

Facility Name & ID Number Community Nursing & Rehabilitation Center

0044750 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	153	Skilled (SNF)	153	55,845	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	153	TOTALS	153	55,845	7

B. Census-For the entire report period.

	1 Level of Care	2 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	30,933	8,206	10,429	49,568	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,933	8,206	10,429	49,568	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.76%

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 04/01/00

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

YES Date 04/01/00 NO

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

YES NO If YES, enter number

of beds certified 153 and days of care provided 5,474

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 Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	287,944	43,829	7,053	338,826		338,826		338,826		1
2	Food Purchase		235,155		235,155		235,155	(10,370)	224,785		2
3	Housekeeping	203,193	48,085		251,278		251,278		251,278		3
4	Laundry	48,463	22,922		71,385		71,385		71,385		4
5	Heat and Other Utilities			160,648	160,648		160,648		160,648		5
6	Maintenance	41,172	19,305	58,313	118,790		118,790		118,790		6
7	Other (specify):*										7
8	TOTAL General Services	580,772	369,296	226,014	1,176,082		1,176,082	(10,370)	1,165,712		8
	B. Health Care and Programs										
9	Medical Director			20,300	20,300		20,300		20,300		9
10	Nursing and Medical Records	2,690,894	91,970	14,310	2,797,174		2,797,174		2,797,174		10
10a	Therapy			399,842	399,842		399,842		399,842		10a
11	Activities	111,757	4,061		115,818		115,818		115,818		11
12	Social Services	36,764			36,764		36,764		36,764		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,839,415	96,031	434,452	3,369,898		3,369,898		3,369,898		16
	C. General Administration										
17	Administrative			230,016	230,016		230,016		230,016		17
18	Directors Fees										18
19	Professional Services			110,331	110,331		110,331		110,331		19
20	Dues, Fees, Subscriptions & Promotions			30,537	30,537		30,537		30,537		20
21	Clerical & General Office Expenses	198,794	22,323	52,947	274,064		274,064	(319)	273,745		21
22	Employee Benefits & Payroll Taxes			596,116	596,116		596,116	10,370	606,486		22
23	Inservice Training & Education			296	296		296		296		23
24	Travel and Seminar			1,509	1,509		1,509		1,509		24
25	Other Admin. Staff Transportation			1,415	1,415		1,415		1,415		25
26	Insurance-Prop.Liab.Malpractice			232,946	232,946		232,946		232,946		26
27	Other (specify):*										27
28	TOTAL General Administration	198,794	22,323	1,256,113	1,477,230		1,477,230	10,051	1,487,281		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,618,981	487,650	1,916,579	6,023,210		6,023,210	(319)	6,022,891		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.

Facility Name & ID Number

Community Nursing & Rehabilitation Center

#0044750

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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			155,996	155,996		155,996	104,746	260,742			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			92,233	92,233		92,233	361,997	454,230			32
33	Real Estate Taxes							117,705	117,705			33
34	Rent-Facility & Grounds			674,155	674,155		674,155	(674,155)				34
35	Rent-Equipment & Vehicles			41,195	41,195		41,195		41,195			35
36	Other (specify):*											36
37	TOTAL Ownership			963,579	963,579		963,579	(89,707)	873,872			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		319,208		319,208		319,208		319,208			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			7,303	7,303		7,303	(3,197)	4,106			41
42	Provider Participation Fee			83,764	83,764		83,764		83,764			42
43	Other (specify):* Nonallowable Cost			45,538	45,538		45,538	(45,538)				43
44	TOTAL Special Cost Centers		319,208	136,605	455,813		455,813	(48,735)	407,078			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,618,981	806,858	3,016,763	7,442,602		7,442,602	(138,761)	7,303,841			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

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	20,551	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,801)	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				18
19	Entertainment				19
20	Contributions	(100)	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				24
25	Fund Raising, Advertising and Promotional	(25,660)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(7,856)	43		28
29	Other-Attach Schedule See Sechedule 5A	(13,637)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (28,503)		\$	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)	(110,258)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (110,258)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (138,761)		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

Community Nursing & Rehabilitation Center

ID# 0044750

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Penalties	\$ (1,403)	43	1
2	Coffee Shop Income	(3,197)	41	2
3	Laboratory	(4,020)	43	3
4	X-Ray	(4,698)	43	4
5	Miscellaneous Income	(319)	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(13,637)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Community Nursing & Rehabilitation Center# 0044750

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	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	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	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
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	(319)	0	0	0	0	0	0	0	0	0	0	(319)	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	TOTAL General Administration	(319)	0	0	0	0	0	0	0	0	0	0	(319)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(319)	0	0	0	0	0	0	0	0	0	0	(319)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	20,551	84,195	0	0	0	0	0	0	0	0	0	104,746	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	361,997	0	0	0	0	0	0	0	0	0	361,997	32
33	Real Estate Taxes	0	117,705	0	0	0	0	0	0	0	0	0	117,705	33
34	Rent-Facility & Grounds	0	(674,155)	0	0	0	0	0	0	0	0	0	(674,155)	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	TOTAL Ownership	20,551	(110,258)	0	(89,707)	37								
	Ancillary Expense													
	E. Special Cost Centers													
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	(3,197)	0	0	0	0	0	0	0	0	0	0	(3,197)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(45,538)	0	0	0	0	0	0	0	0	0	0	(45,538)	43
44	TOTAL Special Cost Centers	(48,735)	0	0	0	0	0	0	0	0	0	0	(48,735)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(28,503)	(110,258)	0	(138,761)	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
Mark and Chana Weldler	29.50	Pine Acres Rehab & Living Center, LLC	DeKalb	Community Nursing and Rehab Realty, LLC		
Steve and Bluma Jeremias	29.50					
Malka Mermelstein	0.50				Naperville	Real Estate
Herman Mermelstein	0.50			Pine Acres Realty, LLC		
Joseph Neumann	30.00				DeKalb	Real Estate
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		\$ 84,195	\$ 84,195	1
2	V	32 Interest Expense		Community Nursing & Rehab. Realty, LLC		361,997	361,997	2
3	V	33 Property Tax		Community Nursing & Rehab. Realty, LLC		117,705	117,705	3
4	V	34 Rent Expense	674,155	Community Nursing & Rehab. Realty, LLC			(674,155)	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		\$ 674,155			\$ 563,897	\$ * (110,258)	14

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

Facility Name & ID Number Community Nursing & Rehabilitation Cente # 0044750 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	Administrative	29.50	55,000	25	50.00	Guar Pymts	\$ 115,008	17(3)	1
2	Mark Weldler	CFO	Finance	29.50	55,000	25	50.00	Guar Pymts	115,008	17(3)	2
3											3
4											4
5			Compensation from Pine Acres Rehab and Living Center, LLC								5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 230,016		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:

01/01/2006

Ending: 2/31/2006

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

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 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 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>07-12-403-042</u>	<u>Nursing Home</u>	\$ <u>115,705.00</u>	\$ <u>115,705.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>115,705.00</u>	\$ <u>115,705.00</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 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 62,087 B. General Construction Type: Exterior Brick Frame Steel Number of Stories Two

C. Does the Operating Entity? (a) Own the Facility (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).

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>164,335</u>	<u>2000</u>	<u>\$ 453,622</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	164,335		\$ 453,622	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center

0044750

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	153		2000	1986	\$ 4,184,589	\$	40	\$ 104,618	\$ 104,618	\$ 706,157	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CABLE		2000		4,305	108	40	108		729	9
10	ELEVATOR DOOR		2000		4,389	110	40	110		733	10
11	PARKING LOT		2000		38,200	955	40	955		6,367	11
12	LANDSCAPING		2000		8,736	218	40	218		1,435	12
13	SIGN		2000		4,541	114	40	114		750	13
14	ARCHITECT FEES		2000		3,060	77	40	77		517	14
15	DOOR LOCK		2000		2,248	56	40	56		369	15
16	CLOSETS		2000		7,729	193	40	193		1,238	16
17	COVE BASE		2000		4,459	111	40	111		694	17
18	HANDRAILS AND KICKPLATES		2000		15,146	379	40	379		2,369	18
19	LIGHTING		2000		65,796	1,645	40	1,645		10,281	19
20	TILE		2000		2,317	58	40	58		362	20
21	FLOORING		2000		16,378	409	40	409		2,507	21
22	EXIT DOORS		2000		1,598	40	40	40		250	22
23	WINDOW AND CUBICLE TREATMENTS		2000		34,021	851	40	851		5,319	23
24	LIGHTING		2000		1,729	43	40	43		269	24
25	CARPETING		2000		27,139	678	40	678		4,238	25
26	FIRE PANEL		2000		4,500	113	40	113		706	26
27	NURSE'S STATION		2000		8,913	223	40	223		1,375	27
28	DOOR HANDLES		2000		1,644	41	40	41		253	28
29	CUBICLE TRACK		2000		915	23	40	23		140	29
30	MOTOR		2000		13,276	332	40	332		2,158	30
31	STOVE HOODS		2000		1,429	36	40	36		219	31
32	COVER BASE - RESIDENTS' ROOMS		2001		865	87	10	87		514	32
33	CERAMIC TILES		2001		10,930	1,093	10	1,093		6,467	33
34	CEILING & LIGHTING		2001		9,063	906	10	906		5,261	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 & ID Number Community Nursing & Rehabilitation Center

0044750

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	\$	\$ 6,249	37
38	TILE & COVE BASE - BASEMENT	2001	2,327	233	10	233		1,398	38
39	SHAMPOO STATION	2001	5,431	543	10	543		3,213	39
40	COVE BASE - SECOND FLOOR	2001	1,699	170	10	170		1,006	40
41	WALLPAPER/COVEBASE/CARPETING/LIGHTING	2001	1,403	140	10	140		829	41
42	ABS PUMP	2001	11,908	1,191	10	1,191		7,047	42
43	CARPETING	2001	14,572	1,457	10	1,457		8,621	43
44	FLOORING	2001	1,320	132	10	132		781	44
45	2ND FLOOR RENOVATIONS	2001	38,875	3,888	10	3,888		22,356	45
46	AVERY	2001	2,419	242	10	242		1,391	46
47	KITCHEN - COOLING AIR UNIT	2001	2,275	228	10	228		1,330	47
48	WALLCOVERINGS	2001	12,289	1,229	10	1,229		7,374	48
49	SIGNAGE/ELECTRIC BALLAST (ADMISSIONS OFFICE)	2001	3,131	313	10	313		1,774	49
50	ROOM CURTAIN DIVIDER	2001	2,003	200	10	200		1,134	50
51	HANDRAILS & BUMPER GUARDS	2001	17,855	1,786	10	1,786		10,120	51
52	FIRE ALARM TRANSFORMER	2001	1,715	172	10	172		974	52
53	TEMP CONTROL ON AIR HANDLER	2001	9,519	952	10	952		5,395	53
54	COVEBASE/LANDSCAPING/LIGHTING/FLOORING	2001	2,642	264	10	264		1,496	54
55	LIGHTING - CORRIDORS & RESIDENT ROOMS	2001	20,544	2,054	10	2,054		11,468	55
56	NEW BEARING & SHAFT	2001	1,402	140	10	140		770	56
57	DIALYSIS ROOM RENOVATIONS	2001	23,351	2,335	10	2,335		11,870	57
58	ASPHALT SEALCOATING & STRIPING	2001	1,405	141	10	141		752	58
59	KITCHEN TILE	2001	930	93	10	93		488	59
60	SEPTIC TANK PUMPS	2001	13,862	1,386	10	1,386		7,277	60
61	CARPETING	2001	5,729	573	10	573		3,199	61
62	PAINTING & WALLPAPER	2001	20,440	2,044	10	2,044		12,264	62
63	PAINTING & WALLPAPER	2001	11,875	1,188	10	1,188		6,831	63
64	PAINTING & WALLPAPER	2001	4,500	450	10	450		2,513	64
65	NEW DOORS	2002	1,731	173	10	173		779	65
66	MURAL FOR SECOND FLOOR DINING ROOM	2002	7,000	700	10	700		3,150	66
67	NEW TROUGH IN LAUNDRY ROOM	2002	6,300	630	10	630		2,835	67
68	WINDOW MOLDINGS	2002	210	21	10	21		95	68
69	NEW THRESHHOLDS	2002	205	21	10	21		94	69
70	TOTAL (lines 4 thru 69)		\$ 4,739,340	\$ 35,044		\$ 139,662	\$ 104,618	\$ 908,550	70

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 Center

0044750

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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		\$ 139,662	\$ 104,618	\$ 908,550	1
2	NEW PVC PIPING IN KITCHEN	2002	1,320	132	10	132		594	2
3	UPGRADE BACKFLOW SYSTEM	2002	1,695	170	10	170		765	3
4	ALARM FOR RAMP EXIT	2002	1,443	144	10	144		648	4
5	FLOORING IN ELEVATOR	2002	856	86	10	86		387	5
6	CORNER GUARDS/WATER SOFTENER	2002	1,328	133	10	133		598	6
7	NEW DRAINAGE PIPES - DISPOSAL	2002	9,985	999	10	999		4,495	7
8	CORNER GUARDS	2003	276	28	10	28		112	8
9	UPGRADE DIALYSIS ROOM	2003	28,103	2,810	10	2,810		11,240	9
10	NEW AWNINGS FOR PATIO	2003	3,940	394	10	394		1,576	10
11	INSTALL GREASE TRAP IN KITCHEN	2003	3,250	325	10	325		1,300	11
12	NEW COIL FOR AIR HANDLER	2003	3,493	349	10	349		1,396	12
13	INSTALL LASER EYE ON ELEVATOR	2003	1,590	159	10	159		636	13
14	UPGRADE DIALYSIS ROOM	2004	30,778	3,078	10	3,078		9,234	14
15	NEW ROOF	2004	8,600	860	10	860		2,580	15
16	REMODEL VESTIBULE, NEW FLOORING	2004	10,044	1,004	10	1,004		3,012	16
17	INSTALL NEW SMOKE DETECTORS	2004	4,911	491	10	491		1,473	17
18	NEW OXYGEN ROOM	2004	5,688	569	10	569		1,707	18
19	NEW ELEVATOR TANK, PUMP AND MOTOR	2004	11,960	1,196	10	1,196		3,588	19
20	ROOF REPLACEMENT	2005	5,800	580	10	580		870	20
21	WIRE GLASS FOR RECEPTION WINDOW	2005	1,348	136	10	136		204	21
22	NEW CEMENT WALKWAYS	2005	2,400	240	10	240		360	22
23	NEW WALL HUNG SINK	2006	3,410	170	10	170		170	23
24	MOTOR FOR A/C	2006	664	33	10	33		33	24
25	NEW PUMP SYSTEM	2006	5,108	255	10	255		255	25
26	NEW HOT WATER HEATER	2006	7,998	400	10	400		400	26
27	SOLID STATE STARTER	2006	3,900	195	10	195		195	27
28	PUMP	2006	1,553	77	10	77		77	28
29	NEW FIRE ALARM	2006	6,800	340	10	340		340	29
30	NEW PUMP FOR BASEMENT A/C	2006	988	49	10	49		49	30
31	PAVE PARKING LOT	2006	3,500	175	10	175		175	31
32	NEW TIME CLOCK	2006	4,345	217	10	217		217	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,916,414	\$ 50,838		\$ 155,456	\$ 104,618	\$ 957,236	34

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	\$ 1,044,702	\$ 103,899	\$ 104,027	\$ 128	3-10	\$ 655,656	71
72	Current Year Purchases	25,178	1,259	1,259		10	1,259	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,069,880	\$ 105,158	\$ 105,286	\$ 128		\$ 656,915	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	\$	\$	\$	5	\$ 3,255	76
77										77
78										78
79										79
80	TOTALS			\$ 3,255	\$	\$	\$		\$ 3,255	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)	\$ 6,443,171	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 155,996	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 260,742	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 104,746	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,617,406	85

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

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

G. Construction-in-Progress

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

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

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

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? YES NO

If NO, see instructions.

		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	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A

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: N/A *

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: \$ 33,694 Description: Computers \$19618; Copier \$2908; Med. Equip. \$9837; Postage Meter \$773; Office Equip \$558

(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>Administrative</u>	<u>2004 Toyota Avalon</u>	\$ <u>577.00</u>	\$ <u>7,501</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>577.00</u>	\$ <u>7,501</u>	21

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. /2007 \$ _____

13. /2008 \$ _____

14. /2009 \$ _____

* 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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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	10A(3)	hrs	\$	826	\$ 49,533	\$	826	\$ 49,533	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		345	20,724		345	20,724	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		5,493	329,585		5,493	329,585	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				242,279		242,279	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Dialysis/Oxygen	39(2)					76,929		76,929	13
14	TOTAL			\$	6,664	\$ 399,842	\$ 319,208	6,664	\$ 719,050	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

Facility Name & ID Number Community Nursing & Rehabilitation Center

0044750

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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	\$ 79,102	\$ 79,831	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	2,668,985	2,668,985	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	109,142	109,142	6
7	Other Prepaid Expenses	983	983	7
8	Accounts Receivable (owners or related parties)	8,057	8,057	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,866,269	\$ 2,866,998	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		453,622	13
14	Buildings, at Historical Cost		4,184,589	14
15	Leasehold Improvements, at Historical Cost	840,487	731,825	15
16	Equipment, at Historical Cost	1,073,135	1,073,135	16
17	Accumulated Depreciation (book methods)	(943,533)	(1,617,406)	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) Mortgage Costs		48,386	22
23	Other(specify): Deposits & Due from Member	101,903	101,903	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,071,992	\$ 4,976,054	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,938,261	\$ 7,843,052	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 860,316	\$ 860,316	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	118,384	118,384	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,022	13,022	31
32	Accrued Real Estate Taxes(Sch.IX-B)		117,000	32
33	Accrued Interest Payable	22,055	22,055	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	2,642,464	506,105	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,656,241	\$ 1,636,882	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,000,000	6,157,629	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)	\$ 1,000,000	\$ 6,157,629	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,656,241	\$ 7,794,511	46
47	TOTAL EQUITY(page 18, line 24)	\$ (717,980)	\$ 48,541	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,938,261	\$ 7,843,052	48

Community Nursing & Rehabilitation Center, LLC
Provider # 0044750
1/1/06 - 12/31/06

Schedule 17A

XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Wage Garnishment	(14,342)	(14,342)
401K Liability	(2,477)	(2,477)
Due To State	(12,808)	(12,808)
Due to Third Party	(5,474)	(5,474)
Due to/from Adminastar	(47,208)	(47,208)
Due To /From Pine Acres Rehab & Living	(107,763)	(107,763)
Due To/From CNRR	(2,136,359)	-
Advance Billing	(210,918)	(210,918)
Resident Trust	(105,115)	(105,115)
Total Line 36	<u>(2,642,464)</u>	<u>(506,105)</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (465,826)	1
2	Restatements (describe):		2
3	POST CLOSING ADJUSTMENT	(4,223)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (470,049)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	37,069	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	(285,000)	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)	\$ (247,931)	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)	\$ (717,980)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 10,162,764	1
2	Discounts and Allowances for all Levels	(4,316,877)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,845,887	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,299,070	6
7	Oxygen	11,159	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,310,229	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	100	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	9,075	15
16	Rental of Facility Space		16
17	Sale of Drugs	244,868	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	57,634	21
22	Laundry	7,169	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 318,846	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	4,709	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,709	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,479,671	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,176,082	31
32	Health Care	3,369,898	32
33	General Administration	1,477,230	33
	B. Capital Expense		
34	Ownership	963,579	34
	C. Ancillary Expense		
35	Special Cost Centers	372,049	35
36	Provider Participation Fee	83,764	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,442,602	40
41	Income before Income Taxes (line 30 minus line 40)**	37,069	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 37,069	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.
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: 01/01/2006

Ending: 12/31/2006

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	1,928	2,102	\$ 79,656	\$ 37.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,406	15,821	425,688	26.91	3
4	Licensed Practical Nurses	25,428	27,069	674,499	24.92	4
5	CNAs & Orderlies	81,576	88,186	1,305,951	14.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,687	5,455	66,773	12.24	8
9	Activity Director	1,485	1,812	28,906	15.95	9
10	Activity Assistants	8,090	8,540	82,851	9.70	10
11	Social Service Workers	1,640	1,934	36,764	19.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,691	2,835	54,585	19.25	14
15	Cook Helpers/Assistants	23,702	25,642	233,359	9.10	15
16	Dishwashers					16
17	Maintenance Workers	2,174	2,398	41,172	17.17	17
18	Housekeepers	21,262	22,892	203,193	8.88	18
19	Laundry	3,923	4,505	48,463	10.76	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,586	14,079	198,794	14.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,693	2,872	40,037	13.94	31
32	Other Health C: <u>MDS Coord.</u>	3,510	3,865	98,290	25.43	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	211,781	230,007	\$ 3,618,981 *	\$ 15.73	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	170	\$ 7,053	1(3)	35
36	Medical Director	Monthly	20,300	9(3)	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)	170	\$ 27,353		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	319	\$ 14,038	10(3)	50
51	Licensed Practical Nurses	7	272	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	326	\$ 14,310		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

0044750

Report Period Beginning: **01/01/2006**

Ending: **12/31/2006**

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	
			\$	Workers' Compensation Insurance	\$ 172,322	IDPH License Fee	\$	
				Unemployment Compensation Insurance	31,439	Advertising: Employee Recruitment	3,626	
				FICA Taxes	276,852	Health Care Worker Background Check		
				Employee Health Insurance	107,181	(Indicate # of checks performed <u>275</u>)	3,300	
				Employee Meals	10,370	Patient Background Checks	4,950	
				Illinois Municipal Retirement Fund (IMRF)*		DuPage Co. Health Department	810	
				Uniforms	6,037	Miscellaneous Dues & Subs.	847	
				Other Employee Benefits	2,285	Illinois Council Long Term Care	15,145	
						Miscellaneous Newspaper subs.	1,859	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$					
B. Administrative - Other								
Description			Amount					
Steve Jeremias, Administrator - Guaranteed Payments			\$ 115,008			Less: Public Relations Expense	()	
Mark Weldler, CFO - Guaranteed Payments			115,008			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 230,016	TOTAL (agree to Schedule V, line 22, col.8)	\$ 606,486	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 30,537	
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Sachnoff & Weaver, LTD	Legal		\$ 565	N/A			Out-of-State Travel	\$
Meyer Magence	Legal		200					
Altschuler, Melvoin & Glasser	Accounting		15,050					
RSM McGladrey	Accounting		32,708				In-State Travel	
Personnel Planners	UC Consultant		862					
Met Life	401K Administration		12,672					
Romano & Assoc, LLC	Operations consultant		125				Seminar Expense	1,509
MDI Technologies	Data Processing		23,124					
Goliath Networking	Data Processing		9,038					
HDSI	Data Processing		5,209					
Emdeon Business Services	Data Processing		1,021					
See Schedule 21A			9,757				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 110,331				TOTAL	\$ 1,509

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Community Nursing & Rehabilitation Center, LLC
Provider # 0044750
1/1/06 - 12/31/06

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
AccuMed	Data Processing	2,411
Ivans	Data Processing	1,085
AOL	Computer services	236
Paylocity	Payroll Processing	<u>6,025</u>
		<u>9,757</u>
Total (agree to Schedule V, line 19, column 3)		110,331
Total (agree to Schedule V, line 19, column 8)		<u><u>110,331</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	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 Community Nursing & Rehabilitation Center

0044750

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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. II Council Long Term Care \$15,145
- (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 expense and the location of this expense on Sch. V. \$ 15,725 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 83,764
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. \$ 10,370 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,197
- (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? 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. \$ 0
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT