



Facility Name & ID Number Claremont Rehab & Living Center

# 0047043 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	200	Skilled (SNF)	200	73,000	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	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	28,358	11,147	18,846	58,351	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,358	11,147	18,846	58,351	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.93%

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

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

I. On what date did you start providing long term care at this location?  
Date started 03/01/2005

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 03/01/2005 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 200 and days of care provided 14,824

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: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Claremont Rehab & Living Center # 0047043 Report Period Beginning: 01/01/10 Ending: 12/31/10

**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
	<b>A. General Services</b>										
1	Dietary	407,285	36,707	23,743	467,735		467,735		467,735		1
2	Food Purchase		374,339		374,339		374,339	(39,174)	335,165		2
3	Housekeeping	226,915	44,891		271,806		271,806		271,806		3
4	Laundry	49,473	14,934		64,407		64,407		64,407		4
5	Heat and Other Utilities			274,707	274,707		274,707	2,276	276,983		5
6	Maintenance	141,062	72,224	176,203	389,489		389,489	5,546	395,035		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	824,735	543,095	474,653	1,842,483		1,842,483	(31,352)	1,811,131		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			36,000	36,000		36,000		36,000		9
10	Nursing and Medical Records	3,706,576	283,610	684,148	4,674,334		4,674,334	25,560	4,699,894		10
10a	Therapy	1,268,038	8,639	77,790	1,354,467		1,354,467		1,354,467		10a
11	Activities	188,328	40,248		228,576		228,576		228,576		11
12	Social Services	69,187		103,396	172,583		172,583		172,583		12
13	CNA Training										13
14	Program Transportation							26,598	26,598		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	5,232,129	332,497	901,334	6,465,960		6,465,960	52,158	6,518,118		16
	<b>C. General Administration</b>										
17	Administrative	117,899		756,301	874,200		874,200	(730,804)	143,396		17
18	Directors Fees										18
19	Professional Services			163,720	163,720		163,720	608	164,328		19
20	Dues, Fees, Subscriptions & Promotions			44,279	44,279		44,279	(2,720)	41,559		20
21	Clerical & General Office Expenses	414,646	77,115	193,388	685,149		685,149	158,042	843,191		21
22	Employee Benefits & Payroll Taxes			1,031,408	1,031,408		1,031,408	39,174	1,070,582		22
23	Inservice Training & Education										23
24	Travel and Seminar			24,608	24,608		24,608	(839)	23,769		24
25	Other Admin. Staff Transportation			32,799	32,799		32,799	(25,364)	7,435		25
26	Insurance-Prop.Liab.Malpractice			291,292	291,292		291,292	1,450	292,742		26
27	Other (specify):* <b>Home Office Benefits</b>							38,314	38,314		27
28	<b>TOTAL General Administration</b>	532,545	77,115	2,537,795	3,147,455		3,147,455	(522,138)	2,625,317		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,589,409	952,707	3,913,782	11,455,898		11,455,898	(501,333)	10,954,565		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Claremont Rehab & Living Center #0047043 Report Period Beginning: 01/01/10 Ending: 12/31/10

## 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	
	<b>D. Ownership</b>											
30	Depreciation			131,214	131,214		131,214	(3,159)	128,055			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			67,302	67,302		67,302	(34,898)	32,404			32
33	Real Estate Taxes							263,819	263,819			33
34	Rent-Facility & Grounds			1,637,155	1,637,155		1,637,155	(257,298)	1,379,857			34
35	Rent-Equipment & Vehicles			44,316	44,316		44,316	3,865	48,181			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,879,987	1,879,987		1,879,987	(27,671)	1,852,316			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		880,691	167,811	1,048,502		1,048,502		1,048,502			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):* <b>Non-Allowable Cos</b>			280,293	280,293		280,293	(280,293)				43
44	<b>TOTAL Special Cost Centers</b>		880,691	557,604	1,438,295		1,438,295	(280,293)	1,158,002			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,589,409	1,833,398	6,351,373	14,774,180		14,774,180	(809,297)	13,964,883			45

\*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

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(14,008)	30		9
10	Interest and Other Investment Income	(38,275)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,445)	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	(10,310)	43		18
19	Entertainment	(4,879)	43		19
20	Contributions	(24,355)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(96,000)	43		24
25	Fund Raising, Advertising and Promotional	(66,063)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(246)	43		28
29	Other-Attach Schedule See Pg 5A	(98,587)	Vari.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (354,168)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(455,129)	Vari.	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (455,129)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (809,297)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Claremont Rehab & Living Center

ID# 0047043

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	To offset Misc. Income - Rental Income	\$ (150)	21	1
2	Cable	(5,209)	43	2
3	To offset misc. income	(3,845)	21	3
4	To disallow non-allowable legal fees	(7,004)	19	4
5	To disallow lobbying expense	(3,932)	20	5
6	Disallow xray expense	(37,548)	43	6
7	Disallow laboratory fees	(34,238)	43	7
8	To offset misc. income - Med. Rec.	(462)	10	8
9	Employee Meal Reclass	(39,174)	2	9
10	Employee Meal Reclass	39,174	22	10
11	To disallow out-of-state training	(1,660)	24	11
12	To disallow un-documented training	(339)	24	12
13	Real Estate Taxes Included in Rent	257,582	33	13
14	Real Estate Taxes Included in Rent	(257,582)	34	14
15	To Reverse A/P Legal Accrual	(4,200)	19	15
16	Reclass Patient Transport	26,598	14	16
17	Reclass Patient Transport	(26,598)	25	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(98,587)		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
See Schedule 6C		See Schedule 6A		See Schedule 6B		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 Professional Fees	\$	Claremont Extended Healthcare Realty, LLC	100.00%	\$ 2,950	\$ 2,950	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ 2,950	\$ * 2,950	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 Utilities	\$	NuCare Management Company	80.00%	\$ 2,276	\$ 2,276 15
16	V	6 Repairs and Maintenance		NuCare Management Company	80.00%	5,546	5,546 16
17	V	17 Management Fees	756,301	NuCare Management Company	80.00%	14,344	(741,957) 17
18	V	19 Professional Fees		NuCare Management Company	80.00%	8,833	8,833 18
19	V	20 Dues, Subscriptions		NuCare Management Company	80.00%	1,183	1,183 19
20	V	21 Office Expense		NuCare Management Company	80.00%	140,640	140,640 20
21	V	24 Education and Seminars		NuCare Management Company	80.00%	1,012	1,012 21
22	V	25 Other Admin Transportation		NuCare Management Company	80.00%	1,030	1,030 22
23	V	26 Insurance		NuCare Management Company	80.00%	1,450	1,450 23
24	V	27 Employee Benefits		NuCare Management Company	80.00%	31,286	31,286 24
25	V	30 Depreciation Expense		NuCare Management Company	80.00%	6,964	6,964 25
26	V	32 Interest & Amortization		NuCare Management Company	80.00%	3,199	3,199 26
27	V	33 Real Estate Taxes		NuCare Management Company	80.00%	6,237	6,237 27
28	V	34 Facility Rent		NuCare Management Company	80.00%	284	284 28
29	V	35 Equipment Rental		NuCare Management Company	80.00%	3,865	3,865 29
30	V	30 Depreciation Expense		NuCare Management Company	80.00%	3,734	3,734 30
31	V	17 Administrative		NuCare Management Company	80.00%	4,763	4,763 31
32	V	17 Administrative		NuCare Management Company	80.00%	6,390	6,390 32
33	V	27 Employee Benefits		NuCare Management Company	80.00%	193	193 33
34	V	27 Employee Benefits		NuCare Management Company	80.00%	258	258 34
35	V						35
36	V						36
37	V						37
38	V						38
39	Total		\$ 756,301			\$ 243,487	\$ * (512,814) 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 Nursing and Medical Records	\$	Cinical Consulting Services, LLC		\$ 26,022	\$ 26,022
16	V	19 Professional Fees		Cinical Consulting Services, LLC		29	29
17	V	20 Dues, Subscriptions		Cinical Consulting Services, LLC		29	29
18	V	21 Office Expense		Cinical Consulting Services, LLC		21,397	21,397
19	V	24 Education and Seminars		Cinical Consulting Services, LLC		148	148
20	V	25 Other Admin Transportation		Cinical Consulting Services, LLC		204	204
21	V	27 Employee Benefits		Cinical Consulting Services, LLC		6,577	6,577
22	V	30 Depreciation Expense		Cinical Consulting Services, LLC		127	127
23	V	32 Interest & Amortization		Cinical Consulting Services, LLC		178	178
24	V	30 Depreciation Expense		Cinical Consulting Services, LLC		24	24
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 54,735	\$ * 54,735

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

## Schedule 6C

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

Provider #: 0047043

1/1/2010 to 12/31/2010

### Schedule 6c

<u>Name</u>	<u>Ownership %</u>
Ross Bottner	4%
Nancy Bottner	1%
Jonah Bruck	4%
Jo Bruck	1%
Barry Carr	4%
Randi S. Carr	4%
Ryan A. Carr	1%
Jared S. Carr	1%
David Hartman	40%
Robert Hartman Dynasty Trust	9.50%
Robert Hartman Family Trust	9.50%
Robert and Debra Hartman Family Foundation	6.75%
Robert Hartman	4.25%
Gerry Jenich	4%
Dawn Jenich	1%
Leonard Weiss	4%
Jessica Weiss	1%
	<hr/>
	100%
	<hr/>

**See Accountants' Compilation Report**

Facility Name & ID Number Claremont Rehab & Living Center # 0047043 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	David Hartman	Member	Administrative	40.00	111,695	0.71	0.02	Mgmt Fee	\$ 88,305	17(7)	1
2	Robert Hartman	Member	Owner	4.25	75,237	1.19	0.03	Salary	4,763	17(7)	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 93,068		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Claremont Rehab & Living Center

# 0047043

Report Period Beginning:

01/01/10

Ending: 12/31/10

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 NuCare Management Company  
 Street Address 7257 N. Lincoln #100  
 City / State / Zip Code Lincolnwood, IL 60712  
 Phone Number (847) 933-2600  
 Fax Number (847) 933-2601

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Bed days available	1,226,110	13	\$ 38,227	\$ 73,000	\$ 2,276	1
2	6	Repairs and Maintenance	Bed days available	1,226,110	13	93,156	73,000	5,546	2
3	17	Management Fees	Bed days available	1,226,110	13	240,928	240,928	14,344	3
4	19	Professional Fees	Bed days available	1,226,110	13	148,362	73,000	8,833	4
5	20	Dues, Subscriptions	Bed days available	1,226,110	13	19,864	73,000	1,183	5
6	21	Office Expense	Bed days available	1,226,110	13	2,362,190	2,024,369	140,640	6
7	24	Education and Seminars	Bed days available	1,226,110	13	16,998	73,000	1,012	7
8	25	Other Admin Transportation	Bed days available	1,226,110	13	17,306	73,000	1,030	8
9	26	Insurance	Bed days available	1,226,110	13	24,362	73,000	1,450	9
10	27	Employee Benefits	Bed days available	1,226,110	13	525,475	73,000	31,286	10
11	30	Depreciation Expense	Bed days available	1,226,110	13	116,967	73,000	6,964	11
12	32	Interest & Amortization	Bed days available	1,226,110	13	53,729	73,000	3,199	12
13	33	Real Estate Taxes	Bed days available	1,226,110	13	104,761	73,000	6,237	13
14	34	Facility Rent	Bed days available	1,226,110	13	4,765	73,000	284	14
15	35	Equipment Rental	Bed days available	1,226,110	13	64,914	73,000	3,865	15
16	30	Depreciation Expense	Direct allocation		1	3,734		3,734	16
17	17	Administrative	Hours		13	80,000	80,000	4,763	17
18	17	Administrative	Hours		5	50,000	50,000	6,390	18
19	27	Employee Benefits	Hours		13	3,234		193	19
20	27	Employee Benefits	Hours		5	2,021		258	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,970,993	\$ 2,395,297	\$ 243,487	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Claremont Rehab & Living Center

# 0047043

Report Period Beginning:

01/01/10

Ending: 12/31/10

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 Cinical Consulting Services, LLC  
 Street Address 7257 N. Lincoln #100  
 City / State / Zip Code Lincolnwood, IL 60712  
 Phone Number (847) 933-2600  
 Fax Number (847) 933-2601

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	10	Nursing and Medical Records	Bed days available	1,226,110	13	\$ 437,066	\$ 437,066	73,000	\$ 26,022	1
2	19	Professional Fees	Bed days available	1,226,110	13	484		73,000	29	2
3	20	Dues, Subscriptions	Bed days available	1,226,110	13	488		73,000	29	3
4	21	Office Expense	Bed days available	1,226,110	13	359,377	319,300	73,000	21,397	4
5	24	Education and Seminars	Bed days available	1,226,110	13	2,480		73,000	148	5
6	25	Other Admin Transportation	Bed days available	1,226,110	13	3,430		73,000	204	6
7	27	Employee Benefits	Bed days available	1,226,110	13	110,468		73,000	6,577	7
8	30	Depreciation Expense	Bed days available	1,226,110	13	2,132		73,000	127	8
9	32	Interest & Amortization	Bed days available	1,226,110	13	2,985		73,000	178	9
10	30	Depreciation Expense	Direct allocation			24			24	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					\$ 918,934	\$ 756,366		\$ 54,735	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Claremont Rehab & Living Center # 0047043 Report Period Beginning: 01/01/10 Ending: 12/31/10

**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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1										1									
2										2									
3										3									
4										4									
5										5									
<b>Working Capital</b>																			
6	Bank of America	X	Line of Credit	Interest Only	2/1/10	2,000,000	1,839,272	3/1/11	0.0325	50,928	6								
7	Bank of America	X	Line of Credit	Interest Only	2/1/10	500,000	385,413	3/1/11	0.0325	16,374	7								
8											8								
9	<b>TOTAL Facility Related</b>					\$ 2,500,000	\$ 2,224,685			\$ 67,302	9								
<b>B. Non-Facility Related*</b>																			
10							Interest Income Offset			(38,275)	10								
11							Management Company allocation			3,377	11								
12											12								
13											13								
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$ (34,898)	14								
15	<b>TOTALS (line 9+line14)</b>					\$ 2,500,000	\$ 2,224,685			\$ 32,404	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																	
1. Real Estate Tax accrual used on 2009 report.			\$		1														
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2009		\$	<b>257,582</b>	2														
3. Under or (over) accrual (line 2 minus line 1).			\$	257,582	3														
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5														
		Allocation from Management Company		6,237															
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>263,819</b>	7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2005	<u>229,068</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2009 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2009 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR BHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2009 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2006	<u>232,336</u>	9																
	2007	<u>234,552</u>	10																
	2008	<u>246,103</u>	11																
	2009	<u>257,582</u>	12																
<b>Based on Prior Year amounts</b>																			

**NOTES:**

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

**SEE ACCOUNTANTS' COMPILATION REPORT**



Facility Name & ID Number Claremont Rehab & Living Center

# 0047043

Report Period Beginning:

01/01/10

Ending:

12/31/10

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 86,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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

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

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

N/A

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocation from management company - NuCare</u>			\$ <u>8,573</u>	1
2	<u>Allocation from management company - CCS</u>			<u>476</u>	2
3	<b>TOTALS</b>			\$ <b>9,049</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Claremont Rehab &amp; Living Center

# 0047043

Report Period Beginning:

01/01/10

Ending:

12/31/10

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Allocation	2005		\$ 99,133	\$	25	\$ 2,832	\$ 2,832	\$ 20,180	4
5										5
6										6
7	HO Allocation - NuCare	2004		77,161		35	2,205	2,205	15,708	7
8	HO Allocation - CCS	2004		4,287		35	122	122	873	8
	<b>Improvement Type**</b>									
9	Data cables & jacks		2005	8,647		20	432	432	2,376	9
10	Electrical work		2005	4,050		20	203	203	1,116	10
11	Landscape architecture		2005	4,500		20	225	225	1,238	11
12	Alarm for door		2005	1,550		20	79	79	432	12
13	Flooring		2005	55,880		20	2,794	2,794	15,367	13
14	Heater		2005	1,578		20	78	78	429	14
15	Sewerline		2005	4,000		20	200	200	1,100	15
16	Nursing Station countertop and cabinet		2005	13,000		20	650	650	3,575	16
17	Draperies		2005	5,013		20	251	251	1,380	17
18	Modulator and DTV box		2005	750		20	37	37	204	18
19	Wireless TV satellite dish		2005	1,137		20	57	57	313	19
20	Concrete by parlor exit		2005	1,575		20	79	79	434	20
21	Microboard		2005	5,110		20	256	256	1,408	21
22	Electrical work		2005	1,720		20	86	86	473	22
23	Chair Rail		2006	4,293		20	215	215	858	23
24	Dining Room Remodel		2006	3,875		20	194	194	775	24
25	Door Repairs		2006	4,440		20	222	222	888	25
26	Electrical Work		2006	19,035		20	952	952	3,807	26
27	Elevator		2006	1,800		20	90	90	360	27
28	Fireproof Basement		2006	2,620		20	131	131	525	28
29	Flooring		2006	41,808		20	2,090	2,090	8,361	29
30	Kitchen Remodel		2006	23,800		20	1,190	1,190	4,760	30
31	Landscaping		2006	16,528		20	826	826	3,305	31
32	Play Area		2006	6,718		20	336	336	1,344	32
33	Remodel Dialysis Unit		2006	3,800		20	190	190	760	33
34	Remodel Resident Rooms		2006	22,640		20	1,132	1,132	4,528	34
35	Roof		2006	1,750		20	88	88	351	35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

01/01/10

Ending:

12/31/10**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	<u>Motor</u>	2006	\$ 2,080	\$	20	\$ 104	\$ 104	\$ 416	37
38	<u>Thermostat</u>	2006	18,900		20	945	945	3,781	38
39	<u>Wall Mural &amp; Wallpaper</u>	2006	5,860		20	293	293	1,173	39
40	<u>Water Heater</u>	2006	30,639		20	1,532	1,532	6,128	40
41	<u>Window Treatments</u>	2006	10,774		20	539	539	2,154	41
42	<u>Compressor</u>	2006	15,410		20	771	771	3,082	42
43	<u>Therpy Rm - Plumbing, tile, &amp; Paint</u>	2007	17,096		20	855	855	2,992	43
44	<u>Showers Demolish, Rebuild, Tiles</u>	2007	22,654		20	1,133	1,133	3,965	44
45	<u>Employee Lounge - Drywall &amp; Paint</u>	2007	8,200		20	410	410	1,435	45
46	<u>Thermostats installed</u>	2007	3,000		20	150	150	525	46
47	<u>Therpy Rm - Cabinets installed</u>	2007	4,300		20	215	215	753	47
48	<u>Elevator Panels and repairs</u>	2007	9,800		20	490	490	1,715	48
49	<u>Thermostats installed</u>	2007	3,975		20	199	199	696	49
50	<u>Therpy Rm - Wall</u>	2007	2,700		20	135	135	473	50
51	<u>Window Installed</u>	2007	15,484		20	774	774	2,710	51
52	<u>Shower Tiles</u>	2007	7,330		20	366	366	1,283	52
53	<u>Door Installed</u>	2007	12,420		20	621	621	2,174	53
54	<u>Built-in Med Rec Shelves</u>	2007	2,702		20	135	135	473	54
55	<u>Door Installed</u>	2007	3,355		20	168	168	587	55
56	<u>Remove/Install Heating Elements</u>	2007	8,100		20	405	405	1,418	56
57	<u>Kitchen - Cooler Repaired &amp; Tile Installed</u>	2007	7,685		20	384	384	1,345	57
58	<u>Elevator Valve</u>	2007	2,800		20	140	140	490	58
59	<u>Built-in Med Rec Shelves</u>	2007	2,878		20	144	144	504	59
60	<u>Motorized Hot/Cold Water Unit</u>	2007	10,050		20	503	503	1,759	60
61	<u>Generator and Water Heater</u>	2007	3,314		20	166	166	580	61
62	<u>Dish Washer Water Heater Booster</u>	2007	3,635		20	182	182	636	62
63	<u>2nd Flr Nurses Stat - Carpeting, Lights</u>	2007	5,411		20	271	271	947	63
64	<u>Alarm System Testing</u>	2007	2,878		20	144	144	504	64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 685,628	\$		\$ 30,413	\$ 30,413	\$ 141,921	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Claremont Rehab &amp; Living Center

# 0047043

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 685,628	\$		\$ 30,413	\$ 30,413	\$ 141,921	1
2	3 Hot/Clod Water Units	2008	9,500		20	475	475	1,188	2
3	Heating Units Fixed	2008	3,550		20	178	178	444	3
4	Patio & Landscaping	2008	31,693		20	1,585	1,585	3,962	4
5	Tube	2008	4,654		20	233	233	582	5
6	Kitchen Heating Tab & Dinning Blinds	2008	5,300		20	265	265	663	6
7	Doors Replaced & Fixed	2008	21,041		20	1,052	1,052	2,630	7
8	Painting & Wallpaper on 3rd floor	2008	38,894		20	1,945	1,945	4,862	8
9	Bathrooms - Toilets, Showers, Tile, etc	2008	62,000		20	3,100	3,100	12,425	9
10	Elevator Control Panel	2008	9,463		20	473	473	1,183	10
11	Shower Remodel - Remove walls, install heating units, etc	2009	10,070		20	504	504	755	11
12	Dinning Room - Replace carpet, wall coverings, etc	2009	85,987		20	4,299	4,299	6,449	12
13	Window Coverings	2009	3,651		20	183	183	274	13
14	Electrical repairs and Digital Thermostats	2009	18,756		20	938	938	1,407	14
15	Resident Room Reno. - Door Closers, Wall Base, Crown Mod.	2009	47,644		20	2,382	2,382	3,573	15
16	Landscaping and Signage	2009	25,617		20	1,281	1,281	1,921	16
17	Laundry Duct Work	2009	23,482		20	1,174	1,174	1,761	17
18	Roof Repair	2009	2,500		20	125	125	188	18
19	Computer Cabling Installed	2009	3,075		20	154	154	231	19
20									20
21	Magnetic Door Holders	2010	2,701		20	68	68	68	21
22	Fire Dampers in Ductwork	2010	7,614		20	190	190	190	22
23	Patio Door and Retaining Wall	2010	4,595		20	115	115	115	23
24	Cabinets Built-In Patient Rooms	2010	19,280		20	482	482	482	24
25	Flex Air Base Station Repeater	2010	3,234		20	81	81	81	25
26	Furnish & install - Hot Water Supply to Laundry	2010	2,615		20	65	65	65	26
27	New Paging System & Camera System	2010	23,818		20	595	595	595	27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,156,361	\$		\$ 52,353	\$ 52,353	\$ 188,012	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 1,156,361	\$		\$ 52,353	\$ 52,353	\$ 188,012	1
2	2009 Allocation from management company:								2
3	Alarm System	2003	697		20	35	35	248	3
4	Buildout of Offices	2004	14,158		20	709	709	4,756	4
5	Security & Fire Alarm System	2004	1,618		20	81	81	527	5
6	Data Cables, Lights & Heat Exchanger	2005	839		20	42	42	246	6
7	Fire Alarm System	2005	7,425		20	479	479	2,545	7
8	Cooling Unit	2006	1,138		20	57	57	248	8
9	Asphalt & Carpet	2008	1,200		20	60	60	135	9
10	Landscaping, 2nd Floor Reconst. (including Phone, Sprinklers,	2009	60,798		20	3,040	3,040	3,802	10
11	Alarm Systems, Kitchen Remodel, Wallcovings, etc..)								11
12	HVAC, Paint/Wallpaper, Electrical, Sprinkler, & Generator Repa	2010	2,968		20	75	75	75	12
13									13
14									14
15									15
16									16
17									17
18									18
19	Current Year Booked Depreciation (B&F and MME)	2010		131,214			(131,214)		19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,247,202	\$ 131,214		\$ 56,931	\$ (74,283)	\$ 200,594	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	\$ 766,515	\$	\$ 60,914	\$ 60,914	10	\$ 214,283	71
72	Current Year Purchases	107,858		5,393	5,393	10	5,393	72
73	Fully Depreciated Assets							73
74	Allocation from management company	65,396		3,900	3,900	3-10	32,279	74
75	TOTALS	\$ 939,769	\$	\$ 70,207	\$ 70,207		\$ 251,955	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Bus	2006	\$ 4,365	\$	\$ 873	\$ 873	5	\$ 3,929	76
77	Allocation from management company			527		44	44		44	77
78										78
79										79
80	TOTALS			\$ 4,892	\$	\$ 917	\$ 917		\$ 3,973	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,200,912	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 131,214	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 128,055	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,159)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 456,522	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: Claremont Extended Healthcare, LLC

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

If NO, see instructions.  YES  NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	<u>1994</u>	<u>200</u>		\$ <u>#REF!</u>	<u>5</u>	<u>15</u>	3
4							4
5	<u>Allocation from Management Company</u>			<u>284</u>			5
6							6
7	<b>TOTAL</b>	<u>200</u>		\$ <u>#REF!</u>			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 N/A.

9. Option to Buy:  YES  NO Terms: \$550,000 option can be exercised 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: \$ 24,976 Description: Storage 2367; Parking 3000; Medical Equip 15744; Mngmnt Alloc 3865

(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>Patients</u>	<u>2008 Ford, E350</u>	\$ <u>750.00</u>	\$ <u>9,000</u>	17
18	<u>Administration</u>	<u>2010 Acrua, RDX</u>	<u>387.78</u>	<u>4,653</u>	18
19	<u>Administration</u>	<u>2009 Infiniti, M45</u>	<u>796.00</u>	<u>9,552</u>	19
20					20
21	<b>TOTAL</b>		\$ <u>1,933.78</u>	\$ <u>23,205</u>	21

10. Effective dates of current rental agreement:

Beginning 3/1/05

Ending 2/28/2011

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

Fiscal Year Ending Annual Rent

12. 12/31/2011 \$ 1,637,155

13. /2012 \$

14. /2013 \$

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	L10A, C3	hrs	\$	269	19,367	\$	269	\$ 19,367	1
2	Licensed Speech and Language Development Therapist	L10A C3	hrs		105	7,581		105	7,581	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A C3	hrs		376	27,062	8,639	376	35,701	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39 C2	# of prescrpts				816,384		816,384	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Schedule 16A</u>	Vari.			3,504	191,591	64,307	3,504	255,898	13
14	TOTAL			\$	4,254	\$ 245,601	\$ 889,330	4,254	\$ 1,134,931	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Claremont Extended Healthcare, LLC D/B/A Claremont Rehab and Living Center  
PROVIDER #0047043  
1/1/10 - 12/31/10

## Schedule 16A

### Schedule 16A

#### XIV. SPECIAL SERVICES (Direct Cost) Line 14

Service	Schedule V Line & Col. Ref	Outside Practitioner		
		Units	Costs	Supplies
Respiratory Therapy	L10A C3	595	23,780	
Special Beds	L39 C2			64,307
Ambulance	L39 C3		22,330	
Hemodialysis	L39 C3	2,910	145,481	
		<u>3,504</u>	<u>191,591</u>	<u>64,307</u>

Facility Name & ID Number Claremont Rehab & Living Center

# 0047043

Report Period Beginning: 01/01/10

Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$ 750	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>(615,523)</u> )	3,220,293	3,220,293	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	105,785	105,785	6
7	Other Prepaid Expenses	655,456	655,456	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See attached Sch 17A</u>	766,910	1,416,910	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,748,444	\$ 5,399,194	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		9,049	13
14	Buildings, at Historical Cost		180,581	14
15	Leasehold Improvements, at Historical Cost	967,582	1,066,621	15
16	Equipment, at Historical Cost	874,810	944,661	16
17	Accumulated Depreciation (book methods)	(392,465)	(456,522)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,449,927	\$ 1,744,390	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,198,371	\$ 7,143,584	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 244,849	\$ 244,849	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,224,685	2,224,685	29
30	Accrued Salaries Payable	796,683	796,683	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,693	28,693	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See attached Sch 17A</u>	1,444,489	2,151,440	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,739,399	\$ 5,446,350	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,739,399	\$ 5,446,350	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,458,972	\$ 1,697,234	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 6,198,371	\$ 7,143,584	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Claremont Extended Healthcare, LLC D/B/A Claremont Rehab and Living Center  
 PROVIDER #0047043  
 1/1/10 - 12/31/10

## Schedule 17A

### Schedule 17A

#### XV. BALANCE SHEET - Unrestricted Operating Fund.

##### A. Current Assets

<b>Other Current Assets (specify):</b>	<b>Operating</b>	<b>After Consolidation</b>
Due from Landlord	-	650,000
CH Deposits	334	334
Due from Related Party	766,576	766,576
<b>Total Line 9 - Other Current Assets (specify):</b>	<b>766,910</b>	<b>1,416,910</b>

##### C. Current Liabilities

<b>Other Current Liabilities (specify):</b>	<b>Operating</b>	<b>After Consolidation</b>
Due to Related Party	-	655,127
Cash in Bank - BOA	298,695	298,695
Wage Assignments & Old Payroll Checks	5,436	5,436
Accrued Expenses	220,930	220,930
Accrued Utilities	(13,220)	(13,220)
Due to Prior Owner	78,359	78,359
Due Nuicare Services Co	839,549	891,373
Due Nuvision	14,740	14,740
<b>Total Line 36 - Other Current Liabilities (specify):</b>	<b>1,444,489</b>	<b>2,151,440</b>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,353,694</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior period adjustments</b>		<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,353,694</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>455,279</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(350,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>105,279</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>	<b>Rounding</b>	<b>(1)</b>	<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(1)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,458,972</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Claremont Rehab & Living Center# 0047043Report Period Beginning: 01/01/10Ending: 12/31/10

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 11,755,597	1
2	Discounts and Allowances for all Levels	(2,774,020)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 8,981,577</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,564,253	6
7	Oxygen	22,878	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 3,587,131</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,952,551	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	218,207	19
20	Radiology and X-Ray	61,874	20
21	Other Medical Services	360,889	21
22	Laundry	1,329	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 2,594,850</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	100	24
25	Interest and Other Investment Income***	38,275	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 38,375</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Misc Income (See Sch 19A for breakdown)</b>	27,526	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 27,526</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 15,229,459</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,842,483	31
32	Health Care	6,465,960	32
33	General Administration	3,147,455	33
<b>B. Capital Expense</b>			
34	Ownership	1,879,987	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,328,795	35
36	Provider Participation Fee	109,500	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 14,774,180</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>455,279</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 455,279</b>	<b>43</b>

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

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

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

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

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

PROVIDER #0047043

1/1/10 - 12/31/10

## Schedule 19A

### Schedule 17A

#### XVII. INCOME STATEMENT (Miscellaneous Income)

##### E. Other Revenue:

<u>Other Current Assets (specify):</u>	<u>Other Current As</u>	<u>Other Current As</u>	<u>Amount</u>
MISCELLANEOUS INCOME - RECORD COPIES			462
MISCELLANEOUS INCOME - Grant			20,400
MISCELLANEOUS INCOME - Donations			10
MISCELLANEOUS INCOME - JURY DUTY			34
MISCELLANEOUS INCOME - OMNICARE			2,573
MISCELLANEOUS INCOME - CONF ROOM RENTAL			100
MISCELLANEOUS INCOME - EMP REFUND W/C			53
MISCELLANEOUS INCOME - REF EMP HEALTH			400
MISCELLANEOUS INCOME - REFUND CONSOLIDATED			53
MISCELLANEOUS INCOME - PATIENT NEEDS			23
MISCELLANEOUS INCOME - Misc Income			3,215
MISCELLANEOUS INCOME - JURY DUTY			52
MISCELLANEOUS INCOME - RENTAL INCOME			150
			<hr/>
<b>Total Line 28 - Misc Income</b>			<b><u><u>27,526</u></u></b>

See Accountants' Compilation Report

Facility Name & ID Number **Claremont Rehab & Living Center**

# **0047043**

Report Period Beginning:

**01/01/10**

Ending:

**12/31/10**

**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	1,933	2,086	\$ 92,699	\$ 44.45	1
2	Assistant Director of Nursing	5,434	6,218	209,087	33.63	2
3	Registered Nurses	34,425	37,350	1,067,732	28.59	3
4	Licensed Practical Nurses	25,184	27,359	624,119	22.81	4
5	CNAs & Orderlies	83,386	93,623	1,019,421	10.89	5
6	CNA Trainees	30,771	31,331	334,048	10.66	6
7	Licensed Therapist	0	0			7
8	Rehab/Therapy Aides	35,808	38,764	1,268,038	32.71	8
9	Activity Director	1,277	1,406	22,067	15.70	9
10	Activity Assistants	12,170	13,770	166,261	12.07	10
11	Social Service Workers	4,255	4,484	69,187	15.43	11
12	Dietician	3,659	4,251	116,773	27.47	12
13	Food Service Supervisor	0	0			13
14	Head Cook	4,025	4,573	66,455	14.53	14
15	Cook Helpers/Assistants	23,189	24,817	224,057	9.03	15
16	Dishwashers	0	0			16
17	Maintenance Workers	3,669	4,046	141,062	34.86	17
18	Housekeepers	23,099	25,570	226,915	8.87	18
19	Laundry	5,146	5,840	49,473	8.47	19
20	Administrator	3,285	3,685	117,899	32.00	20
21	Assistant Administrator	0	0			21
22	Other Administrative	0	0			22
23	Office Manager	0	0			23
24	Clerical	18,441	20,653	414,646	20.08	24
25	Vocational Instruction	0	0			25
26	Academic Instruction	0	0			26
27	Medical Director	0	0			27
28	Qualified MR Prof. (QMRP)	1,873	1,971	51,812	26.28	28
29	Resident Services Coordinator	6,494	6,989	227,147	32.50	29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	2,929	3,136	80,511	25.68	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	330,452	361,922	\$ 6,589,409 *	\$ 18.21	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	545	\$ 23,743	L1,C3	35
36	Medical Director	Monthly	36,000	L9,C3	36
37	Medical Records Consultant	121	6,051	L10, C3	37
38	Nurse Consultant	446	24,530	L10, C3	38
39	Pharmacist Consultant	Monthly	17,415	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	43	2,469	L12,C3	45
46	Other(specify) <u>Medical Consultant</u>	Monthly	75,250	L10,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,155	\$ 185,458		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,472	133,476	L10,C3	50
51	Licensed Practical Nurses	1,071	45,000	L10,C3	51
52	Certified Nurse Assistants/Aides	16,775	369,046	L10,C3	52
53	TOTAL (lines 50 - 52)	20,318	\$ 547,522		53

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	
Rupal Mistry	Administrator	0%	117,899	Workers' Compensation Insurance	\$ 159,676	IDPH License Fee	\$ 1,395	
				Unemployment Compensation Insurance	23,612	Advertising: Employee Recruitment	14,271	
				FICA Taxes	537,943	Health Care Worker Background Check		
				Employee Health Insurance	219,133	(Indicate # of checks performed <u>450</u> )	4,500	
				Employee Meals	39,174	Patient Background Checks	2,309	
				Illinois Municipal Retirement Fund (IMRF)*		Misc. Licenses & Inspections	7,319	
				Miscellaneous Employee Benefits	47,978	IHCA Dues	11,120	
				Life Insurance	19,744	Misc. Dues & Subscriptions	3,365	
				401 (K)	14,791	Less: Lobbying portion of IHCA dues	(3,932)	
				Employee Physicals	3,969	Allocation of management company	1,212	
				Employee Awards	155	Less: Public Relations Expense	( )	
				Uniform Exp	4,406	( )	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 117,899				\$ 1,070,582			\$ 41,559	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
Management Fees (Adjusted in Col. 7)	\$ 756,301						Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense	
\$ 756,301							22,609	
C. Professional Services							Allocation from management company	
Vendor/Payee	Type	Amount					1,160	
RSM/McGladrey & Pullen	Accounting	\$ 28,691						
Frost,Ruttenburg & Rothblatt	Accounting	5,500						
AMERICAN EXPRESS	Accounting	28,950						
Klein Dub & Holleb, Ltd	Legal	38,897						
Much Shelist	Legal	22,563						
Smith Amundsen Llc & Ashman	Legal	526						
Stone,Mcguire&Siegel	Legal	13,414						
Stone,Pogrund & Korey Llc	Legal	4,926						
Vedder Price Pc	Legal	1,842						
Chuhak & Tecson, Pc	Legal	12,542						
A/P Accrual -	Legal	4,200						
Personal Planners, Inc	Unemployment Consult.	1,669						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)							Entertainment Expense	
\$ 163,720							( )	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

Provider #: 0047043  
1/1/2010 to 12/31/2010

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	<u>163,720</u>
Allocation from Real Estate Entity	
Professional Fees - Other	<u>2,950</u>
Allocation from Management Company	
Legal Fees	4,722
Accounting Services	1,079
Other Professional Services	<u>3,032</u>
	<u>8,833</u>
Non-Allowable Legal Fees	
Klein Dub & Holleb, Ltd	(3,294)
Much Shelist	500
Stone,Mcguire&Siegel	(2,525)
Vedder Price Pc	(1,656)
AP Accrual	<u>(4,200)</u>
	<u>(11,175)</u>
Total (agree to Schedule V, line 19, column 8)	<u><u>164,328</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
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Claremont Rehab & Living Center# 0047043Report Period Beginning: 01/01/10Ending: 12/31/10**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA \$11,120 (Lobby offset of \$3,932)
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 334 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 109,500  
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. \$ 39,174 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (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**