

Facility Name & ID Number Pine Acres Rehab & Living Center

0047720 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	119	Skilled (SNF)	119	43,435	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	119	TOTALS	119	43,435	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	18,574	12,593	4,549	35,716	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,574	12,593	4,549	35,716	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.23%

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 02/01/2006

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 02/01/2006 NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 119 and days of care provided 4,549

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Pine Acres Rehab & Living Center # 0047720 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	276,757	18,072	6,670	301,499		301,499		301,499		1
2	Food Purchase		177,291		177,291		177,291	(4,693)	172,598		2
3	Housekeeping	95,911	19,398		115,309		115,309		115,309		3
4	Laundry		3,598	121,332	124,930		124,930		124,930		4
5	Heat and Other Utilities			103,196	103,196		103,196		103,196		5
6	Maintenance	84,925	62,108	48,817	195,850		195,850		195,850		6
7	Other (specify):*										7
8	TOTAL General Services	457,593	280,467	280,015	1,018,075		1,018,075	(4,693)	1,013,382		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,709,272	69,196	68,041	1,846,509		1,846,509		1,846,509		10
10a	Therapy		8,245	483,982	492,227		492,227		492,227		10a
11	Activities	69,639	5,382	1,398	76,419		76,419	(5)	76,414		11
12	Social Services	102,386		943	103,329		103,329		103,329		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,881,297	82,823	563,964	2,528,084		2,528,084	(5)	2,528,079		16
	C. General Administration										
17	Administrative	84,529		120,000	204,529		204,529		204,529		17
18	Directors Fees										18
19	Professional Services			81,972	81,972		81,972		81,972		19
20	Dues, Fees, Subscriptions & Promotions			21,358	21,358		21,358	(1,635)	19,723		20
21	Clerical & General Office Expenses	118,060	14,431	19,464	151,955		151,955	88	152,043		21
22	Employee Benefits & Payroll Taxes			569,301	569,301		569,301		569,301		22
23	Inservice Training & Education			548	548		548		548		23
24	Travel and Seminar			2,058	2,058		2,058		2,058		24
25	Other Admin. Staff Transportation			3,780	3,780		3,780		3,780		25
26	Insurance-Prop.Liab.Malpractice			91,716	91,716		91,716		91,716		26
27	Other (specify):*										27
28	TOTAL General Administration	202,589	14,431	910,197	1,127,217		1,127,217	(1,547)	1,125,670		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,541,479	377,721	1,754,176	4,673,376		4,673,376	(6,245)	4,667,131		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

Pine Acres Rehab & Living Center

#0047720

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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			1,811	1,811		1,811	122,066	123,877			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,751	15,751		15,751	164,901	180,652			32
33	Real Estate Taxes							44,465	44,465			33
34	Rent-Facility & Grounds			410,004	410,004		410,004	(410,004)				34
35	Rent-Equipment & Vehicles			28,109	28,109		28,109		28,109			35
36	Other (specify):*											36
37	TOTAL Ownership			455,675	455,675		455,675	(78,572)	377,103			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		180,685		180,685		180,685		180,685			39
40	Barber and Beauty Shops	32,320	103		32,423		32,423		32,423			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,153	65,153		65,153		65,153			42
43	Other (specify):* Non-allowable Cos	47,958		50,287	98,245		98,245	(98,245)				43
44	TOTAL Special Cost Centers	80,278	180,788	115,440	376,506		376,506	(98,245)	278,261			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,621,757	558,509	2,325,291	5,505,557		5,505,557	(183,062)	5,322,495			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 Pine Acres Rehab & Living Center

0047720

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(4,240)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				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				13
14	Non-Care Related Interest	(53,925)	32		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	(4,300)	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	(37,612)	43		24
25	Fund Raising, Advertising and Promotional	(811)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Pg. 5A</u>	(62,611)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (163,509)		\$	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)	(19,553)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (19,553)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (183,062)		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

Pine Acres Rehab & Living Center

ID# 0047720

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow Labs - Part A	\$ (2,055)	43	1
2	Disallow X-Rays - Part A	(270)	43	2
3	Offset vending machine revenue	(453)	2	3
4	Disallow cable tv expense	(2,916)	43	4
5	Disallow marketing wages	(47,958)	43	5
6	Disallow marketing expense	(2,323)	43	6
7	Offset activity income	(5)	11	7
8	Disallow non-care related Real Estate Taxes	(1,938)	33	8
9	Disallow non-allowable PAC dues	(1,635)	20	9
10	Offset interest income against interest expense	(3,058)	32	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	(62,611)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pine Acres Rehab & Living Center# 0047720

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(4,693)	0	0	0	0	0	0	0	0	0	0	(4,693)	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	(4,693)	0	0	0	0	0	0	0	0	0	0	(4,693)	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	(5)	0	0	0	0	0	0	0	0	0	0	(5)	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	(5)	0	0	0	0	0	0	0	0	0	0	(5)	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	(1,635)	0	0	0	0	0	0	0	0	0	0	(1,635)	20
21	Clerical & General Office Expenses	(10)	98	0	0	0	0	0	0	0	0	0	88	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	(1,645)	98	0	(1,547)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,343)	98	0	(6,245)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pine Acres Rehab & Living Center# 0047720

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	122,066	0	0	0	0	0	0	0	0	0	122,066	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(56,983)	221,884	0	0	0	0	0	0	0	0	0	164,901	32
33	Real Estate Taxes	(1,938)	46,403	0	0	0	0	0	0	0	0	0	44,465	33
34	Rent-Facility & Grounds	0	(410,004)	0	0	0	0	0	0	0	0	0	(410,004)	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	(58,921)	(19,651)	0	(78,572)	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):*	(98,245)	0	0	0	0	0	0	0	0	0	0	(98,245)	43
44	TOTAL Special Cost Centers	(98,245)	0	0	0	0	0	0	0	0	0	0	(98,245)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(163,509)	(19,553)	0	(183,062)	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
Steve and Bluma Jeremias	33%	Wheaton Care Center	Wheaton	Pine Acres Realty,		
Mark and Chana Weldler	33%	Community Nursing & Rehabilitation Center, LLC	Naperville	LLC	DeKalb	Real Estate
Chaim Rajchenbach	11%					
The Family Rajchenbach Trust	11%			Community Nursing		
Abraham J. Stern	4%			and Rehab Realty,		
Susan L. Stern	4%			LLC	Naperville	Real Estate
AMN Limited Partnership	4%					

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	21 Clerical - Other	\$	Pine Acres Realty, LLC		\$ 98	\$	98	1
2	V	30 Depreciation		Pine Acres Realty, LLC		122,066		122,066	2
3	V	32 Interest		Pine Acres Realty, LLC		221,884		221,884	3
4	V	33 Real Estate Taxes		Pine Acres Realty, LLC		46,403		46,403	4
5	V	34 Rent Expense	410,004	Pine Acres Realty, LLC				(410,004)	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		\$ 410,004			\$ 390,451	\$ *	(19,553)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pine Acres Rehab & Living Center # 0047720 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	COO	Administrative	33.00	110,216	25	50.00	Guar Pymnts	\$ 60,000	L17, C3	1
2	Mark Weldler	CFO	Finance	33.00	110,216	25	50.00	Guar Pymnts	60,000	L17, C3	2
3											3
4											4
5	* Mr. Jeremias and Mr. Weldler receive compensation from Community Nursing & Rehab Center										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 120,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pine Acres Rehab & Living Center

0047720 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

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

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

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

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			N/A						8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Pine Acres Rehab & Living Center

0047720

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		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	Brickyard Bank		X	Mortgage	\$17,919.51	02/01/06	\$ 2,350,000	\$ 2,289,612	02/01/11	0.0775	\$ 181,130	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Shareholder Loans	X		Working Capital	None	Varies	760,052	679,470	On Demand	Varies	53,437	6								
7	Community Nursing	X		Working Capital	None	Varies	150,000		On Demand	Varies	488	7								
8												8								
9	TOTAL Facility Related				\$17,919.51		\$ 3,260,052	\$ 2,969,082			\$ 235,055	9								
B. Non-Facility Related*																				
10												10								
11											Amortization of Mortgage Costs	2,580	11							
12											Disallowed Shareholder loan interest	(53,925)	12							
13											Offset interest income	(3,058)	13							
14	TOTAL Non-Facility Related						\$	\$			\$ (54,403)	14								
15	TOTALS (line 9+line14)						\$ 3,260,052	\$ 2,969,082			\$ 180,652	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.		\$	50,000	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	\$	47,403	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,597)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	49,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(1,938)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	44,465	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	114,137	8	
	2003	109,697	9	
	2004	115,559	10	
	2005	50,000	11	
	2006	47,403	12	
Assumed 3% increase on Real Estate Taxes paid during the year.				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

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 Pine Acres Rehab & Living Center COUNTY DeKalb

FACILITY IDPH LICENSE NUMBER 0047720

CONTACT PERSON REGARDING THIS REPORT Mark Weldler

TELEPHONE (815) 758-8151 FAX #: (815) 758-6832

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>08-27-279-003</u>	<u>Nursing Home</u>	\$ <u>45,464.06</u>	\$ <u>45,464.06</u>
2. <u>08-27-279-023</u>	<u>Rental House</u>	\$ <u>1,938.44</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>47,402.50</u>	\$ <u>45,464.06</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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pine Acres Rehab & Living Center

0047720

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,295 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

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: 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Use</u>	<u>126,760</u>	<u>2006</u>	<u>\$ 189,881</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	126,760		\$ 189,881	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	119		2006	1968	\$ 1,736,051	\$	40	\$ 43,401	\$ 43,401	\$ 83,186	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2 Ton Rooftop System		2007		4,562	228	10	228		228	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

*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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			1,740,613	228	43,629	43,401	83,414	

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	\$ 802,474	\$ 1,583	\$ 80,248	\$ 78,665	10	\$ 117,028	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 802,474	\$ 1,583	\$ 80,248	\$ 78,665		\$ 117,028	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				\$	\$	\$	\$		\$	76
77	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 2,732,968	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,811	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 123,877	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 122,066	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 200,442	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	Land & House - 2006	\$ 179,773	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 179,773	\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A

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: \$ \$ 28,109 Description: Computers \$23782; Med. Equip. \$3,503; Postage Meter \$824

(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>N/A</u>	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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. /2008 \$ _____

13. /2009 \$ _____

14. /2010 \$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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(2,3)	hrs	\$	2,844	\$ 170,621	\$ 3,082	2,844	\$ 173,703	1
2	Licensed Speech and Language Development Therapist	10A(2,3)	hrs		1,325	79,497	32	1,325	79,529	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2,3)	hrs		3,898	233,864	5,131	3,898	238,995	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				162,569		162,569	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>Oxygen</u>	39(2)					18,116		18,116	13
14	TOTAL			\$	8,067	\$ 483,982	\$ 188,930	8,067	\$ 672,912	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 Pine Acres Rehab & Living Center

0047720

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 481,647	\$ 482,051	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>50,000</u>)	1,624,428	1,624,428	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	84,107	84,107	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due From Related Party</u>	610	610	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,190,792	\$ 2,191,196	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		189,881	13
14	Buildings, at Historical Cost		1,736,051	14
15	Leasehold Improvements, at Historical Cost	4,562	4,562	15
16	Equipment, at Historical Cost	15,826	802,474	16
17	Accumulated Depreciation (book methods)	(2,536)	(200,442)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		12,895	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(4,945)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: <u>See Sch 17A</u>)		192,979	22
23	Other(specify): <u>Non-Care Assets (Net)</u>		179,773	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 17,852	\$ 2,913,228	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,208,644	\$ 5,104,424	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 551,788	\$ 551,788	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,364	17,364	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	133,021	133,021	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,440	5,440	31
32	Accrued Real Estate Taxes(Sch.IX-B)		49,000	32
33	Accrued Interest Payable		15,281	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	350,442	255,418	36
37	<u>Insurance Payable</u>	54,397	54,397	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,112,452	\$ 1,081,709	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	159,796	2,969,082	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)	\$ 159,796	\$ 2,969,082	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,272,248	\$ 4,050,791	46
47	TOTAL EQUITY (page 18, line 24)	\$ 936,396	\$ 1,053,633	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,208,644	\$ 5,104,424	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Pine Acres Rehab & Living Center, LLC

Provider #: 0047720

1/1/2007 to 12/31/2007

Schedule 17A

XV. Balance Sheet

	<u>Operating</u>	<u>After Consolidation</u>
Line 22 - Other Long Term Assets (specify)		
Construction In Process	0	192,979
Total Line 22 - Other Long Term Assets	0	192,979
Line 36 - Other Current Liabilities (specify)		
401K Liability	451	451
Due To State	33,493	33,493
Due To/From AdminaStar	(18,392)	(18,392)
Due To/From CNRC	13,676	13,676
Due To/From Pine Acres Realty, LLC	95,024	0
Advance Billing	226,190	226,190
Total Line 36 - Other Current Liabilities	350,442	255,418

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 544,948	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 544,948	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	631,447	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	(240,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) ROUNDING	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 391,448	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)	\$ 936,396	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	\$ 5,736,797	1
2	Discounts and Allowances for all Levels	(1,528,970)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,207,827	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,616,858	6
7	Oxygen	43,760	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,660,618	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	23,887	13
14	Non-Patient Meals	4,240	14
15	Telephone, Television and Radio	10	15
16	Rental of Facility Space		16
17	Sale of Drugs	163,081	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,225	19
20	Radiology and X-Ray	959	20
21	Other Medical Services	57,555	21
22	Laundry	8,676	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 261,633	23
	D. Non-Operating Revenue		
24	Contributions	2,940	24
25	Interest and Other Investment Income***	3,058	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,998	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	928	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 928	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,137,004	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,018,075	31
32	Health Care	2,528,084	32
33	General Administration	1,127,217	33
	B. Capital Expense		
34	Ownership	455,675	34
	C. Ancillary Expense		
35	Special Cost Centers	311,353	35
36	Provider Participation Fee	65,153	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,505,557	40
41	Income before Income Taxes (line 30 minus line 40)**	631,447	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 631,447	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 is prepared on the 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.

Pine Acres Rehab & Living Center, LLC

Provider #: 0047720

1/1/2007 to 12/31/2007

Schedule 19A

XVII. Income Statement

Line 27 - Other Revenue

Escort Services	240
Resident Outings	5
Vending Machine Income	453
Other Income	60
Miscellaneous Income	170
Total Line 27 - Other Revenue	<u>928</u>

Facility Name & ID Number Pine Acres Rehab & Living Center

0047720

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,992	2,160	\$ 62,998	\$ 29.17	1
2	Assistant Director of Nursing	1,955	2,167	62,426	28.81	2
3	Registered Nurses	5,640	6,012	171,431	28.51	3
4	Licensed Practical Nurses	18,129	19,429	434,427	22.36	4
5	CNAs & Orderlies	65,480	69,000	844,122	12.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,016	2,071	31,830	15.37	9
10	Activity Assistants	3,794	4,016	37,809	9.41	10
11	Social Service Workers	4,050	4,392	102,386	23.31	11
12	Dietician					12
13	Food Service Supervisor	1,946	2,182	35,829	16.42	13
14	Head Cook	3,568	3,924	52,767	13.45	14
15	Cook Helpers/Assistants	21,894	23,039	188,161	8.17	15
16	Dishwashers					16
17	Maintenance Workers	5,158	5,679	84,925	14.95	17
18	Housekeepers	11,297	11,590	95,911	8.28	18
19	Laundry					19
20	Administrator	1,968	2,160	84,529	39.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,499	11,080	118,060	10.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,635	1,850	20,774	11.23	31
32	Other Health C: See Sch 20A	4,237	4,637	113,094	24.39	32
33	Other(specify) See Sch 20A	3,852	4,201	80,278	19.11	33
34	TOTAL (lines 1 - 33)	169,110	179,589	\$ 2,621,757 *	\$ 14.60	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	159	\$ 6,670	1(3)	35
36	Medical Director	Monthly	9,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	13	400	10(3)	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	25	1,398	11(3)	44
45	Social Service Consultant	19	943	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	216	\$ 19,011		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	39	\$ 1,710	10(3)	50
51	Licensed Practical Nurses	1,718	65,280	10(3)	51
52	Certified Nurse Assistants/Aides	43	651	10(3)	52
53	TOTAL (lines 50 - 52)	1,800	\$ 67,641		53

SEE ACCOUNTANTS' COMPILATION REPORT

Pine Acres Rehab & Living Center, LLC

Provider #: 0047720

1/1/2007 to 12/31/2007

Schedule 20A

	Hours Worked	Hours Paid	Total Wages	Ave. Hrly. Wage
XVIII. Staffing & Salary Costs				
Line 32 - Other				
MDS Coordinator	2,192	2,375	56,841	23.93
Rehab Director	2,045	2,262	56,253	24.87
	<u>4,237</u>	<u>4,637</u>	<u>113,094</u>	<u>24.39</u>
Line 33 - Other				
Beautician	1,806	2,001	32,320	16.15
Marketing Wages	2,046	2,200	47,958	21.80
	<u>3,852</u>	<u>4,201</u>	<u>80,278</u>	<u>19.11</u>

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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007
1		\$		\$	\$	\$	\$ N/A	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
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11																				
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17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pine Acres Rehab & Living Center# 0047720Report Period Beginning: 01/01/2007Ending: 12/31/2007**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL. Council on Long Term Care - \$8,029
- (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? N/A
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ 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. \$ 65,153
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,240
- (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. \$ 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 \$5,000, 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