

Facility Name & ID Number Pine Acres Rehab & Living Center

0047720 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	<u>119</u>	Skilled (SNF)	<u>119</u>	<u>43,435</u>	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	<u>119</u>	TOTALS	<u>119</u>	<u>43,435</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>19,123</u>	<u>14,006</u>	<u>3,660</u>	<u>36,789</u>	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>19,123</u>	<u>14,006</u>	<u>3,660</u>	<u>36,789</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.70%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 2/1/06

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/1/06 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 119 and days of care provided 3,436

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 Pine Acres Rehab & Living Center # 0047720 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	310,577	16,786	6,848	334,211		334,211		334,211		1
2	Food Purchase		216,174		216,174		216,174	(7,436)	208,738		2
3	Housekeeping	95,124	16,296		111,420		111,420		111,420		3
4	Laundry		56	127,226	127,282		127,282	(12,625)	114,657		4
5	Heat and Other Utilities			123,558	123,558		123,558		123,558		5
6	Maintenance	110,982	55,093	55,361	221,436		221,436	1,844	223,280		6
7	Other (specify):*										7
8	TOTAL General Services	516,683	304,405	312,993	1,134,081		1,134,081	(18,217)	1,115,864		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,979,098	96,583	140,057	2,215,738		2,215,738		2,215,738		10
10a	Therapy		6,133	331,072	337,205		337,205		337,205		10a
11	Activities	82,241	6,820	100	89,161		89,161		89,161		11
12	Social Services	111,197		780	111,977		111,977		111,977		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,172,536	109,536	481,609	2,763,681		2,763,681		2,763,681		16
	C. General Administration										
17	Administrative	90,752		120,000	210,752		210,752		210,752		17
18	Directors Fees										18
19	Professional Services			117,063	117,063		117,063	(459)	116,604		19
20	Dues, Fees, Subscriptions & Promotions			14,737	14,737		14,737	250	14,987		20
21	Clerical & General Office Expenses	126,525	21,654	44,507	192,686		192,686	425	193,111		21
22	Employee Benefits & Payroll Taxes			623,443	623,443		623,443		623,443		22
23	Inservice Training & Education			504	504		504		504		23
24	Travel and Seminar			3,186	3,186		3,186		3,186		24
25	Other Admin. Staff Transportation			11,910	11,910		11,910		11,910		25
26	Insurance-Prop.Liab.Malpractice			90,018	90,018		90,018	33,979	123,997		26
27	Other (specify):*										27
28	TOTAL General Administration	217,277	21,654	1,025,368	1,264,299		1,264,299	34,195	1,298,494		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,906,496	435,595	1,819,970	5,162,061		5,162,061	15,978	5,178,039		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pine Acres Rehab & Living Center

#0047720

Report Period Beginning:

1/1/2009

Ending:

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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			8,388	8,388		8,388	165,140	173,528			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			452	452		452	284,610	285,062			32
33	Real Estate Taxes							63,245	63,245			33
34	Rent-Facility & Grounds			410,004	410,004		410,004	(410,004)				34
35	Rent-Equipment & Vehicles			25,712	25,712		25,712		25,712			35
36	Other (specify):*											36
37	TOTAL Ownership			444,556	444,556		444,556	102,991	547,547			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		157,699		157,699		157,699		157,699			39
40	Barber and Beauty Shops	34,394	598		34,992		34,992		34,992			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,148	65,148		65,148		65,148			42
43	Other (specify):* Non-allowable cost	55,650		22,977	78,627		78,627	(78,627)				43
44	TOTAL Special Cost Centers	90,044	158,297	88,125	336,466		336,466	(78,627)	257,839			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,996,540	593,892	2,352,651	5,943,083		5,943,083	40,342	5,983,425			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	(6,269)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,747)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,505)	30		9
10	Interest and Other Investment Income	(12,277)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,600)	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	(5,024)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(932)	43		28
29	Other-Attach Schedule See PG5A	(82,530)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (117,884)		\$	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)	158,226		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 158,226		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 40,342		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

Pine Acres Rehab & Living Center

ID# 0047720

Report Period Beginning: 1/1/2009

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Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Laboratory	\$ (5,479)	43	1
2	Wages-Marketing	(55,650)	43	2
3	Marketing	(5,195)	43	3
4	Offset Laundry Revenue	(12,625)	4	4
5	Offset Vending Machine Income	(1,167)	2	5
6	Non-Care Real Estate Taxes	(3,799)	33	6
7	Expense Assets Less Than \$2,500	1,844	6	7
8	Nonallowable Legal Fees	(459)	19	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
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(82,530)		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
Steve and Bluma Jeremias	33	Wheaton Care Center	Wheaton	Pine Acres Realty,		
Mark and Chana Weldler	33	Community Nursing & Rehabilitation Center, LLC	Naperville	LLC	Dekalb	Real Estate
Chaim Rajchenbach	11					
The Family Rajchenbach Trust	11			Community Nursing		
Abraham J. Stern	4			and Rehab Realty,		
Susan L. Stern	4			LLC	Naperville	Real Estate
AMN Limited Partnership	4					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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		\$			\$	\$	1
2	V	30 Depreciation		Pine Acres Realty, LLC		169,645	169,645	2
3	V	32 Interest		Pine Acres Realty, LLC		296,887	296,887	3
4	V	33 Real Estate Taxes		Pine Acres Realty, LLC		67,044	67,044	4
5	V	34 Rent Expense	410,004	Pine Acres Realty, LLC			(410,004)	5
6	V	20 Licenses		Pine Acres Realty, LLC		250	250	6
7	V	26 Insurance		Pine Acres Realty, LLC		33,979	33,979	7
8	V	21 Bank Fees		Pine Acres Realty, LLC		425	425	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 410,004			\$ 568,230	\$ * 158,226	14

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

Facility Name & ID Number Pine Acres Rehab & Living Center # 0047720 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Steve Jeremias	COO	Administrative	33.00	43,128	25	50.00	Guar Pymnts	\$ 60,000	L17,C3	1
2	Mark Weldler	CFO	Finance	33.00	43,128	25	50.00	Guar Pymnts	60,000	L17,C3	2
3											3
4	* Mr. Jeremias and Mr. Weldler receive compenstation from Community Nursing & Rehab Center										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 120,000		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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0047720

Report Period Beginning:

1/1/2009

Ending: 2/31/2009

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 N/A

Street Address _____

City / State / Zip Code _____

Phone Number ()

Fax Number ()

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

Pine Acres Rehab & Living Center

0047720

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	Brickyard Bank		X	Mortgage	\$17,919.51	01/01/06	\$ 2,350,000	\$	2/1/11	0.7750	\$ 452	1							
2	Cambridge Realty Capital LTD		X	Mortgage	\$17,450.05	07/1/08	6,512,900	6,512,900	5/1/2049	0.0635	374,639	2							
3												3							
4												4							
5												5							
Working Capital																			
6	Shareholder Loans	X		Working Capital	None	Varies	760,052		On Demand	Varies		6							
7												7							
8												8							
9	TOTAL Facility Related				\$35,369.56		\$ 9,622,952	\$ 6,512,900			\$ 375,091	9							
B. Non-Facility Related*																			
10										Capitalized Interest on CIP	(77,752)	10							
11										Offset interest income	(12,277)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (90,029)	14							
15	TOTALS (line 9+line14)						\$ 9,622,952	\$ 6,512,900			\$ 285,062	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.)

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0047720

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1/1/2009

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X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Use</u>	<u>126,760</u>	<u>2006</u>	<u>\$ 196,341</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	126,760		\$ 196,341	3

SEE ACCOUNTANTS' COMPILATION REPORT

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1/1/2009

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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	119		2006	1968	\$ 1,736,051	\$	40	\$ 43,401	\$ 43,401	\$ 169,988	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		2 Ton Rooftop System		2007	4,562	456	10	456		1,140	9
10		Replace Heat Cable		2008	2,626	263	10	263		394	10
11		Replace Fan Motors		2008	3,441	344	10	344		516	11
12		Replace Unit Heater		2008	3,938	394	10	394		591	12
13		Replace Doors		2008	2,696	270	10	270		405	13
14		Move Electrical Box		2008	6,932	693	10	693		1,039	14
15		Sidewalk		2009	6,312	316	10	316		316	15
16		Retrofit Mechanical Room with Sprinklers		2009	2,800	140	10	140		140	16
17		Security Alarm for Front Doors		2009	4,644	232	10	232		232	17
18		Telephone System		2009	37,765	1,888	10	1,888		1,888	18
19		Telephone System Addition		2009	13,143	657	10	657		657	19
20		Fence		2009	5,708	285	10	285		285	20
21		Renovation & New Construction		2009	2,443,769		40	30,547	30,547	30,547	21
22		Architect Fees		2009	122,501		40	1,531	1,531	1,531	22
23		Demolition of Old House		2009	41,210		40	515	515	515	23
24		Carpet, Flooring & Wallcovering		2009	175,473		40	2,193	2,193	2,193	24
25		Construction Period Interest		2009	108,345		40	1,354	1,354	1,354	25
26		North Dining Room & Corridor Remodel		2009	101,743		40	1,272	1,272	1,272	26
27		Architect Fees		2009	102,207		40	1,278	1,278	1,278	27
28		Draw #11 Construction & Architect Fees		2009	13,159		40	165	165	165	28
29		Draw #12		2009	154,568		40	1,932	1,932	1,932	29
30		Doors & Hardware		2009	13,257		40	166	166	166	30
31		Panic Hardware		2009	3,730		40	47	47	47	31
32		Old House		2009	173,313		40	2,166	2,166	2,166	32
33		Ice Cube Machine (Expensed for Medicaid purposes)				92			(92)		33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	5,283,893	\$	6,030	\$	92,505	\$	86,475	\$	220,757	70

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	\$ 807,394	\$ 2,075	\$ 80,740	\$ 78,665	10	\$ 285,982	71
72	Current Year Purchases	5,665	283	283		10	283	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 813,059	\$ 2,358	\$ 81,023	\$ 78,665		\$ 286,265	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	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,293,293	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 8,388	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 173,528	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 165,140	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 507,022	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

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

9. Option to Buy: YES NO Terms: N/A *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 25,712 Description: Non-Med Equip. \$2,810; Medical Equip \$2,022; Computer Equip. \$20,748; Copier Equip \$132

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ <u>N/A</u>	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3,2)	hrs	\$	1,800	\$ 129,602	\$ 1,550	1,800	\$ 131,152	1
2	Licensed Speech and Language Development Therapist	10A(3,2)	hrs		334	24,060	50	334	24,110	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3,2)	hrs		2,464	177,410	4,533	2,464	181,943	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				129,079		129,079	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					28,620		28,620	12
13	Other (specify): _____									13
14	TOTAL			\$	4,598	\$ 331,072	\$ 163,832	4,598	\$ 494,904	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pine Acres Rehab & Living Center

0047720

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009 (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	\$ 167,025	\$ 171,969	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 14,574)	1,242,509	1,242,509	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,172	66,394	6
7	Other Prepaid Expenses	24,723	24,723	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch 17A	250,614	250,614	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,738,043	\$ 1,756,209	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		196,341	13
14	Buildings, at Historical Cost		1,736,051	14
15	Leasehold Improvements, at Historical Cost	94,567	3,547,842	15
16	Equipment, at Historical Cost	28,255	813,059	16
17	Accumulated Depreciation (book methods)	(14,190)	(507,022)	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 See Sch 17A		(654,857)	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 108,632	\$ 5,131,414	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,846,675	\$ 6,887,623	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 456,734	\$ 460,464	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	157,431	157,431	30
31	Accrued Taxes Payable (excluding real estate taxes)	56,734	56,734	31
32	Accrued Real Estate Taxes(Sch.IX-B)		63,650	32
33	Accrued Interest Payable		31,812	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Sch 17A	631,566	431,237	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,302,465	\$ 1,201,328	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		6,512,900	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,512,900	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,302,465	\$ 7,714,228	46
47	TOTAL EQUITY(page 18, line 24)	\$ 544,210	\$ (826,605)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,846,675	\$ 6,887,623	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Pine Acres Rehab & Living Center, LLC

Provider #: 0047720

01/01/09 - 12/31/09

Schedule 17A

XV. Balance Sheet

	<u>Operating</u>	<u>After Consolidation</u>
Line 9 - Other Current Assets (specify)		
Due To/from Adminastar	114,397	114,397
Due To / from CNRC	136,217	136,217
Total Line 9 - Other Current Assets	<u>250,614</u>	<u>250,614</u>
Line 22 - Other Long Term Assets (specify)		
Escrow Construction in Progress	-	158,641
Escrow Non-Critical Rep	-	135,503
Escrow Replacement	-	200,000
Organizational Fees	-	167,336
Accum Amort-Org Fees	-	(6,623)
Total Line 22 - Other Long Term Assets	<u>-</u>	<u>654,857</u>
Line 36 - Other Current Liabilities (specify)		
Due To State	55,856	55,856
Resident Credit Balances	17,641	17,641
Due To/From Pine Acres Realty	311,649	0
Due To/From Lifelink	0	111,320
Advance Billing	246,420	246,420
Total Line 36 - Other Current Liabilities	<u>631,566</u>	<u>431,237</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 531,300	1
2	Restatements (describe):		2
3	Prior Period Adjustment	54,944	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 586,244	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	437,966	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	(480,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (42,034)	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)	\$ 544,210	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pine Acres Rehab & Living Center

0047720

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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	\$ 6,136,015	1
2	Discounts and Allowances for all Levels	(1,128,115)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,007,900	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,083,083	6
7	Oxygen	65,763	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,148,846	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	21,456	13
14	Non-Patient Meals	6,269	14
15	Telephone, Television and Radio	300	15
16	Rental of Facility Space		16
17	Sale of Drugs	126,509	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	184	20
21	Other Medical Services	40,363	21
22	Laundry	12,625	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 207,706	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Sch 19A	16,597	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 16,597	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,381,049	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,134,081	31
32	Health Care	2,763,681	32
33	General Administration	1,264,299	33
B. Capital Expense			
34	Ownership	444,556	34
C. Ancillary Expense			
35	Special Cost Centers	271,318	35
36	Provider Participation Fee	65,148	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,943,083	40
41	Income before Income Taxes (line 30 minus line 40)**	437,966	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 437,966	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
Tax return is prepared on the cash basis.

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

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

Pine Acres Rehab & Living Center, LLC

Provider #: 0047720

01/01/09 - 12/31/09

Schedule 19A

XVII. Income Statement

Line 28 - Other Revenue

Escort Services	30
Contribution Income	2,135
Interest Income	12,277
Vending Machine Income	1,167
Medical Records Income	323
Seniorcare Rebate	131
Phone Income	360
Miscellaneous Income	174
Total Line 28 - Other Revenue	<u>16,597</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pine Acres Rehab & Living Center

0047720

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	1,928	2,080	\$ 80,970	\$ 38.93	1
2	Assistant Director of Nursing	1,880	2,160	68,352	31.64	2
3	Registered Nurses	6,187	6,559	159,190	24.27	3
4	Licensed Practical Nurses	20,038	21,454	493,510	23.00	4
5	CNAs & Orderlies	77,829	82,190	1,043,104	12.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,723	6,208	60,175	9.69	8
9	Activity Director	1,968	2,080	35,378	17.01	9
10	Activity Assistants	4,497	4,951	46,863	9.47	10
11	Social Service Workers	3,946	4,340	111,197	25.62	11
12	Dietician					12
13	Food Service Supervisor	1,904	2,080	37,225	17.90	13
14	Head Cook	3,190	3,405	49,277	14.47	14
15	Cook Helpers/Assistants	20,357	21,089	224,075	10.63	15
16	Dishwashers					16
17	Maintenance Workers	6,416	6,958	110,982	15.95	17
18	Housekeepers	12,907	13,765	95,124	6.91	18
19	Laundry					19
20	Administrator	1,821	2,080	90,752	43.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,419	10,245	126,525	12.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,767	1,983	22,424	11.31	31
32	Other Health C: MDS Coordinator	2,111	2,209	51,373	23.26	32
33	Other(specify) See SCH 20A	3,887	4,135	90,044	21.78	33
34	TOTAL (lines 1 - 33)	187,775	199,971	\$ 2,996,540 *	\$ 14.98	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	\$ 6,848	1(3)	35
36	Medical Director	Monthly	9,600	9(3)	36
37	Medical Records Consultant	Annual	200	10(3)	37
38	Nurse Consultant	Monthly	600	10(3)	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	1	100	11(3)	44
45	Social Service Consultant	13	780	12(3)	45
46	Other(specify) MDS Consulting	Monthly	10,800	10(3)	46
47	Therapy Management	Monthly	12,800	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	14	\$ 41,728		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	131	\$ 6,040	10(3)	50
51	Licensed Practical Nurses	2,646	105,844	10(3)	51
52	Certified Nurse Assistants/Aides	164	3,773	10(3)	52
53	TOTAL (lines 50 - 52)	2,941	\$ 115,657		53

SEE ACCOUNTANTS' COMPILATION REPORT

Pine Acres Rehab & Living Center, LLC

Provider #: 0047720

01/01/09 - 12/31/09

Schedule 20A

XVIII. Staffing & Salary Cost	Hours Wrkd	Hours Pd	Total Wages	Avg Hrly Wage
Line 33 - Other				
Beautician	1,899	2,015	34,394	17.07
Marketing Wages	1,988	2,120	55,650	26.25
	<u>3,887</u>	<u>4,135</u>	<u>90,044</u>	<u>21.78</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
<u>Dalena Kemna-Kahn</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 90,752</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 123,989</u>	<u>IDPH License Fee</u>	<u>\$</u>		
				<u>Unemployment Compensation Insurance</u>	<u>28,232</u>	<u>Advertising: Employee Recruitment</u>	<u>973</u>		
				<u>FICA Taxes</u>	<u>220,649</u>	<u>Health Care Worker Background Check</u>			
				<u>Employee Health Insurance</u>	<u>240,378</u>	<u>(Indicate # of checks performed <u>171</u>)</u>	<u>2,048</u>		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>			
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Illinois Council on Long Term Care</u>	<u>9,782</u>		
				<u>Employee Physicals</u>	<u>929</u>	<u>Miscellaneous Licenses & Fees</u>	<u>1,420</u>		
				<u>Other Employee Benefits</u>	<u>8,262</u>	<u>Miscellaneous Dues & Subscriptions</u>	<u>764</u>		
				<u>Uniform Expense</u>	<u>1,004</u>				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 90,752	TOTAL (agree to Schedule V, line 22, col.8)			\$ 623,443		
(List each licensed administrator separately.)									
B. Administrative - Other							Less: Public Relations Expense ()		
Description			Amount				Non-allowable advertising ()		
<u>Mark Weldler, Admin - Guaranteed Payments</u>			<u>\$ 60,000</u>				Yellow page advertising ()		
<u>Steve Jeremias, CFO - Guaranteed Payments</u>			<u>60,000</u>						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 120,000				TOTAL (agree to Sch. V, line 20, col. 8)		
(Attach a copy of any management service agreement)							\$ 14,987		
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	
<u>Foote, Meyers, Mielke & Flowers</u>	<u>Legal</u>		<u>\$ 180</u>	<u>N/A</u>			<u>Out-of-State Travel</u>	<u>\$</u>	
<u>Law Office of Stephen N Sher</u>	<u>Legal</u>		<u>3,925</u>						
<u>Law Office of A Gutnicki</u>	<u>Legal</u>		<u>4,095</u>						
<u>CT Corporation</u>	<u>Legal</u>		<u>459</u>				<u>In-State Travel</u>		
<u>Reed Smith LLP</u>	<u>Legal</u>		<u>60</u>						
<u>Much Shelist Attorneys at Law</u>	<u>Legal</u>		<u>1,100</u>						
<u>RSM McGladrey</u>	<u>Accounting</u>		<u>43,924</u>						
<u>Paylocity</u>	<u>Payroll Fees</u>		<u>7,201</u>				<u>Seminar Expense</u>	<u>3,186</u>	
<u>Personnel Planners, Inc.</u>	<u>Unemployment Consulting</u>		<u>2,275</u>						
<u>MDI Achieve, Inc.</u>	<u>Computer Services</u>		<u>22,423</u>						
<u>Ehealth Data Solutions</u>	<u>Computer Services</u>		<u>7,317</u>						
<u>Other Vendors</u>	<u>See SCH 21A</u>		<u>24,104</u>				<u>Entertainment Expense</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 117,063	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 3,186
(If total legal fees exceed \$5,000, attach copy of invoices.)									

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Pine Acres Rehab & Living Center, LLC

Provider #: 0047720

01/01/09 - 12/31/09

Schedule 21A

XIX.C. Professional Services	Vendor/Payee	Type	Amount
	Systematic Management Systems	Billing Services	12,500
	Innovative LTC Solutions	Computer Services	2,631
	Medifax-EDI	Software Maintenance	1,407
	Singer Networks	Hardware Maintenance	7,566
			<u>24,104</u>
			To PG21
	Additional Professional Fees	From Page 21	92,959
	Less: Nonallowable Legal Fees (CT Corporation)		<u>(459)</u>
			116,604
	Schedule V, Line 19, Column 8		<u>116,604</u>
	Variance		<u><u>-</u></u>

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 Pine Acres Rehab & Living Center

0047720

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on Long Term Care \$9,782
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 39,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES No NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,148
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,269
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (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