

Facility Name & ID Number EAST MOLINE NURSING & REHAB

0051169 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 _____

	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	72	Skilled (SNF)	72	26,352	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,568	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	15,741		6,045	21,786	8
9	SNF/PED					9
10	ICF		1,732		1,732	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,741	1,732	6,045	23,518	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.55%

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

NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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 10/1/10

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

YES Date 10/1/10 NO

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

YES NO If YES, enter number of beds certified 72 and days of care provided 2,788

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

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

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	176,694	14,530	16,228	207,452		207,452		207,452		1
2	Food Purchase		145,503		145,503		145,503	(53)	145,450		2
3	Housekeeping	117,333	20,501		137,834		137,834		137,834		3
4	Laundry	38,335	16,150		54,485		54,485		54,485		4
5	Heat and Other Utilities			127,013	127,013		127,013		127,013		5
6	Maintenance	36,127	12,064	26,685	74,876		74,876		74,876		6
7	Other (specify):*										7
8	TOTAL General Services	368,489	208,748	169,926	747,163		747,163	(53)	747,110		8
	B. Health Care and Programs										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	1,190,829	121,037	10,088	1,321,954		1,321,954		1,321,954		10
10a	Therapy			347,785	347,785		347,785		347,785		10a
11	Activities	59,044	3,879	4,209	67,132		67,132		67,132		11
12	Social Services	31,222	82		31,304		31,304		31,304		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,281,095	124,998	392,082	1,798,175		1,798,175		1,798,175		16
	C. General Administration										
17	Administrative	127,761		158,119	285,880		285,880	13,217	299,097		17
18	Directors Fees										18
19	Professional Services			246,843	246,843		246,843	64,024	310,867		19
20	Dues, Fees, Subscriptions & Promotions			42,567	42,567		42,567	(20,249)	22,318		20
21	Clerical & General Office Expenses	131,598	28,968	40,964	201,530		201,530	(21,061)	180,469		21
22	Employee Benefits & Payroll Taxes			299,541	299,541		299,541		299,541		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,892	6,892		6,892		6,892		24
25	Other Admin. Staff Transportation			101,155	101,155		101,155	(4,807)	96,348		25
26	Insurance-Prop.Liab.Malpractice			122,329	122,329		122,329		122,329		26
27	Other (specify):*										27
28	TOTAL General Administration	259,359	28,968	1,018,410	1,306,737		1,306,737	31,124	1,337,861		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,908,943	362,714	1,580,418	3,852,075		3,852,075	31,071	3,883,146		29

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

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

EAST MOLINE NURSING & REHAB

#0051169

Report Period Beginning:

1/1/12

Ending:

12/31/12

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			11,697	11,697	11,697	225,725	237,422				30
31	Amortization of Pre-Op. & Org.						9,069	9,069				31
32	Interest			80,655	80,655	80,655	301,802	382,457				32
33	Real Estate Taxes			88,728	88,728	88,728		88,728				33
34	Rent-Facility & Grounds			76,024	76,024	76,024	(76,024)					34
35	Rent-Equipment & Vehicles			14,046	14,046	14,046		14,046				35
36	Other (specify):*											36
37	TOTAL Ownership			271,150	271,150	271,150	460,572	731,722				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers				124,822	124,822		124,822				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee				223,724	223,724		223,724				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers				348,546	348,546		348,546				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,908,943	362,714	1,851,568	4,471,771	4,471,771	491,643	4,963,414				45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(53)	2		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	(19,356)	21		18
19	Entertainment	(6,523)	25		19
20	Contributions	(250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,600)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(20,490)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,778)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(130)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (58,180)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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)	549,823	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 549,823		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 491,643		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

EAST MOLINE NURSING & REHAB

ID# 0051169

Report Period Beginning: 1/1/12

Ending: 12/31/12

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	MISC INCOME	\$ (130)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(130)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number EAST MOLINE NURSING & REHAB

0051169

Report Period Beginning:

1/1/12

Ending:

12/31/12

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(53)	0	0	0	0	0	0	0	0	0	0	(53)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(53)	0	0	0	0	0	0	0	0	0	0	(53)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	13,217	0	0	0	0	0	0	0	13,217	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,600)	0	0	73,624	0	0	0	0	0	0	0	64,024	19
20	Fees, Subscriptions & Promotions	(20,490)	0	0	241	0	0	0	0	0	0	0	(20,249)	20
21	Clerical & General Office Expenses	(21,514)	0	0	453	0	0	0	0	0	0	0	(21,061)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(6,523)	0	0	1,716	0	0	0	0	0	0	0	(4,807)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(58,127)	0	0	89,251	0	31,124	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(58,180)	0	0	89,251	0	31,071	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number EAST MOLINE NURSING & REHAB

0051169

Report Period Beginning:

1/1/12

Ending:

12/31/12

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	225,725	0	0	0	0	0	0	0	0	0	225,725	30
31	Amortization of Pre-Op. & Org.	0	9,069	0	0	0	0	0	0	0	0	0	9,069	31
32	Interest	0	301,802	0	0	0	0	0	0	0	0	0	301,802	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(76,024)	0	0	0	0	0	0	0	0	0	(76,024)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	460,572	0	0	0	0	0	0	0	0	0	460,572	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(58,180)	460,572	0	89,251	0	491,643	45						

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ABRAHAM GUTNICKI	27			CRG MANAGEMENT	BALTIMORE, MD	Management
NOAH WOLFF KAPPA TRUST	25			CRG EM REALTY, LLC		Building
DANIEL LEV	20.25					
JEFFREY KAGAN	20.25					
MEYER MAGENCE	7.5					

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	34 RENT	\$ 76,024	CRG EM REALTY, LLC	100.00%	\$	\$ (76,024)	1
2	V	30 DEPRECIATION				225,725	225,725	2
3	V	32 INTEREST				301,802	301,802	3
4	V	31 AMORTIZATION				9,069	9,069	4
5	V							5
6	V	32 INTEREST	18,200	GUTNICKI LLP		18,200		6
7	V							7
8	V	19 LEGAL FEES	5,124	LAW OFFICE OF ABRAHAM GUTNICKI		5,124		8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 99,348			\$ 559,920	\$ * 460,572	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	17 Home Office	\$ 158,119	CRG MANAGEMENT, LLC	100.00%	\$	\$ (158,119)
16	V	17 Owners Compensation				171,336	171,336
17	V	19 Professional Fees				73,624	73,624
18	V	20 Fees, Subscriptions				241	241
19	V	21 Office Expenses				453	453
20	V	25 Transportation				1,716	1,716
21	V	32 Interest					
22	V						
23	V						
24	V						
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		\$ 158,119			\$ 247,370	\$ * 89,251

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

Facility Name & ID Number

EAST MOLINE NURSING & REHAB

0051169

Report Period Beginning:

1/1/12

Ending:

12/31/12

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number EAST MOLINE NURSING & REHAB # 0051169 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	ABRAHAM GUTNICKI		OWNER	27.00	SEE ATTACHED	3	5.00	Mgt Fees	\$ 67,592	17-03	1
2	JEFFREY KAGAN		OWNER	20.25	SEE ATTACHED	25	50.00	Mgt Fees	51,872	17-03	2
3	DANIEL LEV		OWNER	20.25	SEE ATTACHED	25	50.00	Mgt Fees	51,872	17-03	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 171,336		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

Facility Name & ID Number EAST MOLINE NURSING & REHAB

0051169

Report Period Beginning:

1/1/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization CRG MANAGEMENT, LLC
 Street Address 106 OLD COURT ROAD, SUITE 104
 City / State / Zip Code BALTIMORE, MD 21208
 Phone Number (410) 877-6630
 Fax Number (410) 877-6101

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Owners Compensation	Patient Days	49,872	\$ 363,333	\$	23,518	\$ 171,336	1
2	19	Professional Fees	Patient Days	49,872	2 156,126		23,518	73,624	2
3	20	Fees, Subscriptions	Patient Days	49,872	2 512		23,518	241	3
4	21	Office Expenses	Patient Days	49,872	2 960		23,518	453	4
5	25	Transportation	Patient Days	49,872	2 3,638		23,518	1,716	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				\$ 524,569	\$		\$ 247,370	25

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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1		X	MORTGAGE			\$	\$			\$ 301,802								
2																		
3																		
4																		
5																		
Working Capital																		
6	GUTNICKI LLP	X	WORKING CAPITAL			252,000		4/1/12	10.0000	18,200								
7																		
8	TRADE PAYABLES									62,455								
9	TOTAL Facility Related					\$ 252,000	\$			\$ 382,457								
B. Non-Facility Related*																		
10																		
11																		
12																		
13	ALLOCATION FROM CRG MANAGEMENT																	
14	TOTAL Non-Facility Related					\$	\$			\$								
15	TOTALS (line 9+line14)					\$ 252,000	\$			\$ 382,457								

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2011 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.)		\$	88,728		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	88,728		3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	88,728		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2007	_____	8	FOR BHF USE ONLY		
	2008	_____	9			
	2009	_____	10			
	2010	89,096	11			
	2011	88,728	12			
				13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME EAST MOLINE NURSING & REHAB COUNTY ROCK ISLAND

FACILITY IDPH LICENSE NUMBER 0051169

CONTACT PERSON REGARDING THIS REPORT PAMELA PHILLIPS

TELEPHONE (417) 865-8701 FAX #: (417) 865-0682

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<u>07-514-20-00</u>	<u>Nursing Home</u>	\$ <u>88,728.00</u>	\$ <u>88,728.00</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u><u>88,728.00</u></u>	\$ <u><u>88,728.00</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number EAST MOLINE NURSING & REHAB

0051169 Report Period Beginning:

1/1/12 Ending:

12/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,040 B. General Construction Type: Exterior BRICK Frame WOOD 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).

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: 45,343 2. Number of Years Over Which it is Being Amortized: 5
 3. Current Period Amortization: 9,069 4. Dates Incurred: October 2010

Nature of Costs: _____
 (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				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		2010		\$ 2,008,522	\$ 73,037	27.5	\$ 73,037	\$	\$ 164,333
5									
6									
7									
8									
	Improvement Type**								
9	RESIDENT ROOMS/DINING ROOM-CONTRACT-EAST COAST PRE		2011	27,713		27.5	1,008	1,008	1,680
10	RESIDENT ROOMS/DINING ROOM/BATHS-CONTRACT-EAST COA		2011	63,824		27.5	2,321	2,321	3,675
11	NURSES STATION/DINING ROOM/COORDORS-CONTRACT-EAST		2011	93,739		27.5	3,409	3,409	4,829
12					2,048			(2,048)	
13									
14									
15									
16									
17									
18									
19									
20									
21									
22	SPRINKLER HEADS		2011	5,181	188		188		434
23	3 TON ROOFTOP UNIT		2011	7,750	282		282		559
24	FIRE SHUTTERS		2011	5,250	191		191		317
25	SPRINKLER HEADS		2011	4,770	173		173		216
26	BRUSH ABOVE PAINTING		2011	3,700	135		135		157
27	COILS REPLACED		2011	2,798	34		34		34
28									
29									
30									
31									
32									
33									
34									
35									
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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)		\$ 2,223,247	\$ 76,088		\$ 80,777	\$ 4,689	\$ 176,234	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 48,991	\$ 9,125	\$ 9,125	\$		\$ 14,471	71
72	Current Year Purchases	8,375	1,569	1,569			1,569	72
73	Fully Depreciated Assets							73
74	EM Realty	753,196	150,639	150,639			338,938	74
75	TOTALS	\$ 810,562	\$ 161,333	\$ 161,333	\$		\$ 354,978	75

D. Vehicle Costs. (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				\$	\$	\$	\$		\$	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)		\$ 3,033,809	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 237,421	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 242,110	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 4,689	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 531,212	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 14,046 Description: Med/thp equip 5,911; Copiers 2,310; Dishmach 2,124; Phone 2,711; Postage 179; Softwr 780; Striping 31

(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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name & ID Number EAST MOLINE NURSING & REHAB # 0051169 Report Period Beginning: 1/1/12 Ending: 12/31/12
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>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.

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	10-3	hrs	\$	1,801	\$ 130,271	\$	1,801	\$ 130,271	1
2	Licensed Speech and Language Development Therapist	10-3	hrs		547	39,553		547	39,553	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-3	hrs		2,461	177,961		2,461	177,961	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				121,233		121,233	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>PEN supplies</u>	39-02					3,589		3,589	12
13	Other (specify):									13
14	TOTAL			\$	4,809	\$ 347,785	\$ 124,822	4,809	\$ 472,607	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.

Facility Name & ID Number EAST MOLINE NURSING & REHAB

0051169

Report Period Beginning: 1/1/12

Ending:

12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 14,709	\$	1
2	Cash-Patient Deposits	(629)		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>86,046</u>)	869,942		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	95,647		6
7	Other Prepaid Expenses	5,186		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 984,855	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	29,449		15
16	Equipment, at Historical Cost	57,366		16
17	Accumulated Depreciation (book methods)	(17,757)		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): <u>Deposits</u>	367		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 69,425	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,054,280	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,238,568	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,754		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	113,075		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	89,689		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	112,399		36
37	<u>Due to Ohters</u>	201,336		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,772,821	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,772,821	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (718,541)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,054,280	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (356,720)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (356,720)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(761,819)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) CONTRIBUTIONS	400,000	15
16	Other (describe) ROUNDING	(2)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (361,821)	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)	\$ (718,541)	24 *

* This must agree with page 17, line 47.

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 14,126,313	1
2	Discounts and Allowances for all Levels	(11,065,193)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,061,120	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	559,665	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 559,665	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	89,037	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 89,037	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	MISC INCOME	130	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 130	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,709,952	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	747,163	31
32	Health Care	1,798,175	32
33	General Administration	1,306,737	33
B. Capital Expense			
34	Ownership	271,150	34
C. Ancillary Expense			
35	Special Cost Centers	124,822	35
36	Provider Participation Fee	223,724	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,471,771	40
41	Income before Income Taxes (line 30 minus line 40)**	(761,819)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (761,819)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation. **TAX RETURN NOT FILED BEFORE**

*** See the instructions. If this total amount has not been offset against int C/R PREPARED expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number **EAST MOLINE NURSING & REHAB**

0051169

Report Period Beginning:

1/1/12

Ending:

12/31/12

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	2,146	2,326	\$ 52,890	\$ 22.74	1
2	Assistant Director of Nursing	88	214	5,907	27.60	2
3	Registered Nurses	8,164	8,611	180,859	21.00	3
4	Licensed Practical Nurses	17,664	18,994	337,455	17.77	4
5	CNAs & Orderlies	55,974	59,790	613,718	10.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,040	2,246	33,129	14.75	9
10	Activity Assistants	2,686	2,925	25,915	8.86	10
11	Social Service Workers	2,080	2,311	31,222	13.51	11
12	Dietician					12
13	Food Service Supervisor	3,773	3,872	46,073	11.90	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,267	15,052	130,621	8.68	15
16	Dishwashers					16
17	Maintenance Workers	2,617	2,766	36,127	13.06	17
18	Housekeepers	12,798	13,896	117,333	8.44	18
19	Laundry	3,363	3,805	38,335	10.07	19
20	Administrator	1,888	2,043	127,761	62.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,960	9,774	131,598	13.46	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	138,508	148,625	\$ 1,908,943 *	\$ 12.84	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	383	\$ 15,328	1.3	35
36	Medical Director		30,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	9	520	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	62	4,117	11.3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	454	\$ 49,965		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number EAST MOLINE NURSING & REHAB

0051169

Report Period Beginning:

1/1/12

Ending:

12/31/12

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,912 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 223,724
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? N/A
- (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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? _____ 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? _____
d. Have vehicle usage logs been maintained? N/A
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (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.