

Facility Name & ID Number Claremont Rehab & Living Center

0047043 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	73,200	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	73,200	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	28,547	10,835	19,184	58,566	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,547	10,835	19,184	58,566	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.01%

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 15,152

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Claremont Rehab & Living Center # 0047043 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	395,395	34,770	19,409	449,574		449,574		449,574		1
2	Food Purchase		364,712		364,712		364,712	(41,038)	323,674		2
3	Housekeeping	211,629	59,778		271,407		271,407		271,407		3
4	Laundry	29,737	16,807	35,311	81,855		81,855		81,855		4
5	Heat and Other Utilities			317,446	317,446		317,446	2,495	319,941		5
6	Maintenance	137,612	62,583	189,427	389,622		389,622	5,449	395,071		6
7	Other (specify):*										7
8	TOTAL General Services	774,373	538,650	561,593	1,874,616		1,874,616	(33,094)	1,841,522		8
	B. Health Care and Programs										
9	Medical Director			31,500	31,500		31,500		31,500		9
10	Nursing and Medical Records	3,892,411	319,267	60,669	4,272,347		4,272,347	49,204	4,321,551		10
10a	Therapy	717,968		758,209	1,476,177		1,476,177	(201)	1,475,976		10a
11	Activities	162,281	17,775		180,056		180,056		180,056		11
12	Social Services	86,350		39,658	126,008		126,008	66,712	192,720		12
13	CNA Training										13
14	Program Transportation							31,323	31,323		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,859,010	337,042	890,036	6,086,088		6,086,088	147,038	6,233,126		16
	C. General Administration										
17	Administrative	103,525		383,203	486,728		486,728	(347,333)	139,395		17
18	Directors Fees										18
19	Professional Services			107,036	107,036		107,036	(30,090)	76,946		19
20	Dues, Fees, Subscriptions & Promotions			32,963	32,963		32,963	(3,566)	29,397		20
21	Clerical & General Office Expenses	550,072	74,340	118,956	743,368		743,368	22,051	765,419		21
22	Employee Benefits & Payroll Taxes			855,348	855,348		855,348	40,287	895,635		22
23	Inservice Training & Education										23
24	Travel and Seminar			21,942	21,942		21,942	181	22,123		24
25	Other Admin. Staff Transportation			47,017	47,017		47,017	(30,103)	16,914		25
26	Insurance-Prop.Liab.Malpractice			262,527	262,527		262,527	2,147	264,674		26
27	Other (specify):* Home Office Benefits							33,967	33,967		27
28	TOTAL General Administration	653,597	74,340	1,828,992	2,556,929		2,556,929	(312,459)	2,244,470		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,286,980	950,032	3,280,621	10,517,633		10,517,633	(198,515)	10,319,118		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:

01/01/08

Ending:

12/31/08

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			73,500	73,500		73,500	9,287	82,787			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,450	73,450		73,450	10,036	83,486			32
33	Real Estate Taxes							242,118	242,118			33
34	Rent-Facility & Grounds			1,541,272	1,541,272		1,541,272	(234,139)	1,307,133			34
35	Rent-Equipment & Vehicles			43,060	43,060		43,060	2,893	45,953			35
36	Other (specify):*											36
37	TOTAL Ownership			1,731,282	1,731,282		1,731,282	30,195	1,761,477			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		931,225	168,400	1,099,625		1,099,625		1,099,625			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,800	109,800		109,800		109,800			42
43	Other (specify):* Non-allowable cost			319,197	319,197		319,197	(319,197)				43
44	TOTAL Special Cost Centers		931,225	597,397	1,528,622		1,528,622	(319,197)	1,209,425			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,286,980	1,881,257	5,609,300	13,777,537		13,777,537	(487,517)	13,290,020			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	663	30		9
10	Interest and Other Investment Income	(510)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,660)	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	(25,830)	43		18
19	Entertainment	(9,158)	43		19
20	Contributions	(25,693)	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	(96,000)	43		24
25	Fund Raising, Advertising and Promotional	(91,535)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(782)	43		28
29	Other-Attach Schedule <u>See Page 5A</u>	(130,968)	Vari.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (381,473)		\$	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)	(106,044)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (106,044)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (487,517)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						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	

Claremont Rehab & Living Center

ID# 0047043

Report Period Beginning: 01/01/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	To offset Misc. Income-transportation	\$ (2,630)	21	1
2	Cable	(4,702)	43	2
3	To disallow marketing salary	(19,662)	43	3
4	To offset misc. income	(1,054)	21	4
5				5
6	To disallow non-allowable legal fees	(32,867)	19	6
7				7
8	To disallow lobbying expense	(3,961)	20	8
9	Disallow xray expense	(28,866)	43	9
10	Disallow laboratory fees	(34,971)	43	10
11	To offset misc. income - Med. Rec.	(366)	10	11
12	To offset misc. income - Food Rebates	(751)	2	12
13	To offset misc. income - Maint. Refund	(241)	6	13
14	To offset misc. income - M.S. Trach PT	(201)	10A	14
15	Employee Meal Reclass	(40,287)	2	15
16	Employee Meal Reclass	40,287	22	16
17	To disallow out-of-state travel	(696)	24	17
18	Office Wages related to Nursing	44,708	10	18
19	Office Wages related to Soc. Ser.	66,712	12	19
20	Office Wages related to Marketing Offset above	19,662	43	20
21	Net Office Wages	(131,082)	21	21
22	Resident Transportation	31,323	14	22
23	Resident Transportation	(31,323)	25	23
24	Real Estate Taxes Included in Rent	234,552	33	24
25	Real Estate Taxes Included in Rent	(234,552)	34	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	(130,968)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	(41,038)	0	0	0	0	0	0	0	0	0	0	(41,038)	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	2,495	0	0	0	0	0	0	0	0	2,495	5
6	Maintenance	(241)	0	5,690	0	0	0	0	0	0	0	0	5,449	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(41,279)	0	8,185	0	0	0	0	0	0	0	0	(33,094)	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	44,342	0	0	4,862	0	0	0	0	0	0	0	49,204	10
10a	Therapy	(201)	0	0	0	0	0	0	0	0	0	0	(201)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	66,712	0	0	0	0	0	0	0	0	0	0	66,712	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	31,323	0	0	0	0	0	0	0	0	0	0	31,323	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	142,176	0	0	4,862	0	147,038	16						
	C. General Administration													
17	Administrative	0	0	(347,333)	0	0	0	0	0	0	0	0	(347,333)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(32,867)	250	2,515	12	0	0	0	0	0	0	0	(30,090)	19
20	Fees, Subscriptions & Promotions	(3,961)	0	361	34	0	0	0	0	0	0	0	(3,566)	20
21	Clerical & General Office Expenses	(134,766)	0	154,518	2,299	0	0	0	0	0	0	0	22,051	21
22	Employee Benefits & Payroll Taxes	40,287	0	0	0	0	0	0	0	0	0	0	40,287	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(696)	0	877	0	0	0	0	0	0	0	0	181	24
25	Other Admin. Staff Transportation	(31,323)	0	1,178	42	0	0	0	0	0	0	0	(30,103)	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,147	0	0	0	0	0	0	0	0	2,147	26
27	Other (specify):*	0	0	33,095	872	0	0	0	0	0	0	0	33,967	27
28	TOTAL General Administration	(163,326)	250	(152,642)	3,259	0	(312,459)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(62,429)	250	(144,457)	8,121	0	(198,515)	29						

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	663	0	8,624	0	0	0	0	0	0	0	0	9,287	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(510)	4,073	6,473	0	0	0	0	0	0	0	0	10,036	32
33	Real Estate Taxes	234,552	0	7,566	0	0	0	0	0	0	0	0	242,118	33
34	Rent-Facility & Grounds	(234,552)	0	413	0	0	0	0	0	0	0	0	(234,139)	34
35	Rent-Equipment & Vehicles	0	0	2,893	0	0	0	0	0	0	0	0	2,893	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	153	4,073	25,969	0	0	0	0	0	0	0	0	30,195	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):*	(319,197)	0	0	0	0	0	0	0	0	0	0	(319,197)	43
44	TOTAL Special Cost Centers	(319,197)	0	0	0	0	0	0	0	0	0	0	(319,197)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(381,473)	4,323	(118,488)	8,121	0	(487,517)	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	1
2	V	32 Interest Expense		Claremont Extended Healthcare Realty, LLC	100.00%	4,073		4,073	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$			\$ 4,323	\$ *	4,323	14

* 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%	\$ 2,495	\$ 2,495
16	V	6 Repairs and Maintenance		NuCare Management Company	80.00%	5,690	5,690
17	V	17 Management Fees	383,203	NuCare Management Company	80.00%	29,957	(353,246)
18	V	19 Professional Fees		NuCare Management Company	80.00%	2,515	2,515
19	V	20 Dues, Subscriptions		NuCare Management Company	80.00%	361	361
20	V	21 Office Expense		NuCare Management Company	80.00%	154,518	154,518
21	V	24 Education and Seminars		NuCare Management Company	80.00%	877	877
22	V	25 Other Admin Transportation		NuCare Management Company	80.00%	1,178	1,178
23	V	26 Insurance		NuCare Management Company	80.00%	2,147	2,147
24	V	27 Employee Benefits		NuCare Management Company	80.00%	32,592	32,592
25	V	30 Depreciation Expense		NuCare Management Company	80.00%	8,900	8,900
26	V	32 Interest & Amortization		NuCare Management Company	80.00%	6,473	6,473
27	V	33 Real Estate Taxes		NuCare Management Company	80.00%	7,566	7,566
28	V	34 Facility Rent		NuCare Management Company	80.00%	413	413
29	V	35 Equipment Rental		NuCare Management Company	80.00%	2,893	2,893
30	V						
31	V	30 Depreciation Expense		NuCare Management Company	80.00%	(276)	(276)
32	V	17 Administrative		NuCare Management Company	80.00%	5,913	5,913
33	V	27 Administrative Benefits		NuCare Management Company	80.00%	503	503
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 383,203			\$ 264,715	\$ * (118,488)

* 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	10 Clinical Salaries	\$	Cinical Consulting Services, LLC		\$ 4,862	\$ 4,862	15
16	V	19 Professional Fees		Cinical Consulting Services, LLC		12	12	16
17	V	20 Dues, Subscriptions		Cinical Consulting Services, LLC		34	34	17
18	V	21 Office Expense - Wages		Cinical Consulting Services, LLC		1,975	1,975	18
19	V	21 Office Expense		Cinical Consulting Services, LLC		324	324	19
20	V	25 Other Admin Transportation		Cinical Consulting Services, LLC		42	42	20
21	V	27 Employee Benefits		Cinical Consulting Services, LLC		590	590	21
22	V	27 Employee Benefits		Cinical Consulting Services, LLC		282	282	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 8,121	\$ * 8,121	39

* 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

1/1/2008 to 12/31/2008

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: 01/01/08 Ending: 12/31/08

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	2	3	4	5	6		7		8	11
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1										1
2										2
3	See Schedule 7AA and related Schedules.									
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13							TOTAL	\$		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 Claremont Rehab & Living Center

0047043

Report Period Beginning:

01/01/08

Ending: 12/31/08

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	1,063,296	13	\$ 36,243	\$ 73,200	\$ 2,495	1
2	6	Repairs and Maintenance	Bed days available	1,063,296	13	82,646	73,200	5,690	2
3	17	Management Fees	Bed days available	1,063,296	13	435,152	435,152	29,957	3
4	19	Professional Fees	Bed days available	1,063,296	13	36,529	73,200	2,515	4
5	20	Dues, Subscriptions	Bed days available	1,063,296	13	5,248	73,200	361	5
6	21	Office Expense	Bed days available	1,063,296	13	2,244,511	1,829,739	154,518	6
7	24	Education and Seminars	Bed days available	1,063,296	13	12,739	73,200	877	7
8	25	Other Admin Transportation	Bed days available	1,063,296	13	17,115	73,200	1,178	8
9	26	Insurance	Bed days available	1,063,296	13	31,184	73,200	2,147	9
10	27	Employee Benefits	Bed days available	1,063,296	13	473,425	73,200	32,592	10
11	30	Depreciation Expense	Bed days available	1,063,296	13	129,281	73,200	8,900	11
12	32	Interest & Amortization	Bed days available	1,063,296	13	94,028	73,200	6,473	12
13	33	Real Estate Taxes	Bed days available	1,063,296	13	109,900	73,200	7,566	13
14	34	Facility Rent	Bed days available	1,063,296	13	5,996	73,200	413	14
15	35	Equipment Rental	Bed days available	1,063,296	13	42,030	73,200	2,893	15
16									16
17	30	Depreciation Expense	Direct allocation			(276)		(276)	17
18	17	Administrative	Bed days available	1,063,296	12	85,892	85,892	5,913	18
19	27	Administrative Benefits	Bed days available	1,063,296	12	7,309	73,200	503	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,848,952	\$ 2,350,783	\$ 264,715	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Claremont Rehab & Living Center

0047043

Report Period Beginning:

01/01/08

Ending: 12/31/08

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 Cinical Consulting Services, LLC
 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	10	Clinical Salaries	292,260	13	\$ 77,230	\$ 77,230	18,400	\$ 4,862	1
2	19	Professional Fees	292,260	13	188		18,400	12	2
3	20	Dues, Subscriptions	292,260	13	539		18,400	34	3
4	21	Office Expense - Wages	292,260	13	31,375	31,375	18,400	1,975	4
5	21	Office Expense	292,260	13	5,151		18,400	324	5
6	25	Other Admin Transportation	292,260	13	668		18,400	42	6
7	27	Employee Benefits	292,260	13	9,369		18,400	590	7
8	27	Employee Benefits	292,260	13	4,486		18,400	282	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				\$ 129,006	\$ 108,605		\$ 8,121	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Claremont Rehab & Living Center

0047043

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	LaSalle Bank		X	Note Payable	Interest Only	3/31/05	\$ 300,000	\$ 31,250	3/31/2010	0.0875	\$ 4,073	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	LaSalle Bank		X	Line of Credit	Interest Only	3/31/07	2,000,000	2,000,000	03/31/09	0.0875	73,450	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 2,300,000	\$ 2,031,250			\$ 77,523	9								
B. Non-Facility Related*																				
10							Interest Income Offset				(510)	10								
11							Management Company allocation				6,473	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 5,963	14								
15	TOTALS (line 9+line14)						\$ 2,300,000	\$ 2,031,250			\$ 83,486	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 2007 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.)		2007	\$	234,552	2
3. Under or (over) accrual (line 2 minus line 1).			\$	234,552	3
4. Real Estate Tax accrual used for 2008 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		7,566	
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.			\$	242,118	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2003	215,770	8	FOR BHF USE ONLY	
	2004	224,097	9	13	FROM R. E. TAX STATEMENT FOR 2007 \$ 13
	2005	229,068	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2006	232,336	11	15	LESS REFUND FROM LINE 6 \$ 15
	2007	234,552	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
N/A					

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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>234,552.00</u>	\$ <u>234,552.00</u>
2. <u>10-27-319-028-0000</u>	<u>Management Company</u>	\$ <u>100,273.68</u>	\$ <u>7,566.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>334,825.68</u>	\$ <u>242,118.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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 Claremont Rehab & Living Center

0047043

Report Period Beginning:

01/01/08

Ending:

12/31/08

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>11,015</u>	1
2					2
3	TOTALS			\$ 11,015	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

01/01/08

Ending:

12/31/08**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		\$ 99,133	\$	25	\$ 2,832	\$ 2,832	\$ 14,516	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Data cables & jacks		2005		8,647		20	432	432	1,512	9
10	Electrical work		2005		4,050		20	203	203	710	10
11	Landscape architecture		2005		4,500		20	225	225	788	11
12	Alarm for door		2005		1,550		20	79	79	274	12
13	Flooring		2005		55,880		20	2,794	2,794	9,779	13
14	Heater		2005		1,578		20	78	78	273	14
15	Sewerline		2005		4,000		20	200	200	700	15
16	Nursing Station countertop and cabinet		2005		13,000		20	650	650	2,275	16
17	Draperies		2005		5,013		20	251	251	878	17
18	Modulator and DTV box		2005		750		20	37	37	130	18
19	Wireless TV satellite dish		2005		1,137		20	57	57	199	19
20	Concrete by parlor exit		2005		1,575		20	79	79	276	20
21	Microboard		2005		5,110		20	256	256	896	21
22	Electrical work		2005		1,720		20	86	86	301	22
23	Chair Rail		2006		4,293		20	215	215	429	23
24	Dining Room Remodel		2006		3,875		20	194	194	388	24
25	Door Repairs		2006		4,440		20	222	222	444	25
26	Electrical Work		2006		19,035		20	952	952	1,904	26
27	Elevator		2006		1,800		20	90	90	180	27
28	Fireproof Basement		2006		2,620		20	131	131	263	28
29	Flooring		2006		41,808		20	2,090	2,090	4,180	29
30	Kitchen Remodel		2006		23,800		20	1,190	1,190	2,380	30
31	Landscaping		2006		16,528		20	826	826	1,652	31
32	Play Area		2006		6,718		20	336	336	672	32
33	Remodel Dialysis Unit		2006		3,800		20	190	190	380	33
34	Remodel Resident Rooms		2006		22,640		20	1,132	1,132	2,264	34
35	Roof		2006		1,750		20	88	88	176	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:

01/01/08

Ending:

12/31/08

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	\$	20	\$ 104	\$ 104	\$ 208	37
38	Thermostat	2006	18,900		20	945	945	1,891	38
39	Wall Mural & Wallpaper	2006	5,860		20	293	293	587	39
40	Water Heater	2006	30,639		20	1,532	1,532	3,064	40
41	Window Treatments	2006	10,774		20	539	539	1,077	41
42	Compressor	2006	15,410		20	771	771	1,541	42
43	Therpy Rm - Plumbing, tile, & Paint	2007	17,096		20	855	855	1,282	43
44	Showers Demolish, Rebuild, Tiles	2007	22,654		20	1,133	1,133	1,699	44
45	Employee Lounge - Drywall & Paint	2007	8,200		20	410	410	615	45
46	Thermostats installed	2007	3,000		20	150	150	225	46
47	Therpy Rm - Cabinets installed	2007	4,300		20	215	215	323	47
48	Elevator Panels and repairs	2007	9,800		20	490	490	735	48
49	Thermostats installed	2007	3,975		20	199	199	298	49
50	Therpy Rm - Wall	2007	2,700		20	135	135	203	50
51	Window Installed	2007	15,484		20	774	774	1,161	51
52	Shower Tiles	2007	7,330		20	366	366	550	52
53	Door Installed	2007	12,420		20	621	621	932	53
54	Built-in Med Rec Shelves	2007	2,702		20	135	135	203	54
55	Door Installed	2007	3,355		20	168	168	252	55
56	Remove/Install Heating Elements	2007	8,100		20	405	405	608	56
57	Kitchen - Cooler Repaired & Tile Installed	2007	7,685		20	384	384	576	57
58	Elevator Valve	2007	2,800		20	140	140	210	58
59	Built-in Med Rec Shelves	2007	2,878		20	144	144	216	59
60	Motorized Hot/Cold Water Unit	2007	10,050		20	503	503	754	60
61	Generator and Water Heater	2007	3,314		20	166	166	249	61
62	Dish Washer Water Heater Booster	2007	3,635		20	182	182	273	62
63	2nd Flr Nurses Stat - Carpeting, Lights	2007	5,411		20	271	271	406	63
64	Alarm System Testing	2007	2,878		20	144	144	216	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 604,180	\$		\$ 28,086	\$ 28,086	\$ 69,168	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Claremont Rehab & Living Center

0047043

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 604,180	\$		\$ 28,086	\$ 28,086	\$ 69,168	1
2	3 Hot/Clod Water Units	2008	9,500		20	238	238	238	2
3	Heating Units Fixed	2008	3,550		20	89	89	89	3
4	Patio & Landscaping	2008	31,693		20	792	792	792	4
5	Tube	2008	4,654		20	116	116	116	5
6	Kitchen Heating Tab & Dinning Blinds	2008	5,300		20	133	133	133	6
7	Doors Replaced & Fixed	2008	21,041		20	526	526	526	7
8	Painting & Wallpaper on 3rd floor	2008	38,894		20	972	972	972	8
9	Bathrooms - Toilets, Showers, Tile, etc	2008	248,971		20	6,224	6,224	6,224	9
10	Elevator Control Panel	2008	9,463		20	237	237	237	10
11									11
12									12
13									13
14	2007 Allocation from management company:								14
15	Alarm System	2003	806		20	40	40	207	15
16	Buildout of Offices	2004	16,371		20	820	820	3,860	16
17	Security & Fire Alarm System	2004	9,037		20	583	583	1,931	17
18	Data Cables, Lights & Heat Exchanger	2005	971		20	49	49	187	18
19	Fire Alarm System	2005	1,970		20	99	99	443	19
20	Cooling Unit	2006	1,316		20	66	66	156	20
21	Asphalt & Carpet	2008	1,387		20	69	69	69	21
22									22
23	Current Year Booked Depreciation (B&F and MME)			73,500			(73,500)		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)		\$ 1,009,102	\$ 73,500		\$ 39,138	\$ (34,362)	\$ 85,348	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Claremont Rehab & Living Center

0047043

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	\$ 322,442	\$	\$ 32,244	\$ 32,244	10	\$ 85,989	71
72	Current Year Purchases	129,314		6,466	6,466	10	6,466	72
73	Fully Depreciated Assets							73
74	Allocation from management company	51,945		4,066	4,066		28,661	74
75	TOTALS	\$ 503,701	\$	\$ 42,776	\$ 42,776		\$ 121,116	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	\$ 2,183	76
77										77
78										78
79										79
80	TOTALS			\$ 4,365	\$	\$ 873	\$ 873		\$ 2,183	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)	\$ 1,528,183	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 73,500	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 82,787	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,287	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 208,646	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Claremont Rehab & Living Center

0047043

Report Period Beginning:

01/01/08

Ending:

12/31/08

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:	1994	200		\$ 1,306,720	5	15	3
4	Additions							4
5	Allocation from Management Company				413			5
6								6
7	TOTAL		200		\$ 1,307,133			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>12/31/09</u>	\$ <u>1,608,456</u>
13.		\$
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.

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

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 28,318 Description: Copy Machine 2043; Storage 6450; Parking 6000; Medical Equip 10630; Pager 302, Mngmnt Alloc 2893

(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	Patients	2008 Ford, E350	\$ 720.00	\$ 8,635	17
18	Administration	2007 Infiniti, M35X	750.00	9,000	18
19					19
20					20
21	TOTAL		\$ 1,470.00	\$ 17,635	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	2		3	4		5	6	7	8				
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units of Service			Units	Cost								
1	Licensed Occupational Therapist	L10A, C3	9028	hrs	\$	3,974	\$	238,415	\$	13,001	\$	238,415	1		
2	Licensed Speech and Language Development Therapist	L10A C3	2109	hrs		928		55,681		3,037		55,681	2		
3	Licensed Recreational Therapist			hrs									3		
4	Licensed Physical Therapist	L10A C3	16403	hrs		7,414		444,857		23,817		444,857	4		
5	Physician Care			visits									5		
6	Dental Care			visits									6		
7	Work Related Program			hrs									7		
8	Habilitation			hrs									8		
9	Pharmacy	L39 C2		# of prescripts					829,185			829,185	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs									10		
11	Academic Education			hrs									11		
12	Other (specify):												12		
13	Other (specify): <u>See Schedule 16A</u>	Vari.				3,584		174,874	102,040	3,584		276,914	13		
14	TOTAL				\$	15,900	\$	913,827	\$	931,225	\$	43,440	\$	1,845,052	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Claremont Extended Healthcare, LLC D/B/A Claremont Rehab and Living Center
PROVIDER #0047043
1/1/08 - 12/31/08

Schedule 16A

XIV. SPECIAL SERVICES (Direct Cost) Line 14

Service	Schedule V Line & Col. Ref.	Outside Practitioner		
		Units	Costs	Supplies
Respiratory Therapy	L10A C3	216	6,474	102,040
Hemodialysis	L39 C3	3,368	168,400	
		<u>3,584</u>	<u>174,874</u>	<u>102,040</u>

Facility Name & ID Number Claremont Rehab & Living Center

0047043

Report Period Beginning: 01/01/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(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	\$ 737,145	\$ 737,895	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (324,613))	2,398,131	2,398,131	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,155	96,155	6
7	Other Prepaid Expenses	101,984	101,984	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See attached Sch 17A	630,028	1,280,028	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,963,443	\$ 4,614,193	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		11,015	13
14	Buildings, at Historical Cost		99,133	14
15	Leasehold Improvements, at Historical Cost	869,913	909,969	15
16	Equipment, at Historical Cost	452,192	508,066	16
17	Accumulated Depreciation (book methods)	(156,586)	(208,646)	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)	\$ 1,165,519	\$ 1,319,537	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,128,962	\$ 5,933,730	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 529,307	\$ 529,307	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,000,000	2,031,250	29
30	Accrued Salaries Payable	600,447	600,447	30
31	Accrued Taxes Payable (excluding real estate taxes)	79,543	79,543	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	See attached Sch 17A	695,652	1,368,129	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,904,949	\$ 4,608,676	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,904,949	\$ 4,608,676	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,224,013	\$ 1,325,054	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,128,962	\$ 5,933,730	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Claremont Extended Healthcare, LLC D/B/A Claremont Rehab and Living Center
PROVIDER #0047043
1/1/08 - 12/31/08

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.

A. Current Assets

		After
Other Current Assets (specify):	Operating	Consolidation
Due from Landlord	-	650,000
CH Deposits	9,375	9,375
Due from Related Party	620,653	620,653
	<hr/>	
Total Line 9 - Other Current Assets (specify):	630,028	1,280,028

C. Current Liabilities

		After
Other Current Liabilities (specify):	Operating	Consolidation
Due to Related Party	-	672,477
BOA Cap Loan	500,000	500,000
Accrued Expenses	61,202	61,202
Accrued Utilities	7,832	7,832
Due to Prior Owner	72,529	72,529
Due Nuicare Services Co	44,830	44,830
Due Nuvision	9,259	9,259
	<hr/>	
Total Line 36 - Other Current Liabilities (specify):	695,652	1,368,129

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 931,909	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 931,909	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	742,104	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	(450,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 292,104	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)	\$ 1,224,013	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	\$ 14,107,752	1
2	Discounts and Allowances for all Levels	(5,195,055)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,912,697	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,735,303	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,735,303	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,308,464	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	158,817	19
20	Radiology and X-Ray	38,402	20
21	Other Medical Services	349,239	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,854,922	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	510	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 510	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc Income</u>	13,579	28
28a	<u>Transportation Income</u>	2,630	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 16,209	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,519,641	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,874,616	31
32	Health Care	6,086,088	32
33	General Administration	2,556,929	33
	B. Capital Expense		
34	Ownership	1,731,282	34
	C. Ancillary Expense		
35	Special Cost Centers	1,418,822	35
36	Provider Participation Fee	109,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,777,537	40
41	Income before Income Taxes (line 30 minus line 40)**	742,104	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 742,104	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:

01/01/08

Ending:

12/31/08

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	1,217	1,451	\$ 72,673	\$ 50.09	1
2	Assistant Director of Nursing	1,914	2,091	93,449	44.69	2
3	Registered Nurses	23,602	26,136	882,548	33.77	3
4	Licensed Practical Nurses	30,973	32,727	901,563	27.55	4
5	CNAs & Orderlies	93,848	105,565	1,387,099	13.14	5
6	CNA Trainees	16,153	16,394	208,932	12.74	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	28,631	30,489	717,968	23.55	8
9	Activity Director	1,889	2,075	45,374	21.87	9
10	Activity Assistants	10,256	10,890	116,907	10.74	10
11	Social Service Workers	5,657	5,869	86,350	14.71	11
12	Dietician	3,635	4,306	105,374	24.47	12
13	Food Service Supervisor					13
14	Head Cook	4,760	5,597	70,040	12.51	14
15	Cook Helpers/Assistants	25,347	26,884	219,981	8.18	15
16	Dishwashers					16
17	Maintenance Workers	4,675	4,963	137,612	27.73	17
18	Housekeepers	24,916	26,427	211,629	8.01	18
19	Laundry	3,531	3,835	29,737	7.75	19
20	Administrator	1,869	2,091	103,525	49.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	28,520	32,867	550,072	16.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,009	2,091	42,806	20.47	28
29	Resident Services Coordinator	5,270	6,176	202,562	32.80	29
30	Habilitation Aides (DD Homes)			0		30
31	Medical Records	4,322	4,674	100,778	21.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	322,994	353,598	\$ 6,286,980 *	\$ 17.78	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	432	\$ 19,409	L1,C3	35
36	Medical Director	Monthly	31,500	L9,C3	36
37	Medical Records Consultant	102	5,494	L10,C3	37
38	Nurse Consultant	387	7,681	L10,C3	38
39	Pharmacist Consultant	Monthly	2,944	L10,C3	39
40	Physical Therapy Consultant	108	8,515	L10A,C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	63	4,267	L10A,C3	43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	2,158	L12,C3	45
46	Other(specify) <u>Medical Consultant</u>	Monthly	45,000	L10,C3	46
47	<u>IMRR Consultant</u>	Monthly	550	L10,C3	47
48					48
49	TOTAL (lines 35 - 48)	1,092	\$ 127,518		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
<u>Rupal Mistry</u>	<u>Administrator</u>	<u>0%</u>	<u>103,525</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 94,643</u>	<u>IDPH License Fee</u>	<u>\$ 1,795</u>	
				<u>Unemployment Compensation Insurance</u>	<u>0</u>	<u>Advertising: Employee Recruitment</u>	<u>8,790</u>	
				<u>FICA Taxes</u>	<u>508,714</u>	<u>Health Care Worker Background Check</u>	<u>4,000</u>	
				<u>Employee Health Insurance</u>	<u>177,846</u>	(Indicate # of checks performed <u>400</u>)		
				<u>Employee Meals</u>	<u>40,287</u>	<u>Patient Background Checks</u>	<u>20</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Misc. Licenses & Inspections</u>	<u>6,066</u>	
				<u>Miscellaneous Employee Benefits</u>	<u>32,532</u>	<u>IHCA Dues</u>	<u>11,040</u>	
				<u>Life Insurance</u>	<u>20,460</u>	<u>Misc. Dues & Subscriptions</u>	<u>1,252</u>	
				<u>401 (K)</u>	<u>14,706</u>	<u>Less: Lobbying portion of IHCA dues</u>	<u>(3,961)</u>	
				<u>Employee Physicals</u>	<u>6,262</u>	<u>Allocation of management company</u>	<u>395</u>	
				<u>Employee Awards</u>	<u>185</u>	<u>Less: Public Relations Expense</u>	<u>()</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 103,525	TOTAL (agree to Schedule V, line 22, col.8)		\$ 29,397		
(List each licensed administrator separately.)								
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fees (Adjusted in Col. 7)</u>			<u>\$ 383,203</u>				<u>Out-of-State Travel</u>	<u>\$</u>
							<u>In-State Travel</u>	
							<u>Seminar Expense</u>	<u>21,246</u>
							<u>Allocation from management company</u>	<u>877</u>
							<u>Entertainment Expense</u>	<u>()</u>
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 383,203	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)							\$ 22,123	
C. Professional Services			Amount					
Vendor/Payee	Type							
<u>RSM/McGladrey & Pullen</u>	<u>Accounting</u>	<u>\$ 24,330</u>						
<u>Frost,Ruttenburg & Rothblatt</u>	<u>Accounting</u>	<u>5,350</u>						
<u>Ashman & Stein</u>	<u>Consulting</u>	<u>1,084</u>						
<u>Barbara Demos, Law Offices</u>	<u>Consulting</u>	<u>29,294</u>						
<u>Klein Dub & Holleb</u>	<u>Consulting</u>	<u>3,323</u>						
<u>Lucy W. Dorenfield</u>	<u>Legal</u>	<u>2,966</u>						
<u>Reed, Smith, Sachnoff & Weaver</u>	<u>Legal</u>	<u>2,046</u>						
<u>Sachnoff & Weaver, LTD</u>	<u>Legal</u>	<u>1,518</u>						
<u>Stone, Pogrund, & Korey LLC</u>	<u>Legal</u>	<u>2,540</u>						
<u>Stone, McGuire & Siegel</u>	<u>Legal</u>	<u>32,401</u>						
<u>Polsinelli, Shalton, Etc...</u>	<u>Legal</u>	<u>250</u>						
<u>Personal Planners, Inc</u>	<u>Unemployment Consult.</u>	<u>1,934</u>						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 107,036					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

Provider #: 0047043

1/1/2008 to 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 107,036

Allocation from Real Estate Entity

Professional Fees - Other 250

Allocation from Management Company

Legal Fees 1,328

Accounting Fees 1,187

Consulting 12

2,527

Non-Allowable Legal Fees

Polsinelli, Shalton, Flanigan, Suelthaus PC (250)

Barbara Demos, Law Offices (29,294)

Klein Dub & Holleb (3,323)

(32,867)

Total (agree to Schedule V, line 19, column 8) 76,946

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								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A											
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# 0047043Report Period Beginning: 01/01/08Ending: 12/31/08**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 \$3,961)
- (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. \$ 54,693 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. \$ 109,800
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. \$ 40,287 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (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