

Facility Name & ID Number Community Nursing & Rehabilitation Center

0044750 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	153	Skilled (SNF)	153	55,998	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	153	TOTALS	153	55,998	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	30,551	6,756	7,116	44,423	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,551	6,756	7,116	44,423	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.33%

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

None (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 04/01/2000

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

YES Date 04/01/2000 NO

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

YES NO If YES, enter number of beds certified 153 and days of care provided 4,526

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: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 01/01/08 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	313,107	30,104	8,830	352,041		352,041		352,041		1
2	Food Purchase		222,262		222,262		222,262	(10,643)	211,619		2
3	Housekeeping	197,148	5,172		202,320		202,320		202,320		3
4	Laundry	55,892	19,462		75,354		75,354		75,354		4
5	Heat and Other Utilities			234,600	234,600		234,600		234,600		5
6	Maintenance	42,793	21,081	110,739	174,613		174,613		174,613		6
7	Other (specify):*										7
8	TOTAL General Services	608,940	298,081	354,169	1,261,190		1,261,190	(10,643)	1,250,547		8
	B. Health Care and Programs										
9	Medical Director			21,600	21,600		21,600		21,600		9
10	Nursing and Medical Records	2,797,926	121,075	113,829	3,032,830		3,032,830		3,032,830		10
10a	Therapy			504,911	504,911		504,911		504,911		10a
11	Activities	107,353	5,817	15,053	128,223		128,223	(3,787)	124,436		11
12	Social Services	42,020		2,648	44,668		44,668	(880)	43,788		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,947,299	126,892	658,041	3,732,232		3,732,232	(4,667)	3,727,565		16
	C. General Administration										
17	Administrative			230,016	230,016		230,016		230,016		17
18	Directors Fees										18
19	Professional Services			110,482	110,482		110,482		110,482		19
20	Dues, Fees, Subscriptions & Promotions			54,809	54,809		54,809	(5,843)	48,966		20
21	Clerical & General Office Expenses	179,037	27,768	50,076	256,881		256,881	(25,940)	230,941		21
22	Employee Benefits & Payroll Taxes			582,340	582,340		582,340	10,615	592,955		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,058	2,058		2,058	(85)	1,973		24
25	Other Admin. Staff Transportation			1,896	1,896		1,896		1,896		25
26	Insurance-Prop.Liab.Malpractice			137,754	137,754		137,754	62,384	200,138		26
27	Other (specify):*										27
28	TOTAL General Administration	179,037	27,768	1,169,431	1,376,236		1,376,236	41,131	1,417,367		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,735,276	452,741	2,181,641	6,369,658		6,369,658	25,821	6,395,479		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.

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			166,689	166,689		166,689	105,021	271,710			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,350	52,350		52,350	411,361	463,711			32
33	Real Estate Taxes							124,575	124,575			33
34	Rent-Facility & Grounds			666,521	666,521		666,521	(666,521)				34
35	Rent-Equipment & Vehicles			100,127	100,127		100,127		100,127			35
36	Other (specify):*											36
37	TOTAL Ownership			985,687	985,687		985,687	(25,564)	960,123			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		267,973	79,911	347,884		347,884		347,884			39
40	Barber and Beauty Shops			5,825	5,825		5,825		5,825			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			83,772	83,772		83,772		83,772			42
43	Other (specify):* Non-allowable cost	40,265		39,139	79,404		79,404	(79,404)				43
44	TOTAL Special Cost Centers	40,265	267,973	208,647	516,885		516,885	(79,404)	437,481			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,775,541	720,714	3,375,975	7,872,230		7,872,230	(79,147)	7,793,083			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	504	30		9
10	Interest and Other Investment Income	(8,408)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(561)	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	(8,070)	43		18
19	Entertainment				19
20	Contributions	(3,224)	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	(12,535)	43		24
25	Fund Raising, Advertising and Promotional	(2,853)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(7,913)	43		28
29	Other-Attach Schedule <u>Sch 5A</u>	(102,566)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (145,626)		\$	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)	66,479		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 66,479		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (79,147)		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	

SEE ACCOUNTANTS' COMPILATION REPORT

Community Nursing & Rehabilitation Center

ID# 0044750

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Miscellaneous Income	\$ (26,000)	21	1
2	Labs-Part A	(2,783)	43	2
3	X-Rays-Part A	(1,200)	43	3
4	Cafe Income	(28)	2	4
5	Café Income	(4,667)	11	5
6	Lobbying Expense	(6,093)	20	6
7	Early Extinguishment of Debt	(21,445)	43	7
8	Marketing Salary	(40,265)	43	8
9	Travel & Seminar	(85)	24	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(102,566)		49

STATE OF ILLINOIS

Summary A

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

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(28)	0	0	0	0	0	0	0	0	0	0	(28)	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	(28)	0	0	0	0	0	0	0	0	0	0	(28)	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	(4,667)	0	0	0	0	0	0	0	0	0	0	(4,667)	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	(4,667)	0	0	0	0	0	0	0	0	0	0	(4,667)	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	(6,093)	250	0	0	0	0	0	0	0	0	0	(5,843)	20
21	Clerical & General Office Expenses	(26,000)	60	0	0	0	0	0	0	0	0	0	(25,940)	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	(85)	0	0	0	0	0	0	0	0	0	0	(85)	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	62,384	0	0	0	0	0	0	0	0	0	62,384	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(32,178)	62,694	0	30,516	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(36,873)	62,694	0	25,821	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 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	504	104,517	0	0	0	0	0	0	0	0	0	105,021	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,408)	419,769	0	0	0	0	0	0	0	0	0	411,361	32
33	Real Estate Taxes	0	124,575	0	0	0	0	0	0	0	0	0	124,575	33
34	Rent-Facility & Grounds	0	(666,521)	0	0	0	0	0	0	0	0	0	(666,521)	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	(7,904)	(17,660)	0	(25,564)	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):*	(100,849)	21,445	0	0	0	0	0	0	0	0	0	(79,404)	43
44	TOTAL Special Cost Centers	(100,849)	21,445	0	(79,404)	44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(145,626)	66,479	0	(79,147)	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark and Chana Weldler	29.50	Pine Acres Rehab & Living Center, LLC	DeKalb	Community Nursing & Rehab Realty, LLC	Naperville	Real Estate
Steve and Bluma Jeremias	29.50					
Malka Mermelstein	.50					
Herman Mermelstein	.50			Pine Acres Realty, LLC	DeKalb	Real Estate
Joseph Neumann	30.00					
Hirsch Wolf	10.00					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
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)		
1	V	20 Dues, Subscriptions and Fees	\$	Community Nursing & Rehab Realty, LLC		\$ 250	\$ 250	1	
2	V	30 Depreciation		Community Nursing & Rehab Realty, LLC		104,517	104,517	2	
3	V	32 Interest Expense		Community Nursing & Rehab Realty, LLC		420,409	420,409	3	
4	V	33 Property Tax		Community Nursing & Rehab Realty, LLC		124,575	124,575	4	
5	V	34 Rent Expense	666,521	Community Nursing & Rehab Realty, LLC			(666,521)	5	
6	V	21 Bank Fees		Community Nursing & Rehab Realty, LLC		60	60	6	
7	V	26 Insurance		Community Nursing & Rehab Realty, LLC		62,384	62,384	7	
8	V	32 Interest Income		Community Nursing & Rehab Realty, LLC		(640)	(640)	8	
9	V	43 Loss on early extinguishment of debt		Community Nursing & Rehab Realty, LLC		21,445	21,445	9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 666,521			\$ 733,000	\$ *	66,479	14

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

Facility Name & ID Number Community Nursing & Rehabilitation Cent # 0044750 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Steve Jeremias	Administrator	Administrative	29.50	60,000	25	50.00	Guar Pmts	\$ 115,008	17(3)	1
2	Mark Weldner	CFO	Finance	29.50	60,000	25	50.00	Guar Pmts	115,008	17(3)	2
3											3
4											4
5											5
6											6
7	Compensation from Pine Acres Rehab and Living Center, LLC										7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 230,016		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center

0044750

Report Period Beginning:

01/01/08

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 _____

Street Address _____

N/A

City / State / Zip Code _____

Phone Number _____

()

Fax Number _____

()

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Cente # 0044750 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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	First Bank		X	Mortgage	\$40,394.00	02/2004	\$ 5,600,000		02/2009	0.0600	\$ 74,653	1						
2												2						
3	Cambridge Realty		X	Mortgage	\$43,339.00	03/20/09	7,267,500	7,208,041	02/20/49	0.0595	337,407	3						
4												4						
5												5						
	Working Capital																	
6	First Bank		X	Working Capital	Demand	02/25/04	1,000,000		01/25/08	0.0875	19,703	6						
7	Brickyard Bank	X		Working Capital	Varies	10/01/08		832,412	09/21/09	0.0525	9,575	7						
8	Brickyard Bank	X		Working Capital	Varies	03/06/07	500,000		09/03/08	0.0775	23,072	8						
9	TOTAL Facility Related				\$83,733.00		\$ 14,367,500	\$ 8,040,453			\$ 464,410	9						
	B. Non-Facility Related*																	
10												10						
11											(9,048)	11						
12											8,349	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (699)	14						
15	TOTALS (line 9+line14)						\$ 14,367,500	\$ 8,040,453			\$ 463,711	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.		\$	116,000	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.)	2007	\$	118,575	2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,575	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	122,000	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.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	124,575	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	109,697	8
	2004	115,559	9
	2005	115,705	10
	2006	114,973	11
	2007	118,575	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

Real estate tax accrual based on a portion of prior years tax bill

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 Community Nursing & Rehabilitation Center COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0044750

CONTACT PERSON REGARDING THIS REPORT Mark Weldker, CFO

TELEPHONE (630) 355-3300 FAX #: (630) 355-1417

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>07-12-403-042</u>	<u>Nursing Home</u>	\$ <u>118,575.00</u>	\$ <u>118,575.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>118,575.00</u>	\$ <u>118,575.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center

0044750

Report Period Beginning:

01/01/08

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	153	2000	1986	\$ 4,184,589	\$	40	\$ 104,615	\$ 104,615	\$ 915,387	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	CABLE		2000	4,305	108	40	108		945	9
10	ELEVATOR DOOR		2000	4,389	110	40	110		953	10
11	PARKING LOT		2000	38,200	955	40	955		8,277	11
12	LANDSCAPING		2000	8,736	218	40	218		1,871	12
13	SIGN		2000	4,541	114	40	114		978	13
14	ARCHITECT FEES		2000	3,060	77	40	77		671	14
15	DOOR LOCK		2000	2,248	56	40	56		481	15
16	CLOSETS		2000	7,729	193	40	193		1,624	16
17	COVE BASE		2000	4,459	111	40	111		916	17
18	HANDRAILS AND KICKPLATES		2000	15,146	379	40	379		3,127	18
19	LIGHTING		2000	65,796	1,645	40	1,645		13,571	19
20	TILE		2000	2,317	58	40	58		478	20
21	FLOORING		2000	16,378	409	40	409		3,325	21
22	EXIT DOORS		2000	1,598	40	40	40		330	22
23	WINDOW AND CUBICLE TREATMENTS		2000	34,021	851	40	851		7,021	23
24	LIGHTING		2000	1,729	43	40	43		355	24
25	CARPETING		2000	27,139	678	40	678		5,594	25
26	FIRE PANEL		2000	4,500	113	40	113		932	26
27	NURSE'S STATION		2000	8,913	223	40	223		1,821	27
28	DOOR HANDLES		2000	1,644	41	40	41		335	28
29	CUBICLE TRACK		2000	915	23	40	23		186	29
30	MOTOR		2000	13,276	332	40	332		2,822	30
31	STOVE HOODS		2000	1,429	36	40	36		291	31
32	COVER BASE - RESIDENTS' ROOMS		2001	865	87	10	87		688	32
33	CERAMIC TILES		2001	10,930	1,093	10	1,093		8,653	33
34	CEILING & LIGHTING		2001	9,063	906	10	906		7,073	34
35										35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center

0044750

Report Period Beginning:

01/01/08

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	RENOVATIONS - THERAPY ROOM	2001	\$ 10,558	\$ 1,056	10	\$ 1,056	\$	\$ 8,361	37
38	TILE & COVE BASE - BASEMENT	2001	2,327	233	10	233		1,864	38
39	SHAMPOO STATION	2001	5,431	543	10	543		4,299	39
40	COVE BASE - SECOND FLOOR	2001	1,699	170	10	170		1,346	40
41	WALLPAPER/COVEBASE/CARPETING/LIGHTING	2001	1,403	140	10	140		1,109	41
42	ABS PUMP	2001	11,908	1,191	10	1,191		9,429	42
43	CARPETING	2001	14,572	1,457	10	1,457		11,535	43
44	FLOORING	2001	1,320	132	10	132		1,045	44
45	2ND FLOOR RENOVATIONS	2001	38,875	3,888	10	3,888		30,132	45
46	AVERY	2001	2,419	242	10	242		1,875	46
47	KITCHEN - COOLING AIR UNIT	2001	2,275	228	10	228		1,786	47
48	WALLCOVERINGS	2001	12,289	1,229	10	1,229		9,832	48
49	SIGNAGE/ELECTRIC BALLAST (ADMISSIONS OFFICE)	2001	3,131	313	10	313		2,400	49
50	ROOM CURTAIN DIVIDER	2001	2,003	200	10	200		1,534	50
51	HANDRAILS & BUMPER GUARDS	2001	17,855	1,786	10	1,786		13,692	51
52	FIRE ALARM TRANSFORMER	2001	1,715	172	10	172		1,318	52
53	TEMP CONTROL ON AIR HANDLER	2001	9,519	952	10	952		7,299	53
54	COVEBASE/LANDSCAPING/LIGHTING/FLOORING	2001	2,642	264	10	264		2,024	54
55	LIGHTING - CORRIDORS & RESIDENT ROOMS	2001	20,544	2,054	10	2,054		15,576	55
56	NEW BEARING & SHAFT	2001	1,402	140	10	140		1,050	56
57	DIALYSIS ROOM RENOVATIONS	2001	23,351	2,335	10	2,335		16,540	57
58	ASPHALT SEALCOATING & STRIPING	2001	1,405	141	10	141		1,034	58
59	KITCHEN TILE	2001	930	93	10	93		674	59
60	SEPTIC TANK PUMPS	2001	13,862	1,386	10	1,386		10,049	60
61	CARPETING	2001	5,729	573	10	573		4,345	61
62	PAINTING & WALLPAPER	2001	20,440	2,044	10	2,044		16,352	62
63	PAINTING & WALLPAPER	2001	11,875	1,188	10	1,188		9,207	63
64	PAINTING & WALLPAPER	2001	4,500	450	10	450		3,413	64
65	NEW DOORS	2002	1,731	173	10	173		1,125	65
66	MURAL FOR SECOND FLOOR DINING ROOM	2002	7,000	700	10	700		4,550	66
67	NEW TROUGH IN LAUNDRY ROOM	2002	6,300	630	10	630		4,095	67
68	WINDOW MOLDINGS	2002	210	21	10	21		137	68
69	NEW THRESHHOLDS	2002	205	21	10	21		136	69
70	TOTAL (lines 4 thru 69)		\$ 4,739,340	\$ 35,044		\$ 139,659	\$ 104,615	\$ 1,187,868	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Community Nursing & Rehabilitation Center

0044750

Report Period Beginning:

01/01/08

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		\$ 4,739,340	\$ 35,044		\$ 139,659	\$ 104,615	\$ 1,187,868	1
2	NEW PVC PIPING IN KITCHEN	2002	1,320	132	10	132		858	2
3	UPGRADE BACKFLOW SYSTEM	2002	1,695	170	10	170		1,105	3
4	ALARM FOR RAMP EXIT	2002	1,443	144	10	144		936	4
5	FLOORING IN ELEVATOR	2002	856	86	10	86		559	5
6	CORNER GUARDS/WATER SOFTENER	2002	1,328	133	10	133		864	6
7	NEW DRAINAGE PIPES - DISPOSAL	2002	9,985	999	10	999		6,493	7
8	CORNER GUARDS	2003	276	28	10	28		168	8
9	UPGRADE DIALYSIS ROOM	2003	28,103	2,810	10	2,810		16,860	9
10	NEW AWNINGS FOR PATIO	2003	3,940	394	10	394		2,364	10
11	INSTALL GREASE TRAP IN KITCHEN	2003	3,250	325	10	325		1,950	11
12	NEW COIL FOR AIR HANDLER	2003	3,493	349	10	349		2,094	12
13	INSTALL LASER EYE ON ELEVATOR	2003	1,590	159	10	159		954	13
14	UPGRADE DIALYSIS ROOM	2004	30,778	3,078	10	3,078		15,390	14
15	NEW ROOF	2004	8,600	860	10	860		4,300	15
16	REMODEL VESTIBULE, NEW FLOORING	2004	10,044	1,004	10	1,004		5,020	16
17	INSTALL NEW SMOKE DETECTORS	2004	4,911	491	10	491		2,455	17
18	NEW OXYGEN ROOM	2004	5,688	569	10	569		2,845	18
19	NEW ELEVATOR TANK, PUMP AND MOTOR	2004	11,960	1,196	10	1,196		5,980	19
20	ROOF REPLACEMENT	2005	5,800	580	10	580		2,030	20
21	WIRE GLASS FOR RECEPTION WINDOW	2005	1,348	135	10	135		475	21
22	NEW CEMENT WALKWAYS	2005	2,400	240	10	240		840	22
23	NEW WALL HUNG SINK	2006	3,410	341	10	341		681	23
24	MOTOR FOR A/C	2006	664	66	10	66		132	24
25	NEW PUMP SYSTEM	2006	5,108	511	10	511		1,021	25
26	NEW HOT WATER HEATER	2006	7,998	800	10	800		1,600	26
27	SOLID STATE STARTER	2006	3,900	390	10	390		780	27
28	PUMP	2006	1,553	155	10	155		309	28
29	NEW FIRE ALARM	2006	6,800	680	10	680		1,360	29
30	NEW PUMP FOR BASEMENT A/C	2006	988	99	10	99		197	30
31	PAVE PARKING LOT	2006	3,500	350	10	350		700	31
32	NEW TIME CLOCK	2006	4,345	435	10	435		869	32
33	REPLACE HVAC ROOF TOP UNIT	2007	3,511	351	10	351		527	33
34			\$ 4,919,925	\$ 53,104		\$ 157,719	\$ 104,615	\$ 1,270,584	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Community Nursing & Rehabilitation Center

0044750

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,919,925	\$ 53,104		\$ 157,719	\$ 104,615	\$ 1,270,584	1
2	BALANCE OF TIME CLOCK	2007	4,345	434	10	434		651	2
3	HOT WATER HEATER	2007	9,212	921	10	921		1,382	3
4	SECURITY CAMERAS	2008	5,458	273	10	273		273	4
5	RELOCATE GAS LINE	2008	21,900	1,095	10	1,095		1,095	5
6	FRONT & BACK LANDSCAPING	2008	33,000	1,650	10	1,650		1,650	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,993,840	\$ 57,477		\$ 162,092	\$ 104,615	\$ 1,275,635	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,076,422	\$ 107,909	\$ 108,315	\$ 406		\$ 870,622	71
72	Current Year Purchases	15,275	1,303	1,303			1,303	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,091,697	\$ 109,212	\$ 109,618	\$ 406		\$ 871,925	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1988 Ford Econoline	2000	\$ 3,255	\$	\$	\$		\$ 3,255	76
77										77
78										78
79										79
80	TOTALS			\$ 3,255	\$	\$	\$		\$ 3,255	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,542,414	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 166,689	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 271,710	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 105,021	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,150,815	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Remodel	\$ 352,120	92
93			93
94			94
95		\$ 352,120	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:				\$			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 by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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: \$ 91,700 Description: See attached Scheduled 14A

(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	Administrative	2004 Toyota Avalon	\$ 577.00	\$ 8,427	17
18					18
19					19
20					20
21	TOTAL		\$ 577.00	\$ 8,427	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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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.

Community Nursing & Rehabilitation Center

Provider #: 0044750

12/31/08

Schedule 14A

Sch 12, Sec B, Line 16 - Detail of Movable Rental Equipment

Description	Amount
Non-medical equipment	39,769
Computer Equipment	24,177
Neopost	1,185
Other	437
Copiers	26,132
TOTAL	<u>91,700</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	3,645	\$ 218,700	\$	3,645	\$ 218,700	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,050	63,028		1,050	63,028	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,720	223,183		3,720	223,183	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				242,238		242,238	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					25,735		25,735	12
13	Other (specify): <u>Dialysis Service</u>	39(3)				79,911			79,911	13
14	TOTAL			\$	8,415	\$ 584,822	\$ 267,973	8,415	\$ 852,795	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center

0044750

Report Period Beginning: 01/01/08

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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 80,027	\$ 81,206	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 102,478)	2,193,202	2,193,202	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	137,543	155,713	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	165,551	100,000	8
9	Other(specify): <u>Employee Loans</u>	104,821	977,474	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,681,144	\$ 3,507,595	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		453,622	13
14	Buildings, at Historical Cost		4,184,589	14
15	Leasehold Improvements, at Historical Cost	911,177	809,251	15
16	Equipment, at Historical Cost	1,085,127	1,094,952	16
17	Accumulated Depreciation (book methods)	(1,251,925)	(2,150,815)	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: <u>See Sch 17A</u>)		526,953	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 744,379	\$ 4,918,552	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,425,523	\$ 8,426,147	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 734,274	\$ 734,274	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	150,841	150,841	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,980	13,980	31
32	Accrued Real Estate Taxes(Sch.IX-B)		122,000	32
33	Accrued Interest Payable	3,763	39,503	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See schedule 17A</u>	173,837	173,837	36
37	<u>See schedule 17A</u>	707,170	707,170	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,783,865	\$ 1,941,605	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	832,412	832,412	39
40	Mortgage Payable		7,208,041	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)	\$ 832,412	\$ 8,040,453	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,616,277	\$ 9,982,058	46
47	TOTAL EQUITY(page 18, line 24)	\$ 809,246	\$ (1,555,911)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,425,523	\$ 8,426,147	48

Community Nursing & Rehabilitation Center, LLC

Provider # 0044750

1/1/08-12/31/08

Schedule 17A

XV. Balance Sheet

B. Long Term Assets

22. Other Long Term Assets

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Accumulated Amortization of Mortgage Costs	-	(3,687)
Mortgage Cost	-	178,520
Construction in Progress	-	352,120
	-	526,953

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Accrued Assessment Fee	226	226
Insurance Payable	(76,433)	(76,433)
Due to State	(72,262)	(72,262)
Resident Credit Balances	(25,368)	(25,368)
	(173,837)	(173,837)

37. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due to/From Pine Acres	(445,817)	(445,817)
Advance Billing	(261,353)	(261,353)
	(707,170)	(707,170)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,891,530)	1
2	Restatements (describe):		2
3	Real estate entity post closing adjustment	3,123,904	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,232,374	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(423,128)	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	()	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)	\$ (423,128)	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)	\$ 809,246	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	\$ 8,331,628	1
2	Discounts and Allowances for all Levels	(2,792,960)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,538,668	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,613,618	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,613,618	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	3,251	12
13	Barber and Beauty Care	1,234	13
14	Non-Patient Meals	1,416	14
15	Telephone, Television and Radio	8,910	15
16	Rental of Facility Space	200	16
17	Sale of Drugs	212,790	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,221	19
20	Radiology and X-Ray	1,235	20
21	Other Medical Services	8,434	21
22	Laundry	2,351	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 252,042	23
	D. Non-Operating Revenue		
24	Contributions	1,898	24
25	Interest and Other Investment Income***	8,408	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,306	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Sch 19A</u>	34,468	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 34,468	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,449,102	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,261,190	31
32	Health Care	3,732,232	32
33	General Administration	1,376,236	33
	B. Capital Expense		
34	Ownership	985,687	34
	C. Ancillary Expense		
35	Special Cost Centers	433,113	35
36	Provider Participation Fee	83,772	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,872,230	40
41	Income before Income Taxes (line 30 minus line 40)**	(423,128)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (423,128)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

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

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

Community Nursing & Rehabilitation Center, LLC

Provider # 0044750

1/1/08-12/31/08

Schedule 19A

XVII. Income Statement

E. Other Revenue

28. Other Revenue

<u>Description</u>	<u>Amount</u>
Discounts Earned	28
Prior Year Adjustments	5,412
Misc. Income	29,028
	<u>34,468</u>

Facility Name & ID Number Community Nursing & Rehabilitation Center

0044750

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	1,776	1,953	\$ 78,396	\$ 40.14	1
2	Assistant Director of Nursing	1,960	2,080	83,908	40.34	2
3	Registered Nurses	17,045	18,031	517,346	28.69	3
4	Licensed Practical Nurses	24,363	25,583	590,097	23.07	4
5	CNAs & Orderlies	82,443	89,494	1,309,615	14.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,133	7,826	131,864	16.85	8
9	Activity Director	1,892	2,080	37,929	18.24	9
10	Activity Assistants	7,298	7,608	69,424	9.13	10
11	Social Service Workers	1,776	1,953	42,020	21.52	11
12	Dietician					12
13	Food Service Supervisor	1,939	2,080	38,795	18.65	13
14	Head Cook	5,080	5,519	55,033	9.97	14
15	Cook Helpers/Assistants	2,697	2,959	39,812	13.45	15
16	Dishwashers	16,786	17,887	179,467	10.03	16
17	Maintenance Workers	2,190	2,484	42,793	17.23	17
18	Housekeepers	20,184	21,934	197,148	8.99	18
19	Laundry	2,113	5,641	55,892	9.91	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,500	11,409	179,037	15.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,224	2,535	35,658	14.07	31
32	Other Health C: MDS Coord	2,601	2,944	51,042	17.34	32
33	Other(specify) <u>Mrktg & Admit.</u>	1,896	2,080	40,265	19.36	33
34	TOTAL (lines 1 - 33)	213,896	234,080	\$ 3,775,541 *	\$ 16.13	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	200	\$ 8,830	1(3)	35
36	Medical Director	Monthly	21,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	880	11(3)	44
45	Social Service Consultant	Monthly	1,768	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	216	\$ 33,078		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	574	\$ 61,587	10(3)	50
51	Licensed Practical Nurses	1,493	52,242	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,067	\$ 113,829		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	
N/A			\$	Workers' Compensation Insurance	\$ 157,427	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	19,917	Advertising: Employee Recruitment	7,603	
				FICA Taxes	288,829	Health Care Worker Background Check (Indicate # of checks performed <u>83</u>)	1,000	
				Employee Health Insurance	97,361	Patient Background Checks <u>44</u>	530	
				Employee Meals	10,615	IL Council LTC dues	6,178	
				Illinois Municipal Retirement Fund (IMRF)*		Recruitment Expense	28,212	
				Other Employee Benefits	14,662	Miscellaneous Licenses & Fees	498	
				Uniform Expense	4,144	Miscellaneous Dues & Subscriptions	2,105	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$			DuPage County Health Dept License	850	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
N/A			\$			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 592,955	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 48,966	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
RSM McGladrey, Inc.	Accounting		\$ 45,906			\$	Out-of-State Travel	\$
Paylocity	Payroll Services		6,914					
Personnel Planners	Unemployment Consult		1,723				In-State Travel	
Systematic Mgmt. Systems	Billing Consultant		23,449					
MDI Achieve	Computer Consultant		21,438					
First Bank	Void prior year titlt fees		(2,153)	N/A				
Foote, Myers, et. al.	Legal		1,678				Seminar Expense	
Steven Sher	Legal		6,049				See attached Schedule 21A	1,973
BANK	Legal		5,478					
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 110,482	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,973

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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	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 Community Nursing & Rehabilitation Center

0044750

Report Period Beginning:

01/01/08

Ending:

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. Illinois Council - LTC 12271
- (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? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,318 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 83,772
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. \$ 10,615 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,667
- (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? None
- 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees