General Services</b>										
1 Dietary	301,109	7,320	6,217	314,646		314,646		314,646		1
2 Food Purchase		253,249		253,249		253,249	(11,341)	241,908		2
3 Housekeeping	206,893	7,104		213,997		213,997		213,997		3
4 Laundry	33,041	23,554		56,595		56,595		56,595		4
5 Heat and Other Utilities			185,646	185,646		185,646		185,646		5
6 Maintenance	37,515	15,054	76,895	129,464		129,464		129,464		6
7 Other (specify):*										7
<b>8 TOTAL General Services</b>	<b>578,558</b>	<b>306,281</b>	<b>268,758</b>	<b>1,153,597</b>		<b>1,153,597</b>	<b>(11,341)</b>	<b>1,142,256</b>		<b>8</b>
<b>B. Health Care and Programs</b>										
9 Medical Director			19,200	19,200		19,200		19,200		9
10 Nursing and Medical Records	2,620,696	118,109	114,165	2,852,970		2,852,970		2,852,970		10
10a Therapy		100	264,604	264,704		264,704		264,704		10a
11 Activities	107,483	6,889	214	114,586		114,586		114,586		11
12 Social Services	40,959			40,959		40,959		40,959		12
13 CNA Training										13
14 Program Transportation										14
15 Other (specify):*										15
<b>16 TOTAL Health Care and Programs</b>	<b>2,769,138</b>	<b>125,098</b>	<b>398,183</b>	<b>3,292,419</b>		<b>3,292,419</b>		<b>3,292,419</b>		<b>16</b>
<b>C. General Administration</b>										
17 Administrative			205,772	205,772		205,772		205,772		17
18 Directors Fees										18
19 Professional Services			88,904	88,904		88,904	(4,738)	84,166		19
20 Dues, Fees, Subscriptions & Promotion			21,845	21,845		21,845		21,845		20
21 Clerical & General Office Expense	196,172	12,447	32,889	241,508		241,508	(7,405)	234,103		21
22 Employee Benefits & Payroll Tax			623,919	623,919		623,919	11,341	635,260		22
23 Inservice Training & Education			2,341	2,341		2,341		2,341		23
24 Travel and Seminars			2,599	2,599		2,599		2,599		24
25 Other Admin. Staff Transportation			765	765		765		765		25
26 Insurance-Prop.Liab.Malpractice			218,228	218,228		218,228		218,228		26
27 Other (specify):*										27
<b>28 TOTAL General Administration</b>	<b>196,172</b>	<b>12,447</b>	<b>1,197,262</b>	<b>1,405,881</b>		<b>1,405,881</b>	<b>(802)</b>	<b>1,405,079</b>		<b>28</b>
<b>29 TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,543,868</b>	<b>443,826</b>	<b>1,864,203</b>	<b>5,851,897</b>		<b>5,851,897</b>	<b>(12,143)</b>	<b>5,839,754</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			123,831	123,831		123,831	133,424	257,255			30
31	Amortization of Pre-Op. & Org											31
32	Interest			44,430	44,430		44,430	339,371	383,801			32
33	Real Estate Taxes							129,579	129,579			33
34	Rent-Facility & Grounds			672,587	672,587		672,587	(672,587)				34
35	Rent-Equipment & Vehicle:			39,175	39,175		39,175		39,175			35
36	Other (specify): <sup>3</sup>											36
37	<b>TOTAL Ownership</b>			880,023	880,023		880,023	(70,213)	809,810			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportatio											38
39	Ancillary Service Center:		350,567	32,895	383,462		383,462		383,462			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:			7,435	7,435		7,435	(2,716)	4,719			41
42	Provider Participation Fee			83,774	83,774		83,774		83,774			42
43	Other (specify): <sup>3</sup> <b>Nonallowable Costs</b>			39,445	39,445		39,445	(39,445)				43
44	<b>TOTAL Special Cost Centers</b>		350,567	163,549	514,116		514,116	(42,161)	471,955			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,543,868	794,393	2,907,775	7,246,036		7,246,036	(124,517)	7,121,519			45

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

\*\*See Schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center

# 0044750

Report Period Beginning: 01/01/05

Ending: 12/31/05

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room	(6,338)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciator	28,538	30		9
10	Interest and Other Investment Incom				10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salar				12
13	Sales Tax	(1,347)	43		13
14	Non-Care Related Interes				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona	(14,805)	43		25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	CNA Training for Non-Employee:				27
28	Yellow Page Advertising	(5,862)	43		28
29	Other-Attach Schedule Schedule 5A	(25,952)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (25,766)		\$	30

OHF 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	2	
		Amount	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)	(98,751)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (98,751)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (124,517)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport		x	\$		38
39						39
40	Gift and Coffee Shop		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

**Community Nursing & Rehabilitation Center**

**Provider #: 0044750**

**01/01/05 to 12/31/05**

**Schedule 5A**

VI. Adjustment Detail

Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
Penalties	(3,770)	43
Coffee Shop Income	(2,716)	41
Laboratory	(3,056)	43
X-Ray	(10,605)	43
Legal Fees	(4,738)	19
Miscellaneous income	<u>(1,067)</u>	21
Total	<u><u>(25,952)</u></u>	

**SEE ACCOUNTANTS' COMPILATION REPORT**

Community Nursing & Rehabilitation Center

ID# 0044750

Report Period Beginning: 01/01/05

Ending: 12/31/05

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1			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
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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	<b>Total</b>	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Community Nursing & Rehabilitation Center

# 0044750

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
<b>A. General Services</b>														
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8</b>
<b>B. Health Care and Programs</b>														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
<b>C. General Administration</b>														
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(6,338)	0	0	0	0	0	0	0	0	0	0	(6,338)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(6,338)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,338)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(6,338)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,338)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	28,538	104,886	0	0	0	0	0	0	0	0	0	133,424 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	339,371	0	0	0	0	0	0	0	0	0	339,371 32
33	Real Estate Taxes	0	129,579	0	0	0	0	0	0	0	0	0	129,579 33
34	Rent-Facility & Grounds	0	(672,587)	0	0	0	0	0	0	0	0	0	(672,587) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>28,538</b>	<b>(98,751)</b>	<b>0</b>	<b>(70,213) 37</b>								
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(22,014)	0	0	0	0	0	0	0	0	0	0	(22,014) 43
44	<b>TOTAL Special Cost Centers</b>	<b>(22,014)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(22,014) 44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>186</b>	<b>(98,751)</b>	<b>0</b>	<b>(98,565) 45</b>								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MARK AND CHANA WELDLER	29.50	WHEATON CARE CENTER	WHEATON	COMMUNITY NURSING		
STEVE AND BLUMA JEREMIAS	29.50	LAKEFRONT HEALTHCARE CENTER, INC.	CHICAGO	AND REHAB REALTY,		
MALKA MERMELSTEIN	0.50			LLC	NAPERVILLE	REAL ESTATE
HERMAN MERMELSTEIN	0.50					
JOSEPH NEUMANN	30.00					
HIRSCH WOLF	10.00					

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.  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	30 Depreciation	\$	Community Nursing & Rehab. Realty, LLC		\$ 104,886	\$ 104,886	1
2	V	32 Interest expense		Community Nursing & Rehab. Realty, LLC		339,371	339,371	2
3	V	33 Property taxes		Community Nursing & Rehab. Realty, LLC		129,579	129,579	3
4	V	34 Rent expense	672,587	Community Nursing & Rehab. Realty, LLC			(672,587)	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 672,587			\$ 573,836	\$ * (98,751)	14

\* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number      Community Nursing & Rehabilitation Cente      #      0044750      Report Period Beginning:      01/01/05      Ending:      12/31/05

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	STEVE JEREMIAS	ADMINISTRATOR	ADMINISTRAT.	29.50	None	50	100.00	Guar Pymnts	\$ 98,186	L17,C3	1
2	MARK WELDLER	CFO	FINANCE	29.50	19,115 See Note A	50	100.00	Guar Pymnts	107,586	L17,C3	2
3											3
4											4
5											5
6											6
7											7
8	A - Compensation from Lakefront Healthcare Center for 2005										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 205,772		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$			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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 01/01/05 Ending: 12/31/05

## 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	
						Original	Balance					
	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									
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	First Bank		X	MORTGAGE	\$40,394.00	02/04	\$ 5,600,000	\$ 5,323,164	02/09	0.0600	\$ 328,901	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6	First Bank		X	WORKING CAPITAL	DEMAND	03/05	1,000,000	900,000	03/06	P+.0050	44,430	6
7												7
8												8
9	TOTAL Facility Related				\$40,394.00		\$ 6,600,000	\$ 6,223,164			\$ 383,801	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 6,600,000	\$ 6,223,164			\$ 383,801	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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



**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Community Nursing & Rehabilitation Center 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 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>07-12-403-042</u>	<u>Nursing Home</u>	\$ <u>115,559.00</u>	\$ <u>115,559.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>115,559.00</u>	\$ <u>115,559.00</u>

**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 & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center

# 0044750 Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 62,087 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (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?  (a) Own the Equipment  (b) Rent equipment from a Related Organization  (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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, et

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  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	153	2000	1986	\$ 4,184,589	\$	40	\$ 104,616	\$ 104,616	\$ 601,539	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	CABLE	2000	2000	4,305	108	40	108		621	9
10	ELEVATOR DOOR	2000	2000	4,389	110	40	110		623	10
11	PARKING LOT	2000	2000	38,200	955	40	955		5,412	11
12	LANDSCAPING	2000	2000	8,736	218	40	218		1,217	12
13	SIGN	2000	2000	4,541	114	40	114		636	13
14	ARCHITECT FEES	2000	2000	3,060	77	40	77		440	14
15	DOOR LOCK	2000	2000	2,248	56	40	56		313	15
16	CLOSETS	2000	2000	7,729	193	40	193		1,045	16
17	COVE BASE	2000	2000	4,459	111	40	111		583	17
18	HANDRAILS AND KICKPLATES	2000	2000	15,146	379	40	379		1,990	18
19	LIGHTING	2000	2000	65,796	1,645	40	1,645		8,636	19
20	TILE	2000	2000	2,317	58	40	58		304	20
21	FLOORING	2000	2000	16,378	409	40	409		2,098	21
22	EXIT DOORS	2000	2000	1,598	40	40	40		210	22
23	WINDOW AND CUBICLE TREATMENTS	2000	2000	34,021	851	40	851		4,468	23
24	LIGHTING	2000	2000	1,729	43	40	43		226	24
25	CARPETING	2000	2000	27,139	678	40	678		3,560	25
26	FIRE PANEL	2000	2000	4,500	113	40	113		593	26
27	NURSE'S STATION	2000	2000	8,913	223	40	223		1,152	27
28	DOOR HANDLES	2000	2000	1,644	41	40	41		212	28
29	CUBICLE TRACK	2000	2000	915	23	40	23		117	29
30	MOTOR	2000	2000	13,276	332	40	332		1,826	30
31	STOVE HOODS	2000	2000	1,429	36	40	36		183	31
32	COVER BASE - RESIDENTS' ROOMS	2001	2001	865	87	10	87		427	32
33	CERAMIC TILES	2001	2001	10,930	1,093	10	1,093		5,374	33
34	CEILING & LIGHTING	2001	2001	9,063	906	10	906		4,355	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Community Nursing &amp; Rehabilitation Center

# 0044750

Report Period Beginning:

01/01/05

Ending:

12/31/05

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	RENOVATIONS - THERAPY ROOM	2001	\$ 10,558	\$ 1,056	10	\$ 1,056	\$	\$ 5,193	37
38	TILE & COVE BASE - BASEMENT	2001	2,327	233	10	233		1,165	38
39	SHAMPOO STATION	2001	5,431	543	10	543		2,670	39
40	COVE BASE - SECOND FLOOR	2001	1,699	170	10	170		836	40
41	WALLPAPER/COVEBASE/CARPETING/LIGHTING	2001	1,403	140	10	140		689	41
42	ABS PUMP	2001	11,908	1,191	10	1,191		5,856	42
43	CARPETING	2001	14,572	1,457	10	1,457		7,164	43
44	FLOORING	2001	1,320	132	10	132		649	44
45	2ND FLOOR RENOVATIONS	2001	38,875	3,888	10	3,888		18,468	45
46	AVERY	2001	2,419	242	10	242		1,149	46
47	KITCHEN - COOLING AIR UNIT	2001	2,275	228	10	228		1,102	47
48	WALLCOVERINGS	2001	12,289	1,229	10	1,229		6,145	48
49	SIGNAGE/ELECTRIC BALLAST (ADMISSIONS OFFICE)	2001	3,131	313	10	313		1,461	49
50	ROOM CURTAIN DIVIDER	2001	2,003	200	10	200		934	50
51	HANDRAILS & BUMPER GUARDS	2001	17,855	1,786	10	1,786		8,334	51
52	FIRE ALARM TRANSFORMER	2001	1,715	172	10	172		802	52
53	TEMP CONTROL ON AIR HANDLER	2001	9,519	952	10	952		4,443	53
54	COVEBASE/LANDSCAPING/LIGHTING/FLOORING	2001	2,642	264	10	264		1,232	54
55	LIGHTING - CORRIDORS & RESIDENT ROOMS	2001	20,544	2,054	10	2,054		9,414	55
56	NEW BEARING & SHAFT	2001	1,402	140	10	140		630	56
57	DIALYSIS ROOM RENOVATIONS	2001	23,351	2,335	10	2,335		9,535	57
58	ASPHALT SEALCOATING & STRIPING	2001	1,405	141	10	141		611	58
59	KITCHEN TILE	2001	930	93	10	93		395	59
60	SEPTIC TANK PUMPS	2001	13,862	1,386	10	1,386		5,891	60
61	CARPETING	2001	5,729	573	10	573		2,626	61
62	PAINTING & WALLPAPER	2001	20,440	2,044	10	2,044		10,220	62
63	PAINTING & WALLPAPER	2001	11,875	1,188	10	1,188		5,643	63
64	PAINTING & WALLPAPER	2001	4,500	450	10	450		2,063	64
65	NEW DOORS	2002	1,731	173	10	173		606	65
66	MURAL FOR SECOND FLOOR DINING ROOM	2002	7,000	700	10	700		2,450	66
67	NEW TROUGH IN LAUNDRY ROOM	2002	6,300	630	10	630		2,205	67
68	WINDOW MOLDINGS	2002	210	21	10	21		74	68
69	NEW THRESHHOLDS	2002	205	21	10	21		73	69
70	TOTAL (lines 4 thru 69)		\$ 4,739,340	\$ 35,044		\$ 139,660	\$ 104,616	\$ 768,888	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 4,739,340	\$ 35,044		\$ 139,660	\$ 104,616	\$ 768,888		1
2	NEW PVC PIPING IN KITCHEN	1,320	132	10	132		462		2
3	UPGRADE BACKFLOW SYSTEM	1,695	170	10	170		595		3
4	ALARM FOR RAMP EXIT	1,443	144	10	144		504		4
5	FLOORING IN ELEVATOR	856	86	10	86		301		5
6	CORNER GUARDS/WATER SOFTENER	1,328	133	10	133		465		6
7	NEW DRAINAGE PIPES - DISPOSAL	9,985	999	10	999		3,496		7
8	CORNER GUARDS	276	28	10	28		84		8
9	UPGRADE DIALYSIS ROOM	28,103	2,810	10	2,810		8,430		9
10	NEW AWNINGS FOR PATIO	3,940	394	10	394		1,182		10
11	INSTALL GREASE TRAP IN KITCHEN	3,250	325	10	325		975		11
12	NEW COIL FOR AIR HANDLER	3,493	349	10	349		1,047		12
13	INSTALL LASER EYE ON ELEVATOR	1,590	159	10	159		477		13
14	UPGRADE DIALYSIS ROOM	30,778	3,078	10	3,078		6,156		14
15	NEW ROOF	8,600	860	10	860		1,720		15
16	REMODEL VESTIBULE, NEW FLOORING	10,044	1,004	10	1,004		2,008		16
17	INSTALL NEW SMOKE DETECTORS	4,911	491	10	491		982		17
18	NEW OXYGEN ROOM	5,688	569	10	569		1,138		18
19	NEW ELEVATOR TANK, PUMP AND MOTOR	11,960	1,196	10	1,196		2,392		19
20	ROOF REPLACEMENT	5,800	290	10	290		290		20
21	WIRE GLASS FOR RECEPTION WINDOW	1,348	68	10	68		68		21
22	NEW CEMENT WALKWAYS	2,400	120	10	120		120		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)	\$ 4,878,148	\$ 48,449		\$ 153,065	\$ 104,616	\$ 801,780		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number: Community Nursing & Rehabilitation Cent # 0044750 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,035,848	\$ 74,776	\$ 103,584	\$ 28,808	3-10	\$ 579,995	71
72	Current Year Purchases	8,854	443	443		10	443	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,044,702	\$ 75,219	\$ 104,027	\$ 28,808		\$ 580,438	75

D. Vehicle Depreciation (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	1988 FORD ECONOLINE	2000	\$ 3,255	\$ 163	\$ 163		5	\$ 3,255	76
77										77
78										78
79										79
80	TOTALS			\$ 3,255	\$ 163	\$ 163			\$ 3,255	80

E. Summary of Care-Related Asset

	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)	\$ 6,379,727	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 123,831	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 257,255	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 133,424	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,385,473	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-Progres

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

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

\*\* This must agree with Schedule V line 30, column 1

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES  NO

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

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. \_\_\_\_\_ /2006      \$ \_\_\_\_\_  
13. \_\_\_\_\_ /2007      \$ \_\_\_\_\_  
14. \_\_\_\_\_ /2008      \$ \_\_\_\_\_

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: \_\_\_\_\_ \*

**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: \$ \$ 32,828      Description: Computers - \$19,499; Copier - \$9,776; Air Mattresses \$1,060, Time Clock \$2,493

(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			\$	\$	17
18	<u>ADMINISTRATIVE</u>	<u>2004 TOYOTA AVALON</u>	<u>577.00</u>	<u>6,347</u>	18
19					19
20					20
21	<b>TOTAL</b>		\$ <u>577.00</u>	\$ <u>6,347</u>	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.

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)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	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 Wage (c)				
6 Transportation				
7 Contractual Payment:				
8 CNA Competency Tests				
9 TOTALS	\$	\$	\$	\$
10 SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit;
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit;
- (c) For in-house training programs only. Do not include fringe benefit;
- (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

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	

- (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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	L10A, C3,C2	hrs	\$	4,825	\$ 81,571	\$ 100	4,825	\$ 81,671	1				
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,201	18,910		1,201	18,910	2				
3	Licensed Recreational Therapist		hrs							3				
4	Licensed Physical Therapist	L10A, C3	hrs		10,033	164,123		10,033	164,123	4				
5	Physician Care		visits							5				
6	Dental Care		visits							6				
7	Work Related Program		hrs							7				
8	Habilitation		hrs							8				
9	Pharmacy	L39, C2	# of prescripts					350,567	350,567	9				
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10				
11	Academic Education		hrs							11				
12	Exceptional Care Program									12				
13	Other (specify): <u>Dialysis Service</u>	L39, C3						32,895	32,895	13				
14	TOTAL			\$	16,059	\$ 264,604	\$ 383,562	16,059	\$ 648,166	14				

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 8,700 )	2,314,219	2,314,219	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	121,232	121,232	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,435,451	\$ 2,435,451	10
<b>B. Long-Term Assets</b>				
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	802,221	693,559	15
16	Equipment, at Historical Cost	1,047,957	1,047,957	16
17	Accumulated Depreciation (book methods)	(708,133)	(1,385,473)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	3,000	3,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(3,000)	(3,000)	20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Mortgage Costs)		91,185	22
23	Other(specify): Security Deposits	28,250	28,250	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,170,295	\$ 5,113,689	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,605,746	\$ 7,549,140	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 777,769	\$ 777,307	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	79,946	79,946	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,694	31,694	31
32	Accrued Real Estate Taxes(Sch.IX-B)		115,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	See Schedule 17A	2,282,163	219,254	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,171,572	\$ 1,223,201	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	900,000	6,223,164	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 900,000	\$ 6,223,164	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,071,572	\$ 7,446,365	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (465,826)	\$ 102,775	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,605,746	\$ 7,549,140	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**Community Nursing & Rehabilitation Center**  
**Provider # 0044750**  
**1/1/05 - 12/31/05**

**Schedule 17A**

XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Wage Garnishment	(12,113)	(12,113)
401K Liability	(419)	(419)
Accrued Assessment Fee	(4)	(4)
Due To Credit Union	(2,289)	(2,289)
Due To State	(14,642)	(14,642)
Due To /From Pine Acres Rehab & Living	5,000	5,000
Due To/From CNRR	(2,062,909)	-
Advance Billing	(194,787)	(194,787)
Total Line 36	<u>(2,282,163)</u>	<u>(219,254)</u>

**See Accountants' Compilation Report**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (262,199)	1
2	Restatements (describe):		2
3	<b>POST CLOSING ADJUSTMENT</b>	<b>47,947</b>	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (214,252)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	188,426	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	(440,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (251,574)</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (465,826)</b>	24 *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Community Nursing &amp; Rehabilitation Center # 0044750 Report Period Beginning: 01/01/05

Ending: 12/31/05

## 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 expenses.

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,194,361	1
2	Discounts and Allowances for all Level	(1,170,704)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 6,023,657</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	761,706	6
7	Oxygen	73,160	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 834,866</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Educator		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,716	12
13	Barber and Beauty Care	1,200	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	6,338	15
16	Rental of Facility Space		16
17	Sale of Drugs	512,011	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	35,815	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 558,080</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income**		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Miscellaneous income</b>	17,859	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 17,859</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 7,434,462</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,153,597	31
32	Health Care	3,292,419	32
33	General Administrator	1,405,881	33
<b>B. Capital Expense</b>			
34	Ownership	880,023	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	430,342	35
36	Provider Participation Fee	83,774	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 7,246,036</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>188,426</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 188,426</b>	<b>43</b>

\* 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.  
TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number **Community Nursing & Rehabilitation Center**

# 0044750

Report Period Beginning: 01/01/05

Ending:

12/31/05

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,992	2,219	\$ 77,859	\$ 35.09	1
2	Assistant Director of Nursing	924	1,024	26,394	25.78	2
3	Registered Nurses	18,286	20,227	443,790	21.94	3
4	Licensed Practical Nurses	23,358	24,616	614,093	24.95	4
5	CNAs & Orderlies	85,002	90,219	1,225,239	13.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,792	5,105	73,289	14.36	8
9	Activity Director	1,910	2,080	32,656	15.70	9
10	Activity Assistants	7,742	8,005	74,827	9.35	10
11	Social Service Worker	1,880	2,040	40,959	20.08	11
12	Dietician					12
13	Food Service Supervisor	4,209	4,745	70,525	14.86	13
14	Head Cook	6,528	7,121	81,114	11.39	14
15	Cook Helpers/Assistants	16,924	17,098	149,470	8.74	15
16	Dishwashers					16
17	Maintenance Worker	2,154	2,433	37,515	15.42	17
18	Housekeepers	19,219	21,344	206,893	9.69	18
19	Laundry	4,802	5,634	33,041	5.86	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,073	10,501	196,172	18.68	24
25	Vocational Instructor					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,740	2,972	40,200	13.53	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MDS Coord.</u>	4,305	4,704	119,832	25.47	33
34	TOTAL (lines 1 - 33)	216,840	232,087	\$ 3,543,868 *	\$ 15.27	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	140	\$ 6,217	L1, C3	35
36	Medical Director	Monthly	19,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	140	\$ 25,417		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,571	\$ 114,165	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,571	\$ 114,165		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Cente

# 0044750

Report Period Beginning: 01/01/05

Ending: 12/31/05

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
None			\$	Workers' Compensation Insurance	\$ 160,449	IDPH License Fee	\$ 3,985	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	4,594	
				FICA Taxes	305,911	Health Care Worker Background Check (Indicate # of checks performed 260 )	2,600	
				Employee Health Insurance	149,959	Dupage County Health Department	770	
				Employee Meals	11,341	CLIA Program	150	
				Illinois Municipal Retirement Fund (IMRF)*		Department of Professional	1,990	
				Dreyer Drug Screens	288	Illinois Council	6,678	
				Employee Luncheons / outings	224	Misc Magazine Subscriptions	1,078	
				Uniforms	3,088			
				Christmas Party / Gifts	4,000			
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 635,260	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 21,845	
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Description			Amount	Description	Line #	Amount	Description	Amount
STEVE JEREMIAS, Admin - Guar. Pymnts			\$ 98,186	N/A		\$	Out-of-State Travel	\$
MARK WELDLER, CFO - Guar. Pymnts			107,586					
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 205,772				Seminar Expense	2,599
<b>C. Professional Services</b>								
Vendor/Payee	Type		Amount				Entertainment Expense (agree to Sch. V, line 24, col. 8)	( )
Sachnoff & Weaver	Legal		\$ 6,434				TOTAL	\$ 2,599
Meyer Magence	Legal		558					
Altschuler, Melvojn & Glasser, LLP	Accounting Fees		2,000					
American Express TBS	Accounting Fees		14,152					
Krupnick Bokor	Accounting Fees		18,750					
Personnel Planners	U C Consultant		315					
Payroll Services	Payroll		645					
HDSI	Data Processing		12,600					
AccuMed	Data Processing		2,880					
Ivans	Data Processing		1,085					
Emdeon Business Services	Data Processing		2,045					
See Schedule 21A			27,440					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 88,904	TOTAL		\$		

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**Community Nursing & Rehabilitation Center**

**Provider #: 0044750**

**01/01/05 to 12/31/05**

**Schedule 21A**

XIX. SUPPORT SCHEDULE

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Commed Systems	Data Processing	1,560
XO	Data Processing	360
Robinson & Associates	Hardware Maintenance	25,520
		<u>27,440</u>
Total (agree to Schedule V, line 19, column 3)		88,904
Sachnoff & Weaver		(4,738)
Total (agree to Schedule V, line 19, column 8)		<u><u>84,166</u></u>

**SEE ACCOUNTANTS' COMPILATION REPORT**

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	8 Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	9 FY2005	10 FY2006	11 FY2007	12 FY2008	13 FY2009	13 FY2010
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6									N/A				
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Community Nursing &amp; Rehabilitation Center

# 0044750

Report Period Beginning:

01/01/05

Ending:

12/31/05

## 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: IL COUNCIL LONG TERM CARE \$6,678
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. : 2,372 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease N/A
- (9) Are you presently operating under a sublease agreement YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions 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. \$ 83,774  
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 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 if 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. \$ 11,341 Has any meal income been offset against related costs? No Indicate the amount \$ N/A
- (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 program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0%  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. 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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	301,109	7,320	6,217	314,646	0	314,646	0	314,646
2. Food Purchase	0	253,249	0	253,249	0	253,249	(11,341)	241,908
3. Housekeeping	206,893	7,104	0	213,997	0	213,997	0	213,997
4. Laundry	33,041	23,554	0	56,595	0	56,595	0	56,595
5. Heat and Other Utilities	0	0	185,646	185,646	0	185,646	0	185,646
6. Maintenance	37,515	15,054	76,895	129,464	0	129,464	0	129,464
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	578,558	306,281	268,758	1,153,597	0	1,153,597	(11,341)	1,142,256
9. Medical Director	0	0	19,200	19,200	0	19,200	0	19,200
10. Nursing & Medical Records	2,620,696	118,109	114,165	2,852,970	0	2,852,970	0	2,852,970
10a. Therapy	0	100	264,604	264,704	0	264,704	0	264,704
11. Activities	107,483	6,889	214	114,586	0	114,586	0	114,586
12. Social Services	40,959	0	0	40,959	0	40,959	0	40,959
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,769,138	125,098	398,183	3,292,419	0	3,292,419	0	3,292,419
17. Administrative	0	0	205,772	205,772	0	205,772	0	205,772
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	88,904	88,904	0	88,904	(4,738)	84,166
20. Fees, Subscriptions & Promotion	0	0	21,845	21,845	0	21,845	0	21,845
21. Clerical & General Office	196,172	12,447	32,889	241,508	0	241,508	(7,405)	234,103
22. Employee Benefits & Payroll	0	0	623,919	623,919	0	623,919	11,341	635,260
23. Inservice Training & Education	0	0	2,341	2,341	0	2,341	0	2,341
24. Travel and Seminar	0	0	2,599	2,599	0	2,599	0	2,599
25. Other Admin. Staff Trans	0	0	765	765	0	765	0	765
26. Insurance-Prop.Liab.Malpractice	0	0	218,228	218,228	0	218,228	0	218,228
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	196,172	12,447	1,197,262	1,405,881	0	1,405,881	(802)	1,405,079
29. Total General Administrative	3,543,868	443,826	1,864,203	5,851,897	0	5,851,897	(12,143)	5,839,754
30. Depreciation	0	0	123,831	123,831	0	123,831	133,424	257,255
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	44,430	44,430	0	44,430	339,371	383,801
33. Real Estate	0	0	0	0	0	0	129,579	129,579
34. Rent - Facility & Grounds	0	0	672,587	672,587	0	672,587	(672,587)	0
35. Rent - Equipment & Vehicles	0	0	39,175	39,175	0	39,175	0	39,175
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	880,023	880,023	0	880,023	(70,213)	809,810
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	350,567	32,895	383,462	0	383,462	0	383,462
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	7,435	7,435	0	7,435	(2,716)	4,719
42. Provider Participation	0	0	83,774	83,774	0	83,774	0	83,774
43. Other (specify):*	0	0	39,445	39,445	0	39,445	(39,445)	0
44. Total Special Cost Ce	0	350,567	163,549	514,116	0	514,116	(42,161)	471,955
45. Grand Total	3,543,868	794,393	2,907,775	7,246,036	0	7,246,036	(124,517)	7,121,519

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	0	0
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	2,314,219	2,314,219
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	121,232	121,232
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	2,435,451	2,435,451
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	453,622
14. Buildings, at Historical Cost	0	4,184,589
15. Leasehold Improvements, Historical Cost	802,221	693,559
16. Equipment, at Historical Cost	1,047,957	1,047,957
17. Accumulated Depreciation (book methods)	-708,133	-1,385,473
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	3,000	3,000
20. Accum Amort - Org/Pre-Op Costs	-3,000	-3,000
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	91,185
23. other (specify):	28,250	28,250
24. Total Long-Term Assets	1,170,295	5,113,689
25. Total Assets	3,605,746	7,549,140
CURRENT LIABILITIES		
26. Accounts Payable	777,769	777,307
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	79,946	79,946
31. Accrued Taxes Payable	31,694	31,694
32. Accrued Real Estate Taxes	0	115,000
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	2,282,163	219,254
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	3,171,572	1,223,201
LONG TERM LIABILITES		
39. Long-Term Notes Payable	900,000	6,223,164
40. Mortgage Payable	0	0
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	900,000	6,223,164
46. Total Liabilities	4,071,572	7,446,365
47. Total Equity	-465,826	102,775
48. Total Liabilities and Equity	3,605,746	7,549,140

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	7,194,361
2. Discounts and Allowances for all Levels	-1,170,704
Subtotal - Inpatient Care	6,023,657
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	761,706
7. Oxygen	73,160
Subtotal - Ancillary Revenue	834,866
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	2,716
13. Barber and Beauty Care	1,200
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	6,338
16. Rental of Facility Space	0
17. Sale of Drugs	512,011
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	35,815
22. Laundry	0
Subtotal - Other Operating Revenue	558,080
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	17,859
28. Other Revenue (specify):	0
Subtotal - Other Revenue	17,859
30. Total Revenue	7,434,462
31. General Services	1,153,597
32. Health Care	3,292,419
33. General Administration	1,405,881
34. Ownership	880,023
35. Special Cost Centers	430,342
35. Provider Participation Fee	83,774
37. Other	0
40. Total Expenses	7,246,036
41. Income Before Income Taxes	188,426
42. Income Taxes	0
43. Net Income or Loss for the Year	188,426