

Facility Name & ID Number Community Nursing & Rehabilitation Center

0044750 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	153	Skilled (SNF)	153	55,845	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	153	TOTALS	153	55,845	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	33,269	5,668	6,779	45,716	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,269	5,668	6,779	45,716	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.86%

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 4,803

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: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	319,237	38,591	8,400	366,228		366,228		366,228		1
2	Food Purchase		247,048		247,048		247,048	(16,148)	230,900		2
3	Housekeeping	224,958	7,888		232,846		232,846		232,846		3
4	Laundry	48,497	19,087		67,584		67,584		67,584		4
5	Heat and Other Utilities			210,083	210,083		210,083		210,083		5
6	Maintenance	43,989	19,384	98,833	162,206		162,206	1,785	163,991		6
7	Other (specify):*										7
8	TOTAL General Services	636,681	331,998	317,316	1,285,995		1,285,995	(14,363)	1,271,632		8
	B. Health Care and Programs										
9	Medical Director			44,100	44,100		44,100		44,100		9
10	Nursing and Medical Records	3,104,830	157,401	83,498	3,345,729		3,345,729		3,345,729		10
10a	Therapy			524,543	524,543		524,543		524,543		10a
11	Activities	122,587	3,969	2,885	129,441		129,441	1,907	131,348		11
12	Social Services	46,374		1,907	48,281		48,281	(1,907)	46,374		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,273,791	161,370	656,933	4,092,094		4,092,094		4,092,094		16
	C. General Administration										
17	Administrative			86,256	86,256		86,256		86,256		17
18	Directors Fees										18
19	Professional Services			135,430	135,430		135,430		135,430		19
20	Dues, Fees, Subscriptions & Promotions			38,505	38,505		38,505		38,505		20
21	Clerical & General Office Expenses	180,699	28,812	52,517	262,028		262,028	(27,510)	234,518		21
22	Employee Benefits & Payroll Taxes			574,275	574,275		574,275	10,620	584,895		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,262	3,262		3,262	(605)	2,657		24
25	Other Admin. Staff Transportation			1,029	1,029		1,029		1,029		25
26	Insurance-Prop.Liab.Malpractice			132,979	132,979		132,979	45,232	178,211		26
27	Other (specify):*										27
28	TOTAL General Administration	180,699	28,812	1,024,253	1,233,764		1,233,764	27,737	1,261,501		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,091,171	522,180	1,998,502	6,611,853		6,611,853	13,374	6,625,227		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.

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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			190,540	190,540		190,540	158,914	349,454			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,555	52,555		52,555	400,381	452,936			32
33	Real Estate Taxes							101,973	101,973			33
34	Rent-Facility & Grounds			737,775	737,775		737,775	(737,775)				34
35	Rent-Equipment & Vehicles			101,957	101,957		101,957		101,957			35
36	Other (specify):*											36
37	TOTAL Ownership			1,082,827	1,082,827		1,082,827	(76,507)	1,006,320			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		300,496	96,595	397,091		397,091		397,091			39
40	Barber and Beauty Shops			55	55		55		55			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	41,271		37,912	79,183		79,183	(79,183)				43
44	TOTAL Special Cost Centers	41,271	300,496	218,334	560,101		560,101	(79,183)	480,918			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,132,442	822,676	3,299,663	8,254,781		8,254,781	(142,316)	8,112,465			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	(1,101)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,156)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	33,460	30		9
10	Interest and Other Investment Income	(25,504)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(386)	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	(10,838)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,994)	43		24
25	Fund Raising, Advertising and Promotional	(5,284)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(9,560)	43		28
29	Other-Attach Schedule See PG5A	(65,749)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (105,112)		\$	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)	(37,204)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (37,204)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (142,316)		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	

SEE ACCOUNTANTS' COMPILATION REPORT

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Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Miscellaneous Income	\$ (19,854)	21	1
2	Labs-Part A	(2,947)	43	2
3	Café Income	(4,169)	2	3
4	Marketing Salary	(41,271)	43	4
5	Travel & Seminar	(605)	24	5
6	Prior Year Adjustment	4,045	43	6
7	Cable TV	(948)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
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30				30
31				31
32				32
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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	(65,749)		49

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		Real Estate
Steve and Bluma Jeremias	29.50					
Malka Mermelstein	.50					
Herman Mermelstein	.50			Pine Acres Realty, LLC		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: 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	6 Building - Repairs & Mtce	\$	Community Nursing & Rehab Realty, LLC		\$ 1,785	\$ 1,785	1
2	V	21 Bank Fees		Community Nursing & Rehab Realty, LLC		500	500	2
3	V	26 Insurance		Community Nursing & Rehab Realty, LLC		45,232	45,232	3
4	V	30 Depreciation		Community Nursing & Rehab Realty, LLC		125,454	125,454	4
5	V	32 Interest		Community Nursing & Rehab Realty, LLC		425,885	425,885	5
6	V	33 Real Estate Tax		Community Nursing & Rehab Realty, LLC		101,973	101,973	6
7	V	34 Building Rent	738,033	Community Nursing & Rehab Realty, LLC			(738,033)	7
8	V			Community Nursing & Rehab Realty, LLC				8
9	V							9
10	V			Costs/Revenue listed are pulled from RE trial balance line				10
11	V			8000, 8200, and 8500				11
12	V							12
13	V							13
14	Total		\$ 738,033			\$ 700,829	\$ * (37,204)	14

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

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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	\$ 43,128	17(3)	1
2	Mark Weldler	CFO	Finance	29.50	60,000	25	50.00	Guar Pmts	43,128	17(3)	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 86,256		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

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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____

Street Address N/A

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									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

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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										
										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	Cambridge Realty		X	Mortgage	\$43,339.00	03/20/08	\$ 7,267,500	\$ 7,114,324	02/20/49	0.0595	\$ 425,885	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	Brickyard Bank	X		Working Capital	Varies	10/01/08	1,000,000	880,912	09/21/09	0.0525	52,555	6							
7												7							
8												8							
9	TOTAL Facility Related				\$43,339.00		\$ 8,267,500	\$ 7,995,236			\$ 478,440	9							
B. Non-Facility Related*																			
10												10							
11											Less: Interest Income Offset	(25,504)	11						
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (25,504)	14							
15	TOTALS (line 9+line14)						\$ 8,267,500	\$ 7,995,236			\$ 452,936	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.)

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

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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	\$ 1,020,002	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	CABLE	2000	2000	4,305	108	40	108		1,053	9
10	ELEVATOR DOOR	2000	2000	4,389	110	40	110		1,063	10
11	PARKING LOT	2000	2000	38,200	955	40	955		9,232	11
12	LANDSCAPING	2000	2000	8,736	218	40	218		2,089	12
13	SIGN	2000	2000	4,541	114	40	114		1,092	13
14	ARCHITECT FEES	2000	2000	3,060	77	40	77		748	14
15	DOOR LOCK	2000	2000	2,248	56	40	56		537	15
16	CLOSETS	2000	2000	7,729	193	40	193		1,817	16
17	COVE BASE	2000	2000	4,459	111	40	111		1,027	17
18	HANDRAILS AND KICKPLATES	2000	2000	15,146	379	40	379		3,506	18
19	LIGHTING	2000	2000	65,796	1,645	40	1,645		15,216	19
20	TILE	2000	2000	2,317	58	40	58		536	20
21	FLOORING	2000	2000	16,378	409	40	409		3,734	21
22	EXIT DOORS	2000	2000	1,598	40	40	40		370	22
23	WINDOW AND CUBICLE TREATMENTS	2000	2000	34,021	851	40	851		7,872	23
24	LIGHTING	2000	2000	1,729	43	40	43		398	24
25	CARPETING	2000	2000	27,139	678	40	678		6,272	25
26	FIRE PANEL	2000	2000	4,500	113	40	113		1,045	26
27	NURSE'S STATION	2000	2000	8,913	223	40	223		2,044	27
28	DOOR HANDLES	2000	2000	1,644	41	40	41		376	28
29	CUBICLE TRACK	2000	2000	915	23	40	23		209	29
30	MOTOR	2000	2000	13,276	332	40	332		3,154	30
31	STOVE HOODS	2000	2000	1,429	36	40	36		327	31
32	COVER BASE - RESIDENTS' ROOMS	2001	2001	865	87	10	87		775	32
33	CERAMIC TILES	2001	2001	10,930	1,093	10	1,093		9,746	33
34	CEILING & LIGHTING	2001	2001	9,063	906	10	906		7,979	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

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Ending:

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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	\$	\$ 9,417	37
38	TILE & COVE BASE - BASEMENT	2001	2,327	233	10	233		2,097	38
39	SHAMPOO STATION	2001	5,431	543	10	543		4,842	39
40	COVE BASE - SECOND FLOOR	2001	1,699	170	10	170		1,516	40
41	WALLPAPER/COVEBASE/CARPETING/LIGHTING	2001	1,403	140	10	140		1,249	41
42	ABS PUMP	2001	11,908	1,191	10	1,191		10,620	42
43	CARPETING	2001	14,572	1,457	10	1,457		12,992	43
44	FLOORING	2001	1,320	132	10	132		1,177	44
45	2ND FLOOR RENOVATIONS	2001	38,875	3,888	10	3,888		34,020	45
46	AVERY	2001	2,419	242	10	242		2,117	46
47	KITCHEN - COOLING AIR UNIT	2001	2,275	228	10	228		2,014	47
48	WALLCOVERINGS	2001	12,289	1,229	10	1,229		11,061	48
49	SIGNAGE/ELECTRIC BALLAST (ADMISSIONS OFFICE)	2001	3,131	313	10	313		2,713	49
50	ROOM CURTAIN DIVIDER	2001	2,003	200	10	200		1,734	50
51	HANDRAILS & BUMPER GUARDS	2001	17,855	1,786	10	1,786		15,478	51
52	FIRE ALARM TRANSFORMER	2001	1,715	172	10	172		1,490	52
53	TEMP CONTROL ON AIR HANDLER	2001	9,519	952	10	952		8,251	53
54	COVEBASE/LANDSCAPING/LIGHTING/FLOORING	2001	2,642	264	10	264		2,288	54
55	LIGHTING - CORRIDORS & RESIDENT ROOMS	2001	20,544	2,054	10	2,054		17,630	55
56	NEW BEARING & SHAFT	2001	1,402	140	10	140		1,190	56
57	DIALYSIS ROOM RENOVATIONS	2001	23,351	2,335	10	2,335		18,875	57
58	ASPHALT SEALCOATING & STRIPING	2001	1,405	141	10	141		1,175	58
59	KITCHEN TILE	2001	930	93	10	93		767	59
60	SEPTIC TANK PUMPS	2001	13,862	1,386	10	1,386		11,435	60
61	CARPETING	2001	5,729	573	10	573		4,918	61
62	PAINTING & WALLPAPER	2001	20,440	2,044	10	2,044		18,396	62
63	PAINTING & WALLPAPER	2001	11,875	1,188	10	1,188		10,395	63
64	PAINTING & WALLPAPER	2001	4,500	450	10	450		3,863	64
65	NEW DOORS	2002	1,731	173	10	173		1,298	65
66	MURAL FOR SECOND FLOOR DINING ROOM	2002	7,000	700	10	700		5,250	66
67	NEW TROUGH IN LAUNDRY ROOM	2002	6,300	630	10	630		4,725	67
68	WINDOW MOLDINGS	2002	210	21	10	21		158	68
69	NEW THRESHHOLDS	2002	205	21	10	21		157	69
70	TOTAL (lines 4 thru 69)		\$ 4,739,340	\$ 35,044		\$ 139,659	\$ 104,615	\$ 1,327,527	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:

01/01/09

Ending:

12/31/09

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	\$ 1,327,527	1
2	NEW PVC PIPING IN KITCHEN	2002	1,320	132	10	132		990	2
3	UPGRADE BACKFLOW SYSTEM	2002	1,695	170	10	170		1,275	3
4	ALARM FOR RAMP EXIT	2002	1,443	144	10	144		1,080	4
5	FLOORING IN ELEVATOR	2002	856	86	10	86		645	5
6	CORNER GUARDS/WATER SOFTENER	2002	1,328	133	10	133		997	6
7	NEW DRAINAGE PIPES - DISPOSAL	2002	9,985	999	10	999		7,492	7
8	CORNER GUARDS	2003	276	28	10	28		196	8
9	UPGRADE DIALYSIS ROOM	2003	28,103	2,810	10	2,810		19,670	9
10	NEW AWNINGS FOR PATIO	2003	3,940	394	10	394		2,758	10
11	INSTALL GREASE TRAP IN KITCHEN	2003	3,250	325	10	325		2,275	11
12	NEW COIL FOR AIR HANDLER	2003	3,493	349	10	349		2,443	12
13	INSTALL LASER EYE ON ELEVATOR	2003	1,590	159	10	159		1,113	13
14	UPGRADE DIALYSIS ROOM	2004	30,778	3,078	10	3,078		18,468	14
15	NEW ROOF	2004	8,600	860	10	860		5,160	15
16	REMODEL VESTIBULE, NEW FLOORING	2004	10,044	1,004	10	1,004		6,024	16
17	INSTALL NEW SMOKE DETECTORS	2004	4,911	491	10	491		2,946	17
18	NEW OXYGEN ROOM	2004	5,688	569	10	569		3,414	18
19	NEW ELEVATOR TANK, PUMP AND MOTOR	2004	11,960	1,196	10	1,196		7,176	19
20	ROOF REPLACEMENT	2005	5,800	580	10	580		2,610	20
21	WIRE GLASS FOR RECEPTION WINDOW	2005	1,348	135	10	135		610	21
22	NEW CEMENT WALKWAYS	2005	2,400	240	10	240		1,080	22
23	NEW WALL HUNG SINK	2006	3,410	341	10	341		1,022	23
24	MOTOR FOR A/C	2006	664	66	10	66		198	24
25	NEW PUMP SYSTEM	2006	5,108	511	10	511		1,532	25
26	NEW HOT WATER HEATER	2006	7,998	800	10	800		2,400	26
27	SOLID STATE STARTER	2006	3,900	390	10	390		1,170	27
28	PUMP	2006	1,553	155	10	155		464	28
29	NEW FIRE ALARM	2006	6,800	680	10	680		2,040	29
30	NEW PUMP FOR BASEMENT A/C	2006	988	99	10	99		296	30
31	PAVE PARKING LOT	2006	3,500	350	10	350		1,050	31
32	NEW TIME CLOCK	2006	4,345	435	10	435		1,304	32
33	REPLACE HVAC ROOF TOP UNIT	2007	3,511	351	10	351		878	33
34	TOTAL (lines 1 thru 33)		\$ 4,919,925	\$ 53,104		\$ 157,719	\$ 104,615	\$ 1,428,303	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, LLC

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 12B, Carried Forward		\$ 4,919,925	\$ 53,104		\$ 157,719	\$ 104,615	\$ 1,428,303	1
2	BALANCE OF TIME CLOCK	2007	4,345	434	10	434		1,085	2
3	HOT WATER HEATER	2007	9,212	921	10	921		2,303	3
4	SECURITY CAMERAS	2008	5,458	546	10	546		819	4
5	RELOCATE GAS LINE	2008	21,900	2,190	10	2,190		3,285	5
6	FRONT & BACK LANDSCAPING	2008	33,000	3,300	10	3,300		4,950	6
7									7
8	Architect Services	2009	29,257	1,463	10	1,463		1,463	8
9	Roof	2009	230,100	11,505	10	11,505		11,505	9
10	Construction Period Interest	2009	32,240	1,612	10	1,612		1,612	10
11	1st floor resident room baths - remove existing vinyl floor,								11
12	floor prep, installation of sheet vinyl, ceramic tile	2009	22,546	1,127	10	1,127		1,127	12
13	1st floor dining room - remove existing cove base and sheet								13
14	vinyl, floor prep, pvt install, pvt wallcovering	2009	32,001	1,600	10	1,600		1,600	14
15	Activity room - wall covering, remove cove base, install pvt &								15
16	cove base, cornices, custom built in computer work station,								16
17	remove existing ceiling tile, furnish & install new acoustic								17
18	ceiling tile, furnish & install new can lights	2009	20,443	1,022	10	1,022		1,022	18
19	Shower room - install 4 shower stalls, remove existing cove								19
20	base & sheet vinyl, install new ceramic tile	2009	43,873	2,194	10	2,194		2,194	20
21	Basement corridor - cove base, flooring, paint doors & frames,								21
22	wallpaper purchase & installation	2009	46,436	2,322	10	2,322		2,322	22
23	Therapy room - wallcovering, remove existing cove base and								23
24	vct installation of pvt, glue down carpet, remove cinder-								24
25	block wall and office separating OT & PT rooms, demo of								25
26	old and installation of new acoustical ceiling	2009	30,482	1,524	10	1,524		1,524	26
27	Foyer - remove old flooring, install new ceramic flooring &								27
28	pedimat, wallcovering	2009	12,181	609	10	609		609	28
29	Lobby - remove old cove base and flooring, install new ceramic								29
30	tile and cove base, wallcovering, built in reception desk,								30
31	remove mirror, door, frame & glass. Install new moldings,								31
32	remove existing receptionist wall and rebuild wall, re-								32
33	install door 3 feet from current location	2009	34,706	1,735	10	1,735		1,735	33
34	TOTAL (lines 1 thru 33)		\$ 5,528,105	\$ 87,208		\$ 191,823	\$ 104,615	\$ 1,467,458	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:

01/01/09

Ending:

12/31/09

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 12C, Carried Forward		\$ 5,528,105	\$ 87,208		\$ 191,823	\$ 104,615	\$ 1,467,458	1
2	Building Facade & Renovation								2
3	- General requirements	2009	19,795	990	10	990		990	3
4	- Permits	2009	5,000	250	10	250		250	4
5	- Excavation and site demolition	2009	22,626	1,131	10	1,131		1,131	5
6	- Asphalt Patching	2009	5,928	296	10	296		296	6
7	- Mansard and patio canopy demolition	2009	9,300	465	10	465		465	7
8	- Concrete work	2009	23,807	1,190	10	1,190		1,190	8
9	- Brick pavers	2009	13,440	672	10	672		672	9
10	- Masonry columns & Screen wall	2009	16,190	810	10	810		810	10
11	- Steel	2009	9,700	485	10	485		485	11
12	- Wood fencing	2009	1,580	79	10	79		79	12
13	- Pylon Sign	2009	8,000	400	10	400		400	13
14	- Room framing and sheathing	2009	81,769	4,088	10	4,088		4,088	14
15	- Cut and patch existing roofing for new construction	2009	17,310	866	10	866		866	15
16	- Roofing and sheetmetal	2009	40,835	2,042	10	2,042		2,042	16
17	- Electrical	2009	4,150	208	10	208		208	17
18	- Dry fire sprinkler system	2009	7,000	350	10	350		350	18
19	- Duct demolition	2009	2,160	108	10	108		108	19
20	- Homosote sheathing	2009	7,549	377	10	377		377	20
21	- Eifs	2009	13,350	668	10	668		668	21
22	- Fypon Moldings	2009	6,790	340	10	340		340	22
23	- Painting	2009	3,400	170	10	170		170	23
24	- Main exfrance roof tower	2009	47,588	2,379	10	2,379		2,379	24
25	- Asphalt sidewalk on north side of bldg	2009	4,920	246	10	246		246	25
26	- Landscaping	2009	18,000	900	10	900		900	26
27	- Landscape demo	2009	5,566	278	10	278		278	27
28	- Insurance	2009	3,562	178	10	178		178	28
29	- General contractor fee	2009	13,685	684	10	684		684	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,941,105	\$ 107,858		\$ 212,473	\$ 104,615	\$ 1,488,108	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:

01/01/09

Ending:

12/31/09

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 12D, Carried Forward		\$ 5,941,105	\$ 107,858		\$ 212,473	\$ 104,615	\$ 1,488,108	1
2	1st floor elevator lobby - remove old flooring and install new								2
3	pvt tile, wallcovering	2009	2,699	135	10	135		135	3
4	1st floor corridor - corner guard, remove old and install new								4
5	wood look pvt flooring and carpet, wallcovering	2009	55,531	2,777	10	2,777		2,777	5
6	1st floor wallcovering and paint	2009	38,491	1,925	10	1,925		1,925	6
7	2nd floor shower rooms - remove existing ceramic tile, furnish								7
8	and install new ceramic tile	2009	7,067	353	10	353		353	8
9	1st floor resident rooms - cove base, built in double wardrobe,								9
10	remove old wallpaper and glue, paint ceilings, walls, doors								10
11	and radiators, custom built in wardrobes, cornices and								11
12	cubicle curtains	2009	159,255	7,963	10	7,963		7,963	12
13									13
14									14
15	Landmark-building facade renovation	2009	9,419	471	10	471		471	15
16	Satellite TV-Installation and wiring	2009	9,000	450	10	450		450	16
17	Architect Fees	2009	713	36	10	36		36	17
18	Sprinkler System	2009	134,000	6,700	10	6,700		6,700	18
19	Window Treatments	2009	44,355	2,218	10	2,218		2,218	19
20	Alzheimers Nurses Station Remodel	2009	18,328	916	10	916		916	20
21	Adjust for accounts payable invoice	2009	(23,592)						21
22									22
23	Adjust book depreciation to financial statements			(50,638)			50,638		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)		\$ 6,396,371	\$ 81,163		\$ 236,416	\$ 155,253	\$ 1,512,051	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	\$ 1,091,697	\$ 107,283	\$ 107,283	\$	10-40	\$ 979,208	71
72	Current Year Purchases	115,100	2,094	5,755	3,661	10	5,755	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,206,797	\$ 109,377	\$ 113,038	\$ 3,661		\$ 984,963	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)	\$ 8,060,045	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 190,540	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 349,454	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 158,914	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,500,269	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	N/A	\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

This amount was calculated by dividing the total amount to be amortized 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: \$ 94,452 Description: See attached Schedule 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	<u>Administrative</u>	<u>2004 Toyota Avalon</u>	\$ <u>626</u>	\$ <u>7,505</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>626</u>	\$ <u>7,505</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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, LLC
Provider #: 0044750
12/31/2009

Schedule 14A

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

Description	Amount	
Non-medical equipment	52,194	
Computer Equipment	6,300	
Miscellaneous Rental	2,332	2332
Copiers	33,626	
TOTAL	<u>94,452</u>	

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	2,602	\$ 187,378	\$	2,602	\$ 187,378	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,512	108,877		1,512	108,877	2
3	Licensed Recreational Therapist		hrs		3,171	228,288		3,171	228,288	3
4	Licensed Physical Therapist	10A(3)	hrs							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				261,704		261,704	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					38,792		38,792	12
13	Other (specify): <u>Dialysis Services</u>	39(3)				96,595			96,595	13
14	TOTAL			\$	7,285	\$ 621,138	\$ 300,496	7,285	\$ 921,634	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: 01/01/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09 (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	\$ 87,206	\$ 91,010	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>(74,808)</u>)	1,494,632	1,494,632	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	110,968	119,876	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	116,969	116,969	8
9	Other(specify): <u>Employee Loans</u>	1,453	373,239	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,811,228	\$ 2,195,726	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	1,305,701	2,211,782	15
16	Equipment, at Historical Cost	1,127,010	1,210,052	16
17	Accumulated Depreciation (book methods)	(1,442,465)	(2,500,269)	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 (spe <u>See Sch 17A</u>)	123,269	123,269	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,113,515	\$ 5,683,045	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,924,743	\$ 7,878,771	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 820,793	\$ 951,676	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(4,744)	(4,744)	28
29	Short-Term Notes Payable		99,449	29
30	Accrued Salaries Payable	179,119	179,119	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,703	19,703	31
32	Accrued Real Estate Taxes(Sch.IX-B)		112,000	32
33	Accrued Interest Payable	2,973	38,248	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See schedule 17A</u>	254,577	254,577	36
37	<u>See schedule 17A</u>	359,407	359,407	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,631,828	\$ 2,009,435	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	880,912	880,912	39
40	Mortgage Payable		7,014,875	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43			(170,176)	43
44		3,224	3,224	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 884,136	\$ 7,728,835	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,515,964	\$ 9,738,270	46
47	TOTAL EQUITY(page 18, line 24)	\$ 408,779	\$ (1,859,499)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,924,743	\$ 7,878,771	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XV. Balance Sheet
B. Long Term Assets

22. Other Long Term Assets

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due To/From AdminAstar	123,269	123,269
	<u>123,269</u>	<u>123,269</u>

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
401K Liability	175	175
Accrued Assessment Fee	222	222
Insurance Payable	(79,872)	(79,872)
Due to State	(140,704)	(140,704)
Resident Credit Balances	(34,398)	(34,398)
	<u>(254,577)</u>	<u>(254,577)</u>

37. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due to/From Pine Acres	(136,217)	(136,217)
Advance Billing	(223,190)	(223,190)
	<u>(359,407)</u>	<u>(359,407)</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 809,246	1
2	Restatements (describe):		2
3	Real estate entity post closing adjustment	(175,448)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 633,798	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(225,019)	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)	\$ (225,019)	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)	\$ 408,779	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center# 0044750Report Period Beginning: 01/01/09Ending: 12/31/09

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	\$ 8,947,877	1
2	Discounts and Allowances for all Levels	(3,057,737)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,890,140	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,781,431	6
7	Oxygen	17,124	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,798,555	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	4,169	12
13	Barber and Beauty Care	1,225	13
14	Non-Patient Meals	1,359	14
15	Telephone, Television and Radio	8,156	15
16	Rental of Facility Space		16
17	Sale of Drugs	248,154	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,465	19
20	Radiology and X-Ray		20
21	Other Medical Services	14,835	21
22	Laundry	734	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 293,097	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	25,246	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 25,246	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Sch 19A</u>	22,724	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 22,724	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,029,762	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,285,995	31
32	Health Care	4,092,094	32
33	General Administration	1,233,764	33
B. Capital Expense			
34	Ownership	1,082,827	34
C. Ancillary Expense			
35	Special Cost Centers	476,329	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)*	\$ 8,254,781	40
41	Income before Income Taxes (line 30 minus line 40)**	(225,019)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (225,019)	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 A 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
1/1/09-12/31/09

Schedule 19A

XVII. Income Statement

E. Other Revenue

28. Other Revenue

<u>Description</u>	<u>Amount</u>
Prior Year Adjustments	2,870
Misc. Income	19,854
	<u>22,724</u>

SEE ACCOUNTANTS' COMPILATION REPORT

SEE ACCOUNTANTS' COMPILATION REPORT

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

0044750

Report Period Beginning: **01/01/09**

Ending:

12/31/09

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	1,856	2,079	\$ 85,958	\$ 41.35	1
2	Assistant Director of Nursing	1,336	1,387	62,832	45.30	2
3	Registered Nurses	22,675	24,073	721,831	29.99	3
4	Licensed Practical Nurses	18,162	18,834	488,073	25.91	4
5	CNAs & Orderlies	80,646	88,139	1,391,202	15.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,780	2,080	39,130	18.81	9
10	Activity Assistants	9,643	10,025	83,457	8.32	10
11	Social Service Workers	1,833	2,047	46,374	22.65	11
12	Dietician					12
13	Food Service Supervisor	1,972	2,230	40,799	18.30	13
14	Head Cook	5,818	6,584	60,165	9.14	14
15	Cook Helpers/Assistants	2,748	2,997	42,606	14.22	15
16	Dishwashers	15,891	16,870	175,667	10.41	16
17	Maintenance Workers	2,406	2,664	43,989	16.51	17
18	Housekeepers	20,922	22,729	224,958	9.90	18
19	Laundry	5,095	5,655	48,497	8.58	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,420	11,396	180,699	15.86	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	3,930	4,315	33,851	7.84	31
32	Other Health C: Sch 20A	22,283	23,691	321,083	13.55	32
33	Other(specify) <u>Marketing</u>	1,940	2,132	41,271	19.36	33
34	TOTAL (lines 1 - 33)	231,356	249,927	\$ 4,132,442 *	\$ 16.53	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	Monthly	\$ 8,400	1(3) 35
36	Medical Director	Monthly	44,100	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	35	1,907	11(3) 44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	35	\$ 54,407	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	313	\$ 33,563	10(3) 50
51	Licensed Practical Nurses	593	23,753	10(3) 51
52	Certified Nurse Assistants/Aides	1,659	26,182	10(3) 52
53	TOTAL (lines 50 - 52)	2,565	\$ 83,498	53

SEE ACCOUNTANTS' COMPILATION REPORT

Community Nursing & Rehabilitation Center, LLC
Provider # 0044750
1/1/09-12/31/09

Schedule 20A

Staffing & Salary

<u>Description</u>	<u>Hours Worked</u>	<u>Hours Paid</u>	<u>Amount</u>
MDS Coordinator	2698	2998	86,696
Restorative Aides	11915	12789	133,954
Treatment Nurse	1741	1340	34,940
Nursing Admin	5929	6564	65,493
	<u>22,283</u>	<u>23,691</u>	<u>321,083</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Community Nursing & Rehabilitation Center, LLC
Provider # 0044750
1/1/09-12/31/09

Schedule 21A

C. Professional Services

<u>Vendor</u>	<u>Type</u>	<u>Amount</u>
Foote, Meyers & Flowers	Legal	782
Reed Smith	Legal	215
Much Shelist	Legal	550
Rubin & Norris	Legal	3136
		<u>4,683</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3							N/A													
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center

0044750

Report Period Beginning:

01/01/09

Ending:

12/31/09

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 -12577
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,300 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.

- (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. \$ 10,620 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,222
- (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
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT