

Facility Name & ID Number Claremont Rehab & Living Center

0047043 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	200	Skilled (SNF)	200	73,000	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	200	TOTALS	200	73,000	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	118		18,002	18,120	8
9	SNF/PED					9
10	ICF	29,226	12,574	3,630	45,430	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,344	12,574	21,632	63,550	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.05%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES 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 3/1/05

J. Was the facility purchased or leased after January 1, 1978?

YES Date 3/1/05 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 200 and days of care provided 18,002

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Claremont Rehab & Living Center # 0047043 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs 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
	A. General Services										
1	Dietary	368,633	34,360	13,769	416,762		416,762		416,762		1
2	Food Purchase		388,948		388,948		388,948	(43,762)	345,186		2
3	Housekeeping	258,361	52,983		311,344		311,344		311,344		3
4	Laundry	35,237	31,799	25,410	92,446		92,446		92,446		4
5	Heat and Other Utilities			231,307	231,307		231,307	1,823	233,130		5
6	Maintenance	84,080	62,995	121,125	268,200		268,200	3,327	271,527		6
7	Other (specify):*										7
8	TOTAL General Services	746,311	571,085	391,611	1,709,007		1,709,007	(38,612)	1,670,395		8
	B. Health Care and Programs										
9	Medical Director			60,000	60,000		60,000		60,000		9
10	Nursing and Medical Records	3,954,548	329,099	44,007	4,327,654		4,327,654		4,327,654		10
10a	Therapy	761,620	17,252	385,661	1,164,533		1,164,533		1,164,533		10a
11	Activities	150,593	10,682	2,574	163,849		163,849		163,849		11
12	Social Services	158,861		23,310	182,171		182,171		182,171		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,025,622	357,033	515,552	5,898,207		5,898,207		5,898,207		16
	C. General Administration										
17	Administrative	139,711		392,366	532,077		532,077	(316,861)	215,216		17
18	Directors Fees										18
19	Professional Services			74,789	74,789		74,789	3,718	78,507		19
20	Dues, Fees, Subscriptions & Promotions			43,923	43,923		43,923	(2,051)	41,872		20
21	Clerical & General Office Expenses	283,631	68,526	79,732	431,889		431,889	106,720	538,609		21
22	Employee Benefits & Payroll Taxes			794,675	794,675		794,675	39,562	834,237		22
23	Inservice Training & Education										23
24	Travel and Seminar			21,440	21,440		21,440	1,543	22,983		24
25	Other Admin. Staff Transportation			16,210	16,210		16,210	317	16,527		25
26	Insurance-Prop.Liab.Malpractice			171,406	171,406		171,406	1,162	172,568		26
27	Other (specify):* Home Office Benefits							23,463	23,463		27
28	TOTAL General Administration	423,342	68,526	1,594,541	2,086,409		2,086,409	(142,427)	1,943,982		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,195,275	996,644	2,501,704	9,693,623		9,693,623	(181,039)	9,512,584		29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

**See schedule of adjustments attached at end of cost report.

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	
	D. Ownership											
30	Depreciation			27,116	27,116		27,116	8,233	35,349			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			74,449	74,449		74,449	37,806	112,255			32
33	Real Estate Taxes							233,273	233,273			33
34	Rent-Facility & Grounds			1,625,930	1,625,930		1,625,930	(228,693)	1,397,237			34
35	Rent-Equipment & Vehicles			18,292	18,292		18,292	2,383	20,675			35
36	Other (specify):*											36
37	TOTAL Ownership			1,745,787	1,745,787		1,745,787	53,002	1,798,789			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		935,472	213,637	1,149,109		1,149,109		1,149,109			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):* Nonallowable Cost			501,978	501,978		501,978	(501,978)				43
44	TOTAL Special Cost Centers		935,472	825,115	1,760,587		1,760,587	(501,978)	1,258,609			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,195,275	1,932,116	5,072,606	13,199,997		13,199,997	(630,015)	12,569,982			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.

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 Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	518	30		9
10	Interest and Other Investment Income	(684)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,006)	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	(4,140)	43		18
19	Entertainment	(3,365)	43		19
20	Contributions	(11,280)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(146,000)	43		24
25	Fund Raising, Advertising and Promotional	(129,026)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(7,647)	43		28
29	Other-Attach Schedule See PG5A)	(225,725)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (529,355)		\$	30

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)	(100,660)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (100,660)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (630,015)		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 Shops		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	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Claremont Rehab & Living Center

ID# 0047043

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	To offset Misc. telephone income	\$ 2	21	1
2	Cable	(4,631)	43	2
3	To disallow marketing salary	(80,818)	43	3
4	To offset misc. income	(18,757)	21	4
5	To offset misc. income-meals	(4,200)	2	5
6	To disallow non-allowable legal fees	(848)	19	6
7	To disallow settlement	(3,250)	43	7
8	Disallow lobbying expense	(3,408)	20	8
9	Disallow xray expense	(36,898)	43	9
10	Disallow laboratory fees	(72,917)	43	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	(225,725)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Claremont Rehab & Living Center# 0047043

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	1
2	Food Purchase	(4,200)	0	0	0	#REF!	0	0	0	0	0	0	#REF!	2
3	Housekeeping	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	3
4	Laundry	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	4
5	Heat and Other Utilities	0	0	1,823	0	#REF!	0	0	0	0	0	0	#REF!	5
6	Maintenance	0	0	3,327	0	#REF!	0	0	0	0	0	0	#REF!	6
7	Other (specify):*	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	7
8	TOTAL General Services	(4,200)	0	5,150	0	#REF!	0	0	0	0	0	0	#REF!	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	9
10	Nursing and Medical Records	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	10
10a	Therapy	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	10a
11	Activities	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	11
12	Social Services	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	12
13	CNA Training	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	13
14	Program Transportation	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	14
15	Other (specify):*	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	15
16	TOTAL Health Care and Programs	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	16
	C. General Administration													
17	Administrative	0	0	(316,861)	0	#REF!	0	0	0	0	0	0	#REF!	17
18	Directors Fees	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	18
19	Professional Services	(848)	250	4,316	0	#REF!	0	0	0	0	0	0	#REF!	19
20	Fees, Subscriptions & Promotions	(3,408)	0	1,357	0	#REF!	0	0	0	0	0	0	#REF!	20
21	Clerical & General Office Expenses	(18,755)	0	125,475	0	#REF!	0	0	0	0	0	0	#REF!	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	22
23	Inservice Training & Education	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	23
24	Travel and Seminar	0	0	1,543	0	#REF!	0	0	0	0	0	0	#REF!	24
25	Other Admin. Staff Transportation	0	0	317	0	#REF!	0	0	0	0	0	0	#REF!	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,162	0	#REF!	0	0	0	0	0	0	#REF!	26
27	Other (specify):*	0	0	23,463	0	#REF!	0	0	0	0	0	0	#REF!	27
28	TOTAL General Administration	(23,011)	250	(159,228)	0	#REF!	0	0	0	0	0	0	#REF!	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(27,211)	250	(154,078)	0	#REF!	0	0	0	0	0	0	#REF!	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Claremont Rehab & Living Center# 0047043

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	518	0	7,715	0	#REF!	0	0	0	0	0	0	#REF!	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	31
32	Interest	(684)	25,392	13,098	0	#REF!	0	0	0	0	0	0	#REF!	32
33	Real Estate Taxes	0	0	4,205	0	#REF!	0	0	0	0	0	0	#REF!	33
34	Rent-Facility & Grounds	0	0	375	0	#REF!	0	0	0	0	0	0	#REF!	34
35	Rent-Equipment & Vehicles	0	0	2,383	0	#REF!	0	0	0	0	0	0	#REF!	35
36	Other (specify):*	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	36
37	TOTAL Ownership	(166)	25,392	27,776	0	#REF!	0	0	0	0	0	0	#REF!	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	38
39	Ancillary Service Centers	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	39
40	Barber and Beauty Shops	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	40
41	Coffee and Gift Shops	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	41
42	Provider Participation Fee	0	0	0	0	#REF!	0	0	0	0	0	0	#REF!	42
43	Other (specify):*	(501,978)	0	0	0	#REF!	0	0	0	0	0	0	#REF!	43
44	TOTAL Special Cost Centers	(501,978)	0	0	0	#REF!	0	0	0	0	0	0	#REF!	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(529,355)	25,642	(126,302)	0	#REF!	0	0	0	0	0	0	#REF!	45

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
See Schedule 6C		See Schedule 6A		See Schedule 6B		

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	19 Professional Fees	\$	Claremont Extended Healthcare Realty, LLC	100.00%	\$ 250	\$	250
2	V	32 Interest Expense		Claremont Extended Healthcare Realty, LLC	100.00%	25,392		25,392
3	V							
4	V							
5	V							
6	V							
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$			\$ 25,642	\$ *	25,642

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 Utilities	\$	NuCare Management Company	80.00%	\$ 1,823	\$ 1,823
16	V	6 Repairs and Maintenance		NuCare Management Company	80.00%	3,327	3,327
17	V	17 Management Fees	365,000	NuCare Management Company	80.00%	48,139	(316,861)
18	V	19 Professional Fees		NuCare Management Company	80.00%	4,316	4,316
19	V	20 Dues, Subscriptions		NuCare Management Company	80.00%	1,357	1,357
20	V	21 Office Expense		NuCare Management Company	80.00%	125,475	125,475
21	V	24 Education and Seminars		NuCare Management Company	80.00%	1,543	1,543
22	V	25 Other Admin Transportation		NuCare Management Company	80.00%	317	317
23	V	26 Insurance		NuCare Management Company	80.00%	1,162	1,162
24	V	27 Employee Benefits		NuCare Management Company	80.00%	23,463	23,463
25	V	30 Depreciation Expense		NuCare Management Company	80.00%	7,715	7,715
26	V	32 Interest & Amortization		NuCare Management Company	80.00%	5,237	5,237
27	V	33 Real Estate Taxes		NuCare Management Company	80.00%	4,205	4,205
28	V	34 Facility Rent		NuCare Management Company	80.00%	375	375
29	V	35 Equipment Rental		NuCare Management Company	80.00%	2,383	2,383
30	V						
31	V						
32	V	32 Interest & Amortization		NuCare Management Company	80.00%	7,861	7,861
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 365,000			\$ 238,698	\$ * (126,302)

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

Claremont Rehab & Living Center

PROVIDER # 0047043

1/1/06 - 12/31/06

Schedule 6A

VII. RELATED PARTIES

RELATED NURSING HOMES

PART A COLUMN 2

NAME	CITY
California Gardens Corp.	Chicago
Chevy Chase Corp.	Chicago
Claremont	Buffalo Grove
Forest Villa	Niles
Imperial	Chicago
Jackson Corp.	Chicago
Monroe Pavilion	Chicago
Renaissance at 87th Street	Chicago
Renaissance at Hillside	Hillside
Renaissance at Midway	Chicago
Renaissance at South Shore	Chicago

See Accountants' Compilation Report

Claremont Rehab & Living Center

PROVIDER # 0047043

1/1/06 - 12/31/06

Schedule 6B

VII. RELATED PARTIES

OTHER RELATED BUSINESS ENTITIES

PART A COLUMN 3

<u>NAME</u>	<u>CITY</u>	<u>TYPE OF BUSINESS</u>
NuCare Services	Lincolnwood	Bookkeeping Management
7257 N. Lincoln Avenue, LLC	Lincolnwood	Building Rental
Diamond Insurance	Northbrook	Workers Comp Insurance
Seasons Hospice	** Park Ridge	Hospice
Care Path	Lincolnwood	Management Co.
JLR Management	Lincolnwood	Management Co.
JEM Rehabilitation Serv.	** Chicago	Psychiatric Services
DBD Rehabilitation Serv.	** Chicago	Psychiatric Services

** No Expense paid by home to the related entity
therefore no page 6 or 8 is necessary for this related business.

See Accountants' Compilation Report

Claremont Rehab & Living Center

Provider #: 0047043

01/01/06 to 12/31/06

Schedule 6c

<u>Name</u>	<u>Ownership %</u>
Ross Bottner	4%
Nancy Bottner	1%
Jonah Bruck	4%
Jo Bruck	1%
Barry Carr	4%
Randi S. Carr	4%
Ryan A. Carr	1%
Jared S. Carr	1%
David Hartman	40%
Robert Hartman Dynasty Trust	9.50%
Robert Hartman Family Trust	9.50%
Robert and Debra Hartman Family Foundation	6.75%
Robert Hartman	4.25%
Gerry Jenich	4%
Dawn Jenich	1%
Leonard Weiss	4%
Jessica Weiss	1%
	<u>100%</u>

See Accountants' Compilation Report

Facility Name & ID Number

Claremont Rehab & Living Center

0047043

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	David Hartman	Member	Administrative	40.00	See Sch 7A	13.33	33.00	Mgmt. Fee	\$ 73,333	L17,C8	1
2	Robert Hartman	Member	Administrative	4.25	See Sch 7B	0.68	2.00	Mgmt. Fee	3,393	L17,C8	2
3	Barry Carr	Member	Administrative	4.00	See Sch 7C	3.39	8.00	Mgmt. Fee	6,244	L17,C8	3
4	Ross Bottner	Member	Administrative	4.00	See Sch 7D	4	8.00	Mgmt. Fee	See Sch 7D	L17,C8	4
5	Gerry Jenich	Member	Administrative	4.00	See Sch 7D	4	8.00	Mgmt. Fee	See Sch 7D	L17,C8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 82,970		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

Claremont Rehab & Living Center

Provider #: 0047043

01/01/06 to 12/31/06

Schedule 7D

<u>Name</u>	<u>Ownership %</u>	<u>Compensation</u>
Ross Bottner	4%	**
Gerry Jenich	4%	**

** The above members are employees of NuCare Service Corporation and as such receive salaries. The salary amounts for the above individuals is included within the total clerical salaries of \$1,578,326. The total clerical salaries for all NuCare Service Corporation employees is then allocated to several facilities and this facility is allocated an amount for all clerical employees of \$107,117.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Claremont Rehab & Living Center

0047043

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 NuCare Management Company
 Street Address 7257 N. Lincoln #100
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 933-2600
 Fax Number (847) 933-2601

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	5	Utilities	Bed days available	901,760	11	\$ 26,855	\$ 61,200	\$ 1,823	1	
2	6	Repairs and Maintenance	Bed days available	901,760	11	49,026	61,200	3,327	2	
3	17	Management Fees	Bed days available	901,760	11	223,510	216,927	61,200	15,169	3
4	19	Professional Fees	Bed days available	901,760	11	63,602	61,200	4,316	4	
5	20	Dues, Subscriptions	Bed days available	901,760	11	19,991	61,200	1,357	5	
6	21	Office Expense	Bed days available	901,760	11	1,848,834	1,578,326	61,200	125,475	6
7	24	Education and Seminars	Bed days available	901,760	11	22,739	61,200	1,543	7	
8	25	Other Admin Transportation	Bed days available	901,760	11	4,678	61,200	317	8	
9	26	Insurance	Bed days available	901,760	11	17,115	61,200	1,162	9	
10	27	Employee Benefits	Bed days available	901,760	11	294,714	61,200	20,001	10	
11	30	Depreciation Expense	Bed days available	901,760	11	146,433	61,200	9,938	11	
12	32	Interest & Amortization	Bed days available	901,760	11	77,159	61,200	5,237	12	
13	33	Real Estate Taxes	Bed days available	901,760	11	61,966	61,200	4,205	13	
14	34	Facility Rent	Bed days available	901,760	11	5,526	61,200	375	14	
15	35	Equipment Rental	Bed days available	901,760	11	35,110	61,200	2,383	15	
16									16	
17	30	Depreciation Expense	Direct allocation		11			(2,223)	17	
18	32	Interest & Amortization	Bed days available	901,760	11	115,822	61,200	7,861	18	
19									19	
20	17	Management Fees	Direct allocation		11	212,000		32,970	20	
21	27	Employee Benefits	Direct allocation		11	39,038		3,462	21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 3,264,118	\$ 1,795,253	\$ 238,698	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Claremont Rehab & Living Center# 0047043

Report Period Beginning:

01/01/06

Ending:

12/31/06**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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	LaSalle Bank		X	Note Payable	Interest Only	3/31/05	\$ 300,000	\$ 287,500	3/31/2010	0.0875	\$ 25,392	1						
2												2						
3												3						
4												4						
5												5						
	Working Capital																	
6	LaSalle Bank		X	Line of Credit	Interest Only	3/31/06	1,450,000	1,450,000	03/31/07	0.0875	49,057	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 1,750,000	\$ 1,737,500			\$ 74,449	9						
	B. Non-Facility Related*																	
10									Interest Income Offset		(684)	10						
11									Management Company allocation		38,490	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 37,806	14						
15	TOTALS (line 9+line14)						\$ 1,750,000	\$ 1,737,500			\$ 112,255	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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.			\$		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.)	2005		\$	229,068	2
3. Under or (over) accrual (line 2 minus line 1).			\$	229,068	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		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
		Allocation from Management Company		4,205	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	233,273	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2001	182,528	8	FOR BHF USE ONLY	
	2002	207,185	9	13	FROM R. E. TAX STATEMENT FOR 2005 \$ 13
	2003	215,770	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2004	224,097	11	15	LESS REFUND FROM LINE 6 \$ 15
	2005	229,068	12	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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Claremont Rehab & Living Center COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0047043

CONTACT PERSON REGARDING THIS REPORT Jay Flatt

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>15-33-404-140</u>	<u>Nursing Home</u>	\$ <u>229,067.84</u>	\$ <u>229,067.84</u>
2. <u>10-27-319-028-0000</u>	<u>Management Company</u>	\$ <u>94,936.32</u>	\$ <u>4,205.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>324,004.16</u>	\$ <u>233,272.84</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? X YES 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Claremont Rehab & Living Center

0047043

Report Period Beginning:

01/01/06

Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 86,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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 grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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: N/A

(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	<u>Allocation from management company</u>			<u>\$ 10,608</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 10,608	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Claremont Rehab & Living Center

0047043

Report Period Beginning:

01/01/06

Ending:

12/31/06

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Allocation		2005		\$ 95,471	\$	25	\$ 2,728	\$ 2,728	\$ 8,524	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Data cables & jacks		2005		8,647	432	20	432		648	9
10	Electrical work		2005		4,050	203	20	203		304	10
11	Landscape architecture		2005		4,500	225	20	225		338	11
12	Alarm for door		2005		1,550		20	78	78	117	12
13	Flooring		2005		55,880	2,794	20	2,794		4,191	13
14	Heater		2005		1,578	78	20	78		117	14
15	Sewerline		2005		4,000	200	20	200		300	15
16	Nursing Station countertop and cabinet		2005		13,000	650	20	650		975	16
17	Draperies		2005		5,013	251	20	251		376	17
18	Modulator and DTV box		2005		750	37	20	37		56	18
19	Wireless TV satellite dish		2005		1,137	57	20	57		85	19
20	Concrete by parlor exit		2005		1,575		20	79	79	118	20
21	Microboard		2005		5,110	256	20	256		384	21
22	Electrical work		2005		1,720		20	86	86	129	22
23	Chair Rail		2006		4,293	107	20	107		107	23
24	Dining Room Remodel		2006		3,875	97	20	97		97	24
25	Door Repairs		2006		4,440	111	20	111		111	25
26	Electrical Work		2006		19,035	476	20	476		476	26
27	Elevator		2006		1,800	45	20	45		45	27
28	Fireproof Basement		2006		2,620	66	20	66		66	28
29	Flooring		2006		41,808	1,045	20	1,045		1,045	29
30	Kitchen Remodel		2006		23,800	595	20	595		595	30
31	Landscaping		2006		16,528	413	20	413		413	31
32	Play Area		2006		6,718	168	20	168		168	32
33	Remodel Dialysis Unit		2006		3,800	95	20	95		95	33
34	Remodel Resident Rooms		2006		22,640	566	20	566		566	34
35	Roof		2006		1,750	44	20	44		44	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 & ID Number Claremont Rehab & Living Center

0047043

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	Motor	2006	\$ 2,080	\$ 52	20	\$ 52	\$	\$ 52	37
38	Thermostat	2006	18,900	473	20	473		473	38
39	Wall Mural & Wallpaper	2006	5,860	147	20	147		147	39
40	Water Heater	2006	30,639	766	20	766		766	40
41	Window Treatments	2006	10,774	269	20	269		269	41
42	Compressor	2006	15,410	385	20	385		385	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58	2006 Allocation from management company:								58
59	Alarm System	2003	795		20	40	40	124	59
60	Buildout of Offices	2004	16,139		20	808	808	2,189	60
61	Security & Fire Alarm System	2004	1,897		20	95	95	237	61
62	Data Cables, Lights & Heat Exchanger	2005	957		20	48	48	88	62
63	Fire Alarm System	2005	8,703		20	562	562	736	63
64	Cooling Unit	2006	1,297		20	24	24	24	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 470,539	\$ 11,103		\$ 15,651	\$ 4,548	\$ 25,980	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 103,980	\$ 10,122	\$ 10,396	\$ 274	10	\$ 15,596	71
72	Current Year Purchases	109,085	5,454	5,454		10	5,454	72
73	Fully Depreciated Assets							73
74	Allocation from management company	43,457		3,411	3,411		20,820	74
75	TOTALS	\$ 256,522	\$ 15,576	\$ 19,261	\$ 3,685		\$ 41,870	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	Bus	2006	\$ 4,365	\$ 437	\$ 437	\$	5	\$ 437	76
77										77
78										78
79										79
80	TOTALS			\$ 4,365	\$ 437	\$ 437	\$		\$ 437	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)	\$ 742,034	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 27,116	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 35,349	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,233	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 68,287	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Claremont Extended Healthcare, LLC

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:	<u>1994</u>	<u>200</u>	<u>3/1/05</u>	\$ <u>1,396,862</u>	<u>5</u>	<u>15</u>	3
4	Additions							4
5		<u>Allocation from Management Company</u>			<u>375</u>			5
6								6
7	TOTAL		<u>200</u>		\$ <u>1,397,237</u>			7

10. Effective dates of current rental agreement:

Beginning 3/1/05

Ending 2/28/2010

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/31/07 \$ 1,553,706

13. 12/31/08 \$ 1,599,606

14. 12/31/09 \$ 1,608,456

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 N/A.

N/A

N/A

9. Option to Buy: YES NO Terms: \$550,000 option can be exercised after 10/09 *

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: \$ 16,225 Description: Copy Machine \$3,677; Storage \$4,165; Parking \$6,000; Allocation from management company \$2,383

(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	<u>Patients</u>	<u>99 14 Passenger Bus</u>	\$ <u>899.00</u>	\$ <u>1,798</u>	17
18	<u>Administration</u>	<u>Infiniti</u>	<u>884.00</u>	<u>2,652</u>	18
19					19
20					20
21	TOTAL		\$ <u>1,783.00</u>	\$ <u>4,450</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.

SEE ACCOUNTANTS' COMPILATION REPORT

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?</p> <p><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		3	4
		1	2		
		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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A C1, C3	9038 hrs	\$ 271,154	2,564	\$ 128,244		11,602	\$ 399,398	1
2	Licensed Speech and Language Development Therapist	L10A C1, C3	2356 hrs	70,689	608	36,507		2,964	107,196	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A C1,C2,C3	13993 hrs	419,777	3,971	198,536	17,252	17,964	635,565	4
5	Physician Care		visits							5
6	Dental Care	L39 C3	visits		15	1,820		15	1,820	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39 C2	# of prescrpts				935,472		935,472	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>See Schedule 16A</u>	<u>See Sch 16A</u>			2,461	222,362		2,461	222,362	13
14	TOTAL			\$ 761,620	9,619	\$ 587,469	\$ 952,724	35,006	\$ 2,301,813	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Claremont Rehab & Living Center
PROVIDER #0047043
1/1/06 - 12/31/06

Schedule 16A

XIV. SPECIAL SERVICES (Direct Cost) Line 14

Service	Schedule V Line & Col. Ref.	Outside Practitioner	
		Units	Costs
Respiratory Therapy	L10A C3	352	10,545
Ambulance	L39 C3	2	1,117
Hemodialysis	L39 C3	2,107	210,700
		<u>2,461</u>	<u>222,362</u>

Facility Name & ID Number Claremont Rehab & Living Center

0047043

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,405	\$ 5,155	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>255,274</u>)	2,433,599	2,433,599	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,328	36,328	6
7	Other Prepaid Expenses	77,378	77,378	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Sch 17A</u>	297,971	847,971	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,849,681	\$ 3,400,431	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		10,608	13
14	Buildings, at Historical Cost		95,471	14
15	Leasehold Improvements, at Historical Cost	340,434	375,068	15
16	Equipment, at Historical Cost	214,727	260,887	16
17	Accumulated Depreciation (book methods)	(34,769)	(68,287)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 520,392	\$ 673,747	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,370,073	\$ 4,074,178	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 191,923	\$ 191,923	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,450,000	1,531,250	29
30	Accrued Salaries Payable	516,052	516,052	30
31	Accrued Taxes Payable (excluding real estate taxes)	71,895	71,895	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Sch 17A</u>	381,342	678,138	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,611,212	\$ 2,989,258	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		206,250	39
40	Mortgage Payable			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)	\$	\$ 206,250	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,611,212	\$ 3,195,508	46
47	TOTAL EQUITY(page 18, line 24)	\$ 758,861	\$ 878,670	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,370,073	\$ 4,074,178	48

Claremont Rehab & Living Center
PROVIDER #0047043
1/1/06 - 12/31/06

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.

A. Current Assets

		After
Other Current Assets (specify):	Operating	Consolidation
Option	-	550,000
CH Deposits	1,175	1,175
Due from Related Party	296,796	296,796
Total Line 9 - Other Current Assets (specify):	<u>297,971</u>	<u>847,971</u>

C. Current Liabilities

		After
Other Current Liabilities (specify):	Operating	Consolidation
Due to Related Party	-	(296,796)
Accrued Expenses	(193,513)	(193,513)
Accrued Utilities	(13,173)	(13,173)
401 K Exchange	(1,501)	(1,501)
Due to Prior Owner	(67,743)	(67,743)
Due Nuicare Services Co	(1,831)	(1,831)
Due Nuvision	(1,555)	(1,555)
Resident Credit Balances	(102,026)	(102,026)
Total Line 36 - Other Current Liabilities (specify):	<u>(381,342)</u>	<u>(678,138)</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 440,302	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 440,302	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	468,559	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	(150,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 318,559	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)	\$ 758,861	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Claremont Rehab & Living Center# 0047043Report Period Beginning: 01/01/06Ending: 12/31/06**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 13,450,242	1
2	Discounts and Allowances for all Levels	(4,789,706)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,660,536	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,082,056	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,082,056	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	178	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,022	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,383,051	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	114,796	19
20	Radiology and X-Ray	48,978	20
21	Other Medical Services	355,498	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,906,523	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	684	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 684	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous income</u>	18,757	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,757	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,668,556	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,709,007	31
32	Health Care	5,898,207	32
33	General Administration	2,086,409	33
	B. Capital Expense		
34	Ownership	1,745,787	34
	C. Ancillary Expense		
35	Special Cost Centers	1,651,087	35
36	Provider Participation Fee	109,500	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,199,997	40
41	Income before Income Taxes (line 30 minus line 40)**	468,559	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 468,559	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity is a cash basis taxpayer.

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

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

Facility Name & ID Number Claremont Rehab & Living Center

0047043

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	2,312	2,734	\$ 109,502	\$ 40.05	1
2	Assistant Director of Nursing	499	532	19,233	36.15	2
3	Registered Nurses	37,383	40,099	984,362	24.55	3
4	Licensed Practical Nurses	12,867	13,704	426,051	31.09	4
5	CNAs & Orderlies	93,807	104,275	1,426,800	13.68	5
6	CNA Trainees	33,014	33,806	370,284	10.95	6
7	Licensed Therapist	25,387	25,387	761,620	30.00	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,227	1,326	22,760	17.16	9
10	Activity Assistants	13,938	14,634	127,833	8.74	10
11	Social Service Workers	6,498	7,074	150,015	21.21	11
12	Dietician	3,757	4,251	95,994	22.58	12
13	Food Service Supervisor					13
14	Head Cook	3,485	4,086	46,197	11.31	14
15	Cook Helpers/Assistants	27,733	29,164	226,442	7.76	15
16	Dishwashers					16
17	Maintenance Workers	5,734	6,233	84,080	13.49	17
18	Housekeepers	27,610	29,977	258,361	8.62	18
19	Laundry	3,927	4,413	35,237	7.98	19
20	Administrator	2,080	2,080	111,836	53.77	20
21	Assistant Administrator	811	811	27,875	34.37	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,308	20,840	283,631	13.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	7,727	9,022	257,953	28.59	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,934	4,495	42,918	9.55	31
32	Other Health C: See Sch 20A	20,642	21,736	317,445	14.60	32
33	Other(specify) <u>Rabbi</u>	540	540	8,846	16.38	33
34	TOTAL (lines 1 - 33)	353,220	381,219	\$ 6,195,275 *	\$ 16.25	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	292	\$ 13,769	L1,C3	35
36	Medical Director	Monthly	60,000	L9,C3	36
37	Medical Records Consultant	86	4,317	L10,C3	37
38	Nurse Consultant	324	6,480	L10,C3	38
39	Pharmacist Consultant	Monthly	3,210	L10,C3	39
40	Physical Therapy Consultant	105	6,920	L10A,C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	4,909	L10A,C3	43
44	Activity Consultant	47	2,574	L11,C3	44
45	Social Service Consultant	46	3,310	L12,C3	45
46	Other(specify) <u>Medical Consultant</u>	Monthly	30,000	L10,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	900	\$ 135,489		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

SEE ACCOUNTANTS' COMPILATION REPORT

Claremont Rehab & Living Center

Provider #: 0047043
01/01/06 to **12/31/06**

Schedule 20A

XVIII. STAFFING AND SALARY COSTS

	Hours Worked	Hours Paid	Salary	Avg Hr Wage	Cost Report Line
Rehab Assistants	10,089	10,621	134,032	13.68	10
Specialty Nurses	4,970	4,970	99,401	20.00	10
Case Manager	5,583	6,145	84,012	13.67	10
Total Line 32 - Other Health Care	20,642	21,736	317,445	14.60	

See Accountants' Compilation Report

Claremont Rehab & Living Center

Provider #: 0047043

01/01/06 to 12/31/06

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 74,789

Allocation from Real Estate Entity

Professional Fees - Other 250

Allocation from Management Company

Legal Fees 3,127

Accounting Fees 1,189

4,316

Non-Allowable Legal Fees

Sachnoff & Weaver, LTD (348)

Foley & Lardner LLP (500)

(848)

Total (agree to Schedule V, line 19, column 8) 78,507

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	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7	N/A											
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Claremont Rehab & Living Center# 0047043Report Period Beginning: 01/01/06Ending: 12/31/06**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. IHCA \$11,120
- (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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 49,419 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. \$ 109,500
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. \$ 39,562 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,200
- (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? N/A
- 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? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No
- 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT