

Facility Name & ID Number Claremont Rehab & Living Center

0047043 Report Period Beginning: 01/01/07 Ending: 12/31/07

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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			14,924	14,924	8
9	SNF/PED					9
10	ICF	31,974	12,980	4,431	49,385	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,974	12,980	19,355	64,309	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.09%

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 Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
 YES NO

I. On what date did you start providing long term care at this location?
 Date started 03/01/2005

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 03/01/2005 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 14,924

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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Claremont Rehab & Living Center # 0047043 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	408,357	44,193	17,803	470,353		470,353		470,353		1
2	Food Purchase		379,528		379,528		379,528	(40,106)	339,422		2
3	Housekeeping	221,733	62,968	16,314	301,015		301,015		301,015		3
4	Laundry	41,786	33,533	21,797	97,116		97,116		97,116		4
5	Heat and Other Utilities			317,798	317,798		317,798	1,792	319,590		5
6	Maintenance	117,629	95,870	143,261	356,760		356,760	3,064	359,824		6
7	Other (specify):*										7
8	TOTAL General Services	789,505	616,092	516,973	1,922,570		1,922,570	(35,250)	1,887,320		8
	B. Health Care and Programs										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	4,118,055	305,683	50,350	4,474,088		4,474,088		4,474,088		10
10a	Therapy	981,898	13,301	476,818	1,472,017		1,472,017		1,472,017		10a
11	Activities	150,698	17,929	2,860	171,487		171,487		171,487		11
12	Social Services	153,828		25,245	179,073		179,073		179,073		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,404,479	336,913	585,273	6,326,665		6,326,665		6,326,665		16
	C. General Administration										
17	Administrative	146,296		387,990	534,286		534,286	(295,277)	239,009		17
18	Directors Fees										18
19	Professional Services			87,923	87,923		87,923	(8,518)	79,405		19
20	Dues, Fees, Subscriptions & Promotions			48,356	48,356		48,356	(3,896)	44,460		20
21	Clerical & General Office Expenses	318,333	68,089	106,821	493,243		493,243	95,738	588,981		21
22	Employee Benefits & Payroll Taxes			781,161	781,161		781,161	38,509	819,670		22
23	Inservice Training & Education										23
24	Travel and Seminar			28,354	28,354		28,354	415	28,769		24
25	Other Admin. Staff Transportation			22,484	22,484		22,484	(512)	21,972		25
26	Insurance-Prop.Liab.Malpractice			215,652	215,652		215,652	1,050	216,702		26
27	Other (specify):* Home Office Benefits							29,261	29,261		27
28	TOTAL General Administration	464,629	68,089	1,678,741	2,211,459		2,211,459	(143,230)	2,068,229		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,658,613	1,021,094	2,780,987	10,460,694		10,460,694	(178,480)	10,282,214		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Claremont Rehab & Living Center

#0047043

Report Period Beginning:

01/01/07

Ending:

12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			48,317	48,317		48,317	7,935	56,252			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			82,835	82,835		82,835	24,351	107,186			32
33	Real Estate Taxes							236,160	236,160			33
34	Rent-Facility & Grounds			1,486,029	1,486,029		1,486,029	(231,970)	1,254,059			34
35	Rent-Equipment & Vehicles			34,078	34,078		34,078	2,772	36,850			35
36	Other (specify):*											36
37	TOTAL Ownership			1,651,259	1,651,259		1,651,259	39,248	1,690,507			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		963,651	219,450	1,183,101		1,183,101		1,183,101			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):* Non-allowable Cos	79,215		458,471	537,686		537,686	(537,686)				43
44	TOTAL Special Cost Centers	79,215	963,651	787,421	1,830,287		1,830,287	(537,686)	1,292,601			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,737,828	1,984,745	5,219,667	13,942,240		13,942,240	(676,918)	13,265,322			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Claremont Rehab & Living Center

0047043

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	590	30		9
10	Interest and Other Investment Income	(3,816)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,045)	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	(36,433)	43		18
19	Entertainment	(7,231)	43		19
20	Contributions	(12,115)	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	(111,000)	43		24
25	Fund Raising, Advertising and Promotional	(124,723)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,487)	43		28
29	Other-Attach Schedule See Pg. 5A	(298,586)	Vari.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (596,846)		\$	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)	(80,072)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (80,072)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (676,918)		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: 01/01/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	To offset Misc. Income-transportation	\$ (1,388)	43	1
2	To offset Cable Expenses	(4,771)	43	2
3	To disallow marketing salary	(79,215)	43	3
4	To offset misc. income	(29,624)	21	4
5	To offset misc. income meals	(1,597)	2	5
6	To disallow non-allowable legal fees	(17,544)	19	6
7	To disallow settlement	(10,000)	43	7
8	To disallow lobbying expense	(3,236)	20	8
9	Disallow xray expense	(114,109)	43	9
10	Disallow laboratory fees	(34,557)	43	10
11	Disallow Out-of-State Travel for Seminars	(975)	24	11
12	Disallow Chamber of Commerce Expense	(1,570)	20	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	(298,586)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,597)	0	0	0	0	0	0	0	0	0	0	(1,597)	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	1,792	0	0	0	0	0	0	0	0	1,792	5
6	Maintenance	0	0	3,064	0	0	0	0	0	0	0	0	3,064	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,597)	0	4,856	0	3,259	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	(295,277)	0	0	0	0	0	0	0	0	(295,277)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(17,544)	250	8,776	0	0	0	0	0	0	0	0	(8,518)	19
20	Fees, Subscriptions & Promotions	(4,806)	0	910	0	0	0	0	0	0	0	0	(3,896)	20
21	Clerical & General Office Expenses	(29,624)	0	125,362	0	0	0	0	0	0	0	0	95,738	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	(975)	0	1,390	0	0	0	0	0	0	0	0	415	24
25	Other Admin. Staff Transportation	0	0	876	0	0	0	0	0	0	0	0	876	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,050	0	0	0	0	0	0	0	0	1,050	26
27	Other (specify):*	0	0	29,261	0	0	0	0	0	0	0	0	29,261	27
28	TOTAL General Administration	(52,949)	250	(127,652)	0	(180,351)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(54,546)	250	(122,796)	0	(177,092)	29							

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	7,345	0	0	0	0	0	0	0	0	7,345	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	14,858	13,309	0	0	0	0	0	0	0	0	28,167	32
33	Real Estate Taxes	0	0	3,824	0	0	0	0	0	0	0	0	3,824	33
34	Rent-Facility & Grounds	0	0	366	0	0	0	0	0	0	0	0	366	34
35	Rent-Equipment & Vehicles	0	0	2,772	0	0	0	0	0	0	0	0	2,772	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	14,858	27,616	0	0	0	0	0	0	0	0	42,474	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	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(371,250)	0	0	0	0	0	0	0	0	0	0	(371,250)	43
44	TOTAL Special Cost Centers	(371,250)	0	0	0	0	0	0	0	0	0	0	(371,250)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(425,796)	15,108	(95,180)	0	0	0	0	0	0	0	0	(505,868)	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%	14,858		14,858
3	V							
4	V							
5	V							
6	V							
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$			\$ 15,108	\$ *	15,108

* 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%	\$ 1,792	\$ 1,792
16	V	6 Repairs and Maintenance		NuCare Management Company	80.00%	3,064	3,064
17	V	17 Management Fees	362,000	NuCare Management Company	80.00%	66,723	(295,277)
18	V	19 Professional Fees		NuCare Management Company	80.00%	8,776	8,776
19	V	20 Dues, Subscriptions		NuCare Management Company	80.00%	910	910
20	V	21 Office Expense		NuCare Management Company	80.00%	125,362	125,362
21	V	24 Education and Seminars		NuCare Management Company	80.00%	1,390	1,390
22	V	25 Other Admin Transportation		NuCare Management Company	80.00%	876	876
23	V	26 Insurance		NuCare Management Company	80.00%	1,050	1,050
24	V	27 Employee Benefits		NuCare Management Company	80.00%	29,261	29,261
25	V	30 Depreciation Expense		NuCare Management Company	80.00%	7,345	7,345
26	V	32 Interest & Amortization		NuCare Management Company	80.00%	5,931	5,931
27	V	33 Real Estate Taxes		NuCare Management Company	80.00%	3,824	3,824
28	V	34 Facility Rent		NuCare Management Company	80.00%	366	366
29	V	35 Equipment Rental		NuCare Management Company	80.00%	2,772	2,772
30	V						
31	V						
32	V	32 Interest & Amortization		NuCare Management Company	80.00%	7,378	7,378
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 362,000			\$ 266,820	\$ * (95,180)

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

Claremont Extended Healthcare, LLC D/B/A Claremont Rehab and Living Center

Provider #: 0047043

01/01/07 to 12/31/2007

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:

01/01/07

Ending:

12/31/07

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	\$ 76,667	L17,C8	1
2	Robert Hartman	Member	Administrative	4.25	See Sch 7B	0.64	2.00	Mgmt. Fee	11,472	L17,C8	2
3	Barry Carr	Member	Administrative	4.00	See Sch 7C	3.19	8.00	Mgmt. Fee	6,501	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	\$ 94,640		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

01/01/07 to 12/31/07

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 \$1,967,056. 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 \$125,362.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Claremont Rehab & Living Center

0047043

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	960,286	12	\$ 28,115	\$ 61,200	\$ 1,792	1
2	6	Repairs and Maintenance	Bed days available	960,286	12	48,079	61,200	3,064	2
3	17	Management Fees	Bed days available	960,286	12	346,499	216,927	22,083	3
4	19	Professional Fees	Bed days available	960,286	12	137,702	61,200	8,776	4
5	20	Dues, Subscriptions	Bed days available	960,286	12	14,277	61,200	910	5
6	21	Office Expense	Bed days available	960,286	12	1,967,056	1,578,326	125,362	6
7	24	Education and Seminars	Bed days available	960,286	12	21,810	61,200	1,390	7
8	25	Other Admin Transportation	Bed days available	960,286	12	13,739	61,200	876	8
9	26	Insurance	Bed days available	960,286	12	16,477	61,200	1,050	9
10	27	Employee Benefits	Bed days available	960,286	12	264,371	61,200	16,849	10
11	30	Depreciation Expense	Bed days available	960,286	12	135,649	61,200	8,645	11
12	32	Interest & Amortization	Bed days available	960,286	12	93,063	61,200	5,931	12
13	33	Real Estate Taxes	Bed days available	960,286	12	60,000	61,200	3,824	13
14	34	Facility Rent	Bed days available	960,286	12	5,749	61,200	366	14
15	35	Equipment Rental	Bed days available	960,286	12	43,501	61,200	2,772	15
16									16
17	30	Depreciation Expense	Direct allocation		12			(1,300)	17
18	32	Interest & Amortization	Bed days available	960,286	12	115,760	61,200	7,378	18
19									19
20	17	Management Fees	Direct allocation		12	362,000		44,640	20
21	27	Employee Benefits	Direct allocation		12	125,284		12,412	21
22									22
23									23
24									24
25	TOTALS					\$ 3,799,131	\$ 1,795,253	\$ 266,820	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Claremont Rehab & Living Center

0047043

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	\$ 106,250	3/31/2010	0.0875	\$ 14,858	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	LaSalle Bank		X	Line of Credit	Interest Only	3/31/06	1,350,228	1,350,228	03/31/08	0.0875	82,835	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 1,650,228	\$ 1,456,478			\$ 97,693	9						
B. Non-Facility Related*																		
10									Interest Income Offset		(3,816)	10						
11									Management Company allocation		13,309	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 9,493	14						
15	TOTALS (line 9+line14)						\$ 1,650,228	\$ 1,456,478			\$ 107,186	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 2006 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.)		2006	\$	232,336	2
3. Under or (over) accrual (line 2 minus line 1).			\$	232,336	3
4. Real Estate Tax accrual used for 2007 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		3,824	
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.			\$	236,160	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2002	207,185	8	FOR BHF USE ONLY	
	2003	215,770	9	13	FROM R. E. TAX STATEMENT FOR 2006 \$ 13
	2004	224,097	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2005	229,068	11	15	LESS REFUND FROM LINE 6 \$ 15
	2006	232,336	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>232,335.85</u>	\$ <u>232,335.85</u>
2. <u>10-27-319-028-0000</u>	<u>Management Company</u>	\$ <u>100,273.68</u>	\$ <u>3,824.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>332,609.53</u>	\$ <u>236,159.85</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/07

Ending:

12/31/07

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>\$ 10,197</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 10,197	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

01/01/07

Ending:

12/31/07**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		\$ 91,772	\$	25	\$ 2,622	\$ 2,622	\$ 10,816	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Data cables & jacks		2005		8,647	432	20	432		1,080	9
10	Electrical work		2005		4,050	203	20	203		507	10
11	Landscape architecture		2005		4,500	225	20	225		563	11
12	Alarm for door		2005		1,550		20	79	79	195	12
13	Flooring		2005		55,880	2,782	20	2,794	12	6,985	13
14	Heater		2005		1,578	78	20	78		195	14
15	Sewerline		2005		4,000	200	20	200		500	15
16	Nursing Station countertop and cabinet		2005		13,000	650	20	650		1,625	16
17	Draperies		2005		5,013	251	20	251		627	17
18	Modulator and DTV box		2005		750	37	20	37		93	18
19	Wireless TV satellite dish		2005		1,137	57	20	57		142	19
20	Concrete by parlor exit		2005		1,575		20	79	79	197	20
21	Microboard		2005		5,110	256	20	256		640	21
22	Electrical work		2005		1,720		20	86	86	215	22
23	Chair Rail		2006		4,293	215	20	215		214	23
24	Dining Room Remodel		2006		3,875	194	20	194		194	24
25	Door Repairs		2006		4,440	222	20	222		222	25
26	Electrical Work		2006		19,035	952	20	952		952	26
27	Elevator		2006		1,800	90	20	90		90	27
28	Fireproof Basement		2006		2,620	131	20	131		132	28
29	Flooring		2006		41,808	2,090	20	2,090		2,090	29
30	Kitchen Remodel		2006		23,800	1,190	20	1,190		1,190	30
31	Landscaping		2006		16,528	826	20	826		826	31
32	Play Area		2006		6,718	336	20	336		336	32
33	Remodel Dialysis Unit		2006		3,800	190	20	190		190	33
34	Remodel Resident Rooms		2006		22,640	1,132	20	1,132		1,132	34
35	Roof		2006		1,750	88	20	88		88	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:

01/01/07

Ending:

12/31/07

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	\$ 104	20	\$ 104		\$ 104	37
38	Thermostat	2006	18,900	945	20	945		946	38
39	Wall Mural & Wallpaper	2006	5,860	293	20	293		294	39
40	Water Heater	2006	30,639	1,532	20	1,532		1,532	40
41	Window Treatments	2006	10,774	539	20	539		538	41
42	Compressor	2006	15,410	771	20	771		770	42
43	Therpy Rm - Plumbing, tile, & Paint	2007	17,096	427	20	427		427	43
44	Showers Demolish, Rebuild, Tiles	2007	22,654	566	20	566		566	44
45	Employee Lounge - Drywall & Paint	2007	8,200	205	20	205		205	45
46	Thermostats installed	2007	3,000	75	20	75		75	46
47	Therpy Rm - Cabinets installed	2007	4,300	108	20	108		108	47
48	Elevator Panels and repairs	2007	9,800	245	20	245		245	48
49	Thermostats installed	2007	3,975	99	20	99		99	49
50	Therpy Rm - Wall	2007	2,700	68	20	68		68	50
51	Window Installed	2007	15,484	387	20	387		387	51
52	Shower Tiles	2007	7,330	183	20	183		183	52
53	Door Installed	2007	12,420	311	20	311		311	53
54	Built-in Med Rec Shelves	2007	2,702	68	20	68		68	54
55	Door Installed	2007	3,355	84	20	84		84	55
56	Remove/Install Heating Elements	2007	8,100	203	20	203		203	56
57	Kitchen - Cooler Repaired & Tile Installed	2007	7,685	192	20	192		192	57
58	Elevator Valve	2007	2,800	70	20	70		70	58
59	Built-in Med Rec Shelves	2007	2,878	72	20	72		72	59
60	Motorized Hot/Cold Water Unit	2007	10,050	251	20	251		251	60
61	Generator and Water Heater	2007	3,314	83	20	83		83	61
62	Dish Washer Water Heater Booster	2007	3,635	91	20	91		91	62
63	2nd Flr Nurses Stat - Carpeting, Lights	2007	5,411	135	20	135		135	63
64	Alarm System Testing	2007	2,878		20	72	72	72	64
65									65
66	Rounding Vari								66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 596,819	\$ 20,932		\$ 23,882	\$ 2,950	\$ 40,214	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 596,819	\$ 20,932		\$ 23,882	\$ 2,950	\$ 40,214	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	2007 Allocation from management company:								14
15	Alarm System	2003	764		20	37	37	154	15
16	Buildout of Offices	2004	15,156		20	759	759	2,814	16
17	Security & Fire Alarm System	2004	1,824		20	91	91	319	17
18	Data Cables, Lights & Heat Exchanger	2005	899		20	45	45	128	18
19	Fire Alarm System	2005	8,366		20	540	540	1,248	19
20	Cooling Unit	2006	1,218		20	61	61	83	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 625,046	\$ 20,932		\$ 25,415	\$ 4,483	\$ 44,960	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	\$ 213,065	\$ 21,102	\$ 21,307	\$ 205	10	\$ 48,276	71
72	Current Year Purchases	109,377	5,410	5,469	59	10	5,469	72
73	Fully Depreciated Assets							73
74	Allocation from management company	43,726		3,188	3,188		22,737	74
75	TOTALS	\$ 366,168	\$ 26,512	\$ 29,964	\$ 3,452		\$ 76,482	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	\$ 873	\$ 873	\$	5	\$ 1,310	76
77										77
78										78
79										79
80	TOTALS			\$ 4,365	\$ 873	\$ 873	\$		\$ 1,310	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)	\$ 1,005,776	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 48,317	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 56,252	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,935	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 122,752	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	N/A				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>1,253,693</u>	<u>5</u>	<u>15</u>	3
4	Additions							4
5	<u>Allocation from Management Company</u>				<u>366</u>			5
6								6
7	TOTAL		<u>200</u>		\$ <u>1,254,059</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.	<u>12/31/08</u>	\$ <u>1,599,606</u>
13.	<u>12/31/09</u>	\$ <u>1,608,456</u>
14.		\$

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 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: \$ 25,180 Description: Copy Machine 4425; Storage 2295; Parking 6000; ACP Equip 9688; Management Alloc 2772

(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>2008 Ford, E350</u>	\$ <u>750.00</u>	\$ <u>2,250</u>	17
18	<u>Administration</u>	<u>2007 Infiniti, M35X</u>	<u>785.00</u>	<u>9,420</u>	18
19					19
20					20
21	TOTAL		\$ <u>1,535.00</u>	\$ <u>11,670</u>	21

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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	9269 hrs	\$ 330,480	2,564	\$ 155,520		11,833	\$ 486,000	1
2	Licensed Speech and Language Development Therapist	L10A C1, C3	2036 hrs	72,602	669	34,165		2,705	106,767	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A C1,C2,C3	16234 hrs	578,816	3,971	272,384	13,301	20,205	864,501	4
5	Physician Care		visits							5
6	Dental Care	L39 C3	visits		8	1,000		8	1,000	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39 C2	# of prescripts				963,651		963,651	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>			4,606	225,554		4,606	225,554	13
14	TOTAL			\$ 981,898	11,818	\$ 688,623	\$ 976,952	39,357	\$ 2,647,473	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.

482,474
490,119

SEE ACCOUNTANTS' COMPILATION REPORT

Claremont Rehab & Living Center
PROVIDER #0047043
1/1/07 - 12/31/07

Schedule 16A

XIV. SPECIAL SERVICES (Direct Cost) Line 14

Service	Schedule V Line & Col. Ref.	Outside Practitioner	
		Units	Costs
Respiratory Therapy	L10A C3	237	7,104
Hemodialysis	L39 C3	4,369	218,450
		<u>4,606</u>	<u>225,554</u>

Facility Name & ID Number Claremont Rehab & Living Center

0047043

Report Period Beginning: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(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	\$ 2,150	\$ 2,900	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>341,798</u>)	2,398,131	2,398,131	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,775	4,775	6
7	Other Prepaid Expenses	93,395	93,395	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See attached Sch 17A</u>	622,027	1,291,525	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,120,478	\$ 3,790,726	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		10,197	13
14	Buildings, at Historical Cost		91,773	14
15	Leasehold Improvements, at Historical Cost	496,848	533,273	15
16	Equipment, at Historical Cost	322,879	370,533	16
17	Accumulated Depreciation (book methods)	(83,086)	(122,752)	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)	\$ 736,641	\$ 883,024	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,857,119	\$ 4,673,750	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 419,794	\$ 419,794	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,350,228	1,431,478	29
30	Accrued Salaries Payable	569,951	569,951	30
31	Accrued Taxes Payable (excluding real estate taxes)	74,588	74,588	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>	510,649	1,123,301	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,925,210	\$ 3,619,112	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		25,000	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)	\$	\$ 25,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,925,210	\$ 3,644,112	46
47	TOTAL EQUITY(page 18, line 24)	\$ 931,909	\$ 1,029,638	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,857,119	\$ 4,673,750	48

Claremont Rehab & Living Center
PROVIDER #0047043
1/1/07 - 12/31/07

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.

A. Current Assets

<u>Other Current Assets (specify):</u>	<u>Operating</u>	<u>After</u>
		<u>Consolidation</u>
Option	100,000	650,000
Due from Landlord	(100,000)	19,498
CH Deposits	9,375	9,375
Due from Related Party	612,652	612,652
Total Line 9 - Other Current Assets (specify):	622,027	1,291,525

C. Current Liabilities

<u>Other Current Liabilities (specify):</u>	<u>Operating</u>	<u>After</u>
		<u>Consolidation</u>
Due to Related Party	-	612,652
Bank Overdraft	235,069	235,069
Accrued Expenses	147,162	147,162
Accrued Utilities	20,016	20,016
Due to Prior Owner	72,529	72,529
Due Nuicare Services Co	34,354	34,354
Due Nuvision	1,519	1,519
Total Line 36 - Other Current Liabilities (specify):	510,649	1,123,301

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 758,861	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 758,861	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	473,053	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	(300,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(5)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 173,048	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)	\$ 931,909	24 *

* 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	\$ 14,037,990	1
2	Discounts and Allowances for all Levels	(5,338,591)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,699,399	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,931,781	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,931,781	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		13
14	Non-Patient Meals	1,597	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,230,806	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	125,106	19
20	Radiology and X-Ray	42,804	20
21	Other Medical Services	348,972	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,749,285	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,816	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,816	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc Income</u>	29,624	28
28a	<u>Transportation Income</u>	1,388	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 31,012	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,415,293	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,922,570	31
32	Health Care	6,326,665	32
33	General Administration	2,211,459	33
	B. Capital Expense		
34	Ownership	1,651,259	34
	C. Ancillary Expense		
35	Special Cost Centers	1,720,787	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)*	\$ 13,942,240	40
41	Income before Income Taxes (line 30 minus line 40)**	473,053	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 473,053	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.
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:

01/01/07

Ending:

12/31/07

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	1,865	2,041	\$ 103,270	\$ 50.60	1
2	Assistant Director of Nursing	1,907	2,086	81,664	39.15	2
3	Registered Nurses	34,550	37,470	1,129,931	30.16	3
4	Licensed Practical Nurses	17,790	18,437	502,848	27.27	4
5	CNAs & Orderlies	113,549	127,695	1,704,400	13.35	5
6	CNA Trainees	30,210	30,736	386,167	12.56	6
7	Licensed Therapist	27,540	29,900	981,898	32.84	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,822	2,225	42,279	19.00	9
10	Activity Assistants	11,228	11,862	108,419	9.14	10
11	Social Service Workers	6,407	7,128	153,828	21.58	11
12	Dietician	3,562	4,206	103,552	24.62	12
13	Food Service Supervisor					13
14	Head Cook	5,775	6,550	82,330	12.57	14
15	Cook Helpers/Assistants	25,722	27,366	222,475	8.13	15
16	Dishwashers					16
17	Maintenance Workers	4,654	4,908	117,629	23.97	17
18	Housekeepers	24,974	26,682	221,733	8.31	18
19	Laundry	4,754	5,296	41,786	7.89	19
20	Administrator	3,821	4,610	146,296	31.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,344	22,578	318,333	14.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	6,248	6,990	209,775	30.01	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	1,850	2,005	79,215	39.51	33
34	TOTAL (lines 1 - 33)	348,572	380,771	\$ 6,737,828 *	\$ 17.70	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	421	\$ 17,803	L1,C3	35
36	Medical Director	Monthly	30,000	L9,C3	36
37	Medical Records Consultant	131	6,538	L10,C3	37
38	Nurse Consultant	392	7,830	L10,C3	38
39	Pharmacist Consultant	Monthly	3,212	L10,C3	39
40	Physical Therapy Consultant	109	7,645	L10A,C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	52	2,860	L11,C3	44
45	Social Service Consultant	55	5,245	L12,C3	45
46	Other(specify) <u>Medical Consultant</u>	Monthly	30,000	L10,C3	46
47	<u>IMRR Consultant</u>	Monthly	2,770	L10,C3	47
48					48
49	TOTAL (lines 35 - 48)	1,160	\$ 113,903		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

Facility Name & ID Number **Claremont Rehab & Living Center**

0047043

Report Period Beginning: **01/01/07**

Ending: **12/31/07**

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	
Lawrence Putz	Administrator	0%	\$ 56,337	Workers' Compensation Insurance	\$ 112,629	IDPH License Fee	\$	
Rupal Mistry	Administrator	0%	89,959	Unemployment Compensation Insurance		Advertising: Employee Recruitment	17,808	
				FICA Taxes	453,016	Health Care Worker Background Check (Indicate # of checks performed <u>243</u>)	4,300	
				Employee Health Insurance	148,117	Patient Background Checks	3,000	
				Employee Meals	38,509	Misc. Licenses & Inspections	7,151	
				Illinois Municipal Retirement Fund (IMRF)*		IHCA Dues	11,040	
				Miscellaneous Employee Benefits	29,842	Misc. Dues & Subscriptions	5,057	
				Life Insurance	20,923	Less: Lobbying portion of IHCA dues	(3,236)	
				401 (K)	10,285	Allocation of management company	910	
				Employee Physicals	5,125	Less: Public Relations Expense	()	
				Employee Awards	1,224	Chamber of Commerce Dues	(1,570)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		\$ 44,460
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees (Adjusted in Col. 7)			\$ 362,000				Out-of-State Travel	\$
Gerry Jenich			25,990					
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 387,990				Seminar Expense	28,354
							Allocation from management company	1,390
							Less: Out-of-State Training	(975)
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
C. Professional Services							TOTAL	\$ 28,769
Vendor/Payee	Type		Amount					
RSM/McGladrey & Pullen	Accounting		\$ 8,763					
Frost,Ruttenburg & Rothblatt	Accounting		4,560					
Achieve Accreditation	Consulting		6,730					
CPI Qualified Plan Consultants	Consulting		3,381					
Growth Design	Consulting		477					
Sachnoff & Weaver, LTD	Legal		2,360					
Stone, McGuire & Siegel	Legal		19,096					
Barbara Demos, Law Offices	Legal		10,075					
Klein Dub & Holleb	Legal		6,757					
Reed, Smith, Sachnoff & Weaver	Legal		21,863					
Foley & Lardner LLP/Ashman	Legal		2,337					
Personal Planners, Inc	Unemployment Consult.		1,524					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 87,923	TOTAL		\$		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Claremont Rehab & Living Center

Provider #: 0047043

01/01/07 to 12/31/07

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 87,923

Allocation from Real Estate Entity

Professional Fees - Other 250

Allocation from Management Company

Legal Fees 6,975
Accounting Fees 1,555
Consulting 246
8,776

Non-Allowable Legal Fees

Ashman & Stein (711)
Barbara Demos, Law Offices (10,075)
Klein Dub & Holleb (6,757)
(17,543)

Total (agree to Schedule V, line 19, column 8) 79,406

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	Amount of Expense Amortized Per Year								
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1	N/A		\$		\$	\$	\$	\$ N/A	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
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# 0047043

Report Period Beginning:

01/01/07

Ending:

12/31/07**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 \$11,040 (Lobby offset of \$3,236)
- (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. \$ 56,523 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.

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- (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. \$ 38,509 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,597
- (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