



Facility Name & ID Number Pine Acres Rehab & Living Center

# 0047720 Report Period Beginning: 01/01/12 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 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	119	Skilled (SNF)	119	43,554	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	119	TOTALS	119	43,554	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	17,633	9,998	6,748	34,379	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,633	9,998	6,748	34,379	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.93%

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

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 2/1/06

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

YES  Date 2/1/06 NO

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

YES  NO  If YES, enter number of beds certified 119 and days of care provided 6,386

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
	<b>A. General Services</b>										
1	Dietary	328,396	15,681	12,508	356,585		356,585		356,585		1
2	Food Purchase		228,231		228,231		228,231	(2,362)	225,869		2
3	Housekeeping	106,944	13,639		120,583		120,583		120,583		3
4	Laundry	18,243	1,431	108,594	128,268		128,268		128,268		4
5	Heat and Other Utilities			76,212	76,212		76,212		76,212		5
6	Maintenance	111,159	86,911	41,529	239,599		239,599	2,376	241,975		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	564,742	345,893	238,843	1,149,478		1,149,478	14	1,149,492		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,600	15,600		15,600		15,600		9
10	Nursing and Medical Records	2,498,503	200,933	12,791	2,712,227		2,712,227		2,712,227		10
10a	Therapy										10a
11	Activities	84,460	6,815	3,869	95,144		95,144		95,144		11
12	Social Services	20,357	15	1,111	21,483		21,483		21,483		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,603,320	207,763	33,371	2,844,454		2,844,454		2,844,454		16
	<b>C. General Administration</b>										
17	Administrative	108,368		159,600	267,968		267,968		267,968		17
18	Directors Fees										18
19	Professional Services			136,505	136,505		136,505	(296)	136,209		19
20	Dues, Fees, Subscriptions & Promotions			21,080	21,080		21,080	(4,478)	16,602		20
21	Clerical & General Office Expenses	207,672	18,466	38,231	264,369		264,369	(6,202)	258,167		21
22	Employee Benefits & Payroll Taxes			642,894	642,894		642,894		642,894		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,814	1,814		1,814		1,814		24
25	Other Admin. Staff Transportation			7,201	7,201		7,201		7,201		25
26	Insurance-Prop.Liab.Malpractice			66,789	66,789		66,789	12,158	78,947		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	316,040	18,466	1,074,114	1,408,620		1,408,620	1,182	1,409,802		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,484,102	572,122	1,346,328	5,402,552		5,402,552	1,196	5,403,748		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 Pine Acres Rehab & Living Center

#0047720

Report Period Beginning:

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			53,758	53,758	53,758	121,154	174,912				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,988	36,988	36,988	394,518	431,506				32
33	Real Estate Taxes						86,248	86,248				33
34	Rent-Facility & Grounds			623,600	623,600	623,600	(623,600)					34
35	Rent-Equipment & Vehicles			30,204	30,204	30,204		30,204				35
36	Other (specify):* <b>Mortgage Insurance</b>						39,056	39,056				36
37	<b>TOTAL Ownership</b>			744,550	744,550	744,550	17,376	761,926				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		246,621	891,136	1,137,757	1,137,757		1,137,757				39
40	Barber and Beauty Shops	14,518	211		14,729	14,729		14,729				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			228,206	228,206	228,206		228,206				42
43	Other (specify):* <b>Non-Allowable Co</b>	65,428		116,605	182,033	182,033	(182,033)					43
44	<b>TOTAL Special Cost Centers</b>	79,946	246,832	1,235,947	1,562,725	1,562,725	(182,033)	1,380,692				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,564,048	818,954	3,326,825	7,709,827	7,709,827	(163,461)	7,546,366				45

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

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**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	(2,315)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,735)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(87,579)	30		9
10	Interest and Other Investment Income	(13,232)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,908)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(296)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(81,608)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(619)	43		28
29	Other-Attach Schedule See Pg 5A	(98,749)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (298,041)		\$	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)	134,580		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 134,580		36
	(sum of SUBTOTALS)			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (163,461)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Pine Acres Rehab & Living Center

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs - Part A	\$ (11,820)	43	1
2	X-Rays - Part A	(424)	43	2
3	Wages-Marketing	(65,428)	43	3
4	Marketing	(8,491)	43	4
5	Offset Vending Machine Income	(47)	2	5
6	Non-Care Real Estate Taxes	(4,027)	32	6
7	Equipment Repair and Maintenance	2,376	6	7
8	Offset Telephone Income	(2,617)	21	8
9	Non-Allowable Chamber of Commerce	(902)	20	9
10	Non-Allowable PAC Contributions	(3,826)	20	10
11	Offset Misc. Income	(3,543)	21	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	<b>Total</b>		(98,749)	49

**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
Steve Jeremias	33	Community Nursing & Rehabilitation Center, LLC	Naperville	Pine Acres Realty,		
Mark Weldler	33	The Springs at Crystal Lake, LLC	Crystal Lake	LLC	Dekalb	Real Estate
Chaim Rajchenbach	11					
The Family Rajchenbach Trust	11			Community Nursing		
Abraham J. Stern	4			and Rehab Realty,		
Susan L. Stern	4			LLC	Naperville	Real Estate
ABM Limited Partnership	4			TS Realty, LLC	Crystal Lake	Real Estate

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	30 Depreciation	\$	Pine Acres Realty, LLC		\$ 208,733	\$ 208,733	1
2	V	32 Interest	310	Pine Acres Realty, LLC		408,060	407,750	2
3	V	33 Real Estate Taxes		Pine Acres Realty, LLC		90,275	90,275	3
4	V	34 Rent Expense	623,600	Pine Acres Realty, LLC			(623,600)	4
5	V	20 Licenses		Pine Acres Realty, LLC		250	250	5
6	V	26 Insurance		Pine Acres Realty, LLC		51,214	51,214	6
7	V	21 Bank Fees	42	Pine Acres Realty, LLC			(42)	7
8	V	19 Professional Fees		Pine Acres Realty, LLC				8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 623,952			\$ 758,532	\$ * 134,580	14

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

Facility Name & ID Number Pine Acres Rehab & Living Center # 0047720 Report Period Beginning: 01/01/12 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	Steve Jeremias	COO	Administrative	33.00	180,000	25	50.00	Guar Pymnts	\$ 79,800	L17,C3	1
2	Mark Weldler	CFO	Finance	33.00	689,136	25	50.00	Guar Pymnts	79,800	L17,C3	2
3											3
4											4
5			*Mark Weldler received \$509,136 from The Springs at Crystal Lake								5
6			*Steve Jeremias and Mark Weldler each received \$180,000 from Community Nursing & Rehabilitation Center								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 159,600		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

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VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization N/A  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	Name of Lender	2		3	4	5	6		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	Cambridge Realty Capital LTD		X	Mortgage	\$17,450.05	07/1/08	\$ 6,695,044	\$ 6,405,924	5/1/2049	0.0635	\$ 408,060						
2																	
3																	
4																	
5																	
<b>Working Capital</b>																	
6	Lake Forest Bank & Trust Co.		X	Line of Credit	None	9/15/12	1,000,000	632,000	9/1/13	0.0500	36,988						
7																	
8																	
9	<b>TOTAL Facility Related</b>				\$17,450.05		\$ 7,695,044	\$ 7,037,924			\$ 445,048						
<b>B. Non-Facility Related*</b>																	
10								Offset interest income			(13,542)						
11																	
12																	
13																	
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (13,542)						
15	<b>TOTALS (line 9+line14)</b>						\$ 7,695,044	\$ 7,037,924			\$ 431,506						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 39,056 Line # 36

\* 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**

		<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 2011 report.			\$	<b>85,900</b>	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.)	2011		\$	<b>85,925</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	25	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>90,250</b>	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
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.				(4,027)	
<b>TOTAL REFUND</b>	\$	For	Tax Year.	<b>(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>86,248</b>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	<u>44,465</u>		8	
	2008	<u>58,394</u>		9	
	2009	<u>60,435</u>		10	
	2010	<u>82,545</u>		11	
	2011	<u>85,925</u>		12	
<b>Assumed approximately a 4% increase on real estate taxes paid during the year</b>					
<b>FOR BHF USE ONLY</b>					
	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 Pine Acres Rehab & Living Center COUNTY DeKalb  
 FACILITY IDPH LICENSE NUMBER 0047720  
 CONTACT PERSON REGARDING THIS REPORT Mark Weldler  
 TELEPHONE (815) 758-8151 FAX #: (815) 758-6832

**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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-27-279-003</u>	<u>Nursing Home</u>	\$ <u>81,897.88</u>	\$ <u>81,897.88</u>
2. <u>08-27-279-023</u>	<u>Rental House</u>	\$ <u>4,027.04</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>85,924.92</u></u>	\$ <u><u>81,897.88</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?      X   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 Pine Acres Rehab & Living Center

# 0047720 Report Period Beginning:

01/01/12 Ending:

12/31/12

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

Facility Name &amp; ID Number Pine Acres Rehab &amp; Living Center

# 0047720

Report Period Beginning:

01/01/12

Ending:

12/31/12

**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	119		2006	1968	\$ 1,736,051	\$	40	\$ 43,401	\$ 43,401	\$ 300,191	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		2 Ton Rooftop System	2007		4,562	456	10	456		2,508	9
10		Replace Heat Cable	2008		2,626	263	10	263		1,183	10
11		Replace Fan Motors	2008		3,441	344	10	344		1,548	11
12		Replace Unit Heater	2008		3,938	394	10	394		1,773	12
13		Replace Doors	2008		2,696	270	10	270		1,215	13
14		Move Electrical Box	2008		6,932	693	10	693		3,118	14
15		Sidewalk	2009		6,312	316	10	631	315	2,209	15
16		Retrofit Mechanical Room with Sprinklers	2009		2,800	140	10	280	140	980	16
17		Security Alarm for Front Doors	2009		4,644	232	10	464	232	1,624	17
18		Telephone System	2009		37,765	1,888	10	3,777	1,889	13,219	18
19		Telephone System Addition	2009		13,143	657	10	1,314	657	4,599	19
20		Fence	2009		5,708	285	10	571	286	1,998	20
21		Renovation & New Construction	2009		2,443,769		40	61,094	61,094	213,829	21
22		Architect Fees	2009		122,501		40	3,063	3,063	10,720	22
23		Demolition of Old House	2009		41,210		40	1,030	1,030	3,605	23
24		Carpet, Flooring & Wallcovering	2009		175,473		40	4,387	4,387	15,354	24
25		Construction Period Interest	2009		108,345		40	2,709	2,709	9,481	25
26		North Dining Room & Corridor Remodel	2009		101,743		40	2,544	2,544	8,904	26
27		Architect Fees	2009		102,207		40	2,555	2,555	8,943	27
28		Draw #11 Construction & Architect Fees	2009		13,159		40	329	329	1,152	28
29		Draw #12	2009		154,568		40	3,864	3,864	13,524	29
30		Doors & Hardware	2009		13,257		40	331	331	1,159	30
31		Panic Hardware	2009		3,730		40	93	93	326	31
32		Old House	2009		173,313		40	4,333	4,333	15,165	32
33		Ice Cube Machine (Expensed for Medicaid purposes)	2009			92			(92)		33
34		Telephone System Addition	2010		6,277		40	157	157	392	34
35		Satellite TV Installation	2010		8,250		10	825	825	2,063	35
36		A/C Unit Replacement (North Dining Room)	2010		10,000		10	1,000	1,000	2,500	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 Piping and Wiring (outside lights)	2010	\$ 2,896	\$	40	\$ 72	\$ 72	\$ 180	37
38								38
39 Water Heater	2011	7,442		15	496	496	744	39
40 Rooftop A/C replacement	2011	5,721		20	286	286	429	40
41 Replace 19 window cranks	2011	3,419		7	488	488	732	41
42								42
43 Set Up Wireless Access	2012	4,919		10	246	246	246	43
44 Kitchen HVAC Unit	2012	6,507		10	325	325	325	44
45								45
46								46
47								47
48								48
49 To adjust to financial statement depreciation								49
50			15,902			(15,902)		50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 5,339,324	\$ 21,932		\$ 143,086	\$ 121,154	\$ 645,939	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	\$ 918,015	\$ 31,359	\$ 31,359	\$	10	\$ 490,213	71
72	Current Year Purchases	4,671	467	467		5	467	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 922,686	\$ 31,826	\$ 31,826	\$		\$ 490,680	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	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,458,351	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 53,758	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 174,912	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 121,154	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,136,619	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	North Wing Sprinkler System	\$ 29,520	92
93	North Wing CIP	146,358	93
94	RE CIP	45,314	94
95		\$ 221,192	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

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

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 \_\_\_\_\_.

N/A

N/A

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

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

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

16. Rental Amount for movable equipment: \$ 21,805 Description: Non-Med Equip. \$479; Medical Equip \$15993; Computer Equip. \$1519; Copier Equip. \$3814

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Administrative</u>	<u>2008 Nissan Maxima</u>	\$ <u>699.90</u>	\$ <u>8,399</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>699.90</u>	\$ <u>8,399</u>	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 Pine Acres Rehab & Living Center # 0047720 Report Period Beginning: 01/01/12 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><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	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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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.

**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	39(2),(3)	hrs	\$	4,003	\$ 288,223	\$ 2,211	4,003	\$ 290,434	1
2	Licensed Speech and Language Development Therapist	39(2),(3)	hrs		1,377	99,167	75	1,377	99,242	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2),(3)	hrs		6,996	503,746	335	6,996	504,081	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				215,598		215,598	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					28,402		28,402	12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	12,376	\$ 891,136	\$ 246,621	12,376	\$ 1,137,757	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 Pine Acres Rehab & Living Center

# 0047720

Report Period Beginning: 01/01/12

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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>40,317</u> )	<u>1,992,002</u>	<u>1,992,002</u>	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	<u>82,292</u>	<u>95,503</u>	6
7	Other Prepaid Expenses	<u>303,200</u>	<u>303,200</u>	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Sch 17A</u>	<u>124,678</u>	<u>195,239</u>	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 2,502,172</b>	<b>\$ 2,585,944</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		<u>196,341</u>	13
14	Buildings, at Historical Cost		<u>1,736,051</u>	14
15	Leasehold Improvements, at Historical Cost	<u>225,041</u>	<u>3,603,273</u>	15
16	Equipment, at Historical Cost	<u>225,866</u>	<u>922,686</u>	16
17	Accumulated Depreciation (book methods)	<u>(148,257)</u>	<u>(1,136,619)</u>	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): <u>See Sch 17A</u>	<u>175,878</u>	<u>798,351</u>	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 478,528</b>	<b>\$ 6,120,083</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 2,980,700</b>	<b>\$ 8,706,027</b>	<b>25</b>

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ <u>779,164</u>	\$ <u>783,425</u>	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	<u>244,527</u>	<u>244,527</u>	30
31	Accrued Taxes Payable (excluding real estate taxes)	<u>48,072</u>	<u>48,072</u>	31
32	Accrued Real Estate Taxes(Sch.IX-B)		<u>90,250</u>	32
33	Accrued Interest Payable	<u>3,367</u>	<u>37,265</u>	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Sch 17A</u>	<u>420,369</u>	<u>174,625</u>	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 1,495,499</b>	<b>\$ 1,378,164</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	<u>632,000</u>	<u>7,037,924</u>	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>	<b>\$ 632,000</b>	<b>\$ 7,037,924</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 2,127,499</b>	<b>\$ 8,416,088</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 853,201</b>	<b>\$ 289,939</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 2,980,700</b>	<b>\$ 8,706,027</b>	<b>48</b>

\*(See instructions.)

Pine Acres Rehab & Living Center, LLC  
 Provider #: 0047720  
 01/01/12 - 12/31/12

Schedule 17A

XV. Balance Sheet

	Operating	After Consolidation
<b>Line 9 - Other Current Assets (specify)</b>		
A/R - Employee Loans	881.00	881.00
RE Escrow -MIP		20,853.00
RE Escrow - RE Taxes		28,000.00
RE Escrow - Insurance		21,708.00
Due To/from Adminastar	142,437.00	142,437.00
Due To / from Primary Insurance	(18,640.00)	(18,640.00)
<b>        Total Line 9 - Other Current Assets</b>	<b><u>124,678</u></b>	<b><u>195,239</u></b>
<b>Line 22 - Other Long Term Assets (specify)</b>		
Construction in Progress	175,878	221,192
Escrow Replacement		407,422
Mortgage Costs		188,910
Accum Amort-Org Fees		(19,173)
<b>        Total Line 22 - Other Long Term Assets</b>	<b><u>175,878</u></b>	<b><u>798,351</u></b>
<b>Line 36 - Other Current Liabilities (specify)</b>		
Accrued Assessment Fee #2	85216.00	85,216
Due To State	118,210	118,210
Due To / from Primary Insurance	957	957
Resident Credit Balances	11,672	11,672
Due To/From Pine Acres Realty	245,744	0
Due To/From CNRC	(41,430)	(41,430)
<b>        Total Line 36 - Other Current Liabilities</b>	<b><u>420,369</u></b>	<b><u>174,625</u></b>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 767,229	1
2	Restatements (describe):		2
3	Prior Period Adjustment	153,739	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 920,968	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	352,233	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	(420,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (67,767)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 853,201	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,185,349	1
2	Discounts and Allowances for all Levels	(459,908)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,725,441</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,050,239	6
7	Oxygen	9,258	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,059,497</b>	8
<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	707	12
13	Barber and Beauty Care	14,959	13
14	Non-Patient Meals	2,315	14
15	Telephone, Television and Radio	2,617	15
16	Rental of Facility Space		16
17	Sale of Drugs	198,040	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	30,160	21
22	Laundry	8,806	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 257,604</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	13,232	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 13,232</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Schedule 19A</u>	6,286	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 6,286</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 8,062,060</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,149,478	31
32	Health Care	2,844,454	32
33	General Administration	1,408,620	33
<b>B. Capital Expense</b>			
34	Ownership	744,550	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,334,519	35
36	Provider Participation Fee	228,206	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>\$ 7,709,827</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>352,233</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 352,233</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 2,379,610	44
45	Private Pay - Net Inpatient Revenue	1,836,817	45
46	Medicare - Net Inpatient Revenue	1,379,602	46
47	Other-(specify) <u>Managed Care</u>	51,105	47
48	Other-(specify) <u>Hospice</u>	78,307	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 5,725,441</b>	49

\* 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.

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

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

^ - LLC Members are cash basis tax payers.

**Pine Acres Rehab & Living Center, LLC**  
**Provider #: 0047720**  
**01/01/12 - 12/31/12**

Schedule 19A

XVII. Income Statement

Line 28 - Other Revenue

Contribution Income	1,795
Prior Year Adjustment	901
Vending Machine Income	47
Miscellaneous Income	<u>3,543</u>
Total Line 28 - Other Revenue	<u><u>6,286</u></u>

Facility Name & ID Number Pine Acres Rehab & Living Center

# 0047720

Report Period Beginning: 01/01/12

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	1,848	2,080	\$ 83,057	\$ 39.93	1
2	Assistant Director of Nursing	1,876	2,080	74,475	35.81	2
3	Registered Nurses	20,285	21,587	586,796	27.18	3
4	Licensed Practical Nurses	15,177	16,224	407,530	25.12	4
5	CNAs & Orderlies	81,840	86,631	1,058,297	12.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,932	2,080	34,072	16.38	9
10	Activity Assistants	4,929	5,240	50,388	9.62	10
11	Social Service Workers	1,231	1,231	20,357	16.54	11
12	Dietician					12
13	Food Service Supervisor	1,664	1,919	53,642	27.95	13
14	Head Cook	6,014	6,846	88,356	12.91	14
15	Cook Helpers/Assistants	20,746	21,600	186,398	8.63	15
16	Dishwashers					16
17	Maintenance Workers	5,662	6,025	111,159	18.45	17
18	Housekeepers	11,174	11,854	106,944	9.02	18
19	Laundry	1,846	1,967	18,243	9.27	19
20	Administrator	1,804	2,080	108,368	52.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,922	14,813	207,672	14.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,637	1,985	24,773	12.48	31
32	Other Health C: See Sch 20A	11,449	12,977	263,575	20.31	32
33	Other(specify) See Sch 20A	2,678	2,951	79,946	27.09	33
34	TOTAL (lines 1 - 33)	207,714	222,170	\$ 3,564,048 *	\$ 16.04	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	90	\$ 12,508	1(3)	35
36	Medical Director	Monthly	15,600	9(3)	36
37	Medical Records Consultant	16	960	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	60	3,869	11(3)	44
45	Social Service Consultant	17	1,111	12(3)	45
46	Other(specify)				46
47	Therapy Management	Monthly	9,600	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	183	\$ 43,648		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	29	\$ 1,722	10(3)	50
51	Licensed Practical Nurses	13	509	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	42	\$ 2,231		53

Pine Acres Rehab & Living Center, LLC

Provider #: 0047720

01/01/12 - 12/31/12

Schedule 20A

XVIII. Staffing & Salary Cost	<u>Hours Wrkd</u>	<u>Hours Pd</u>	<u>Total Wages</u>	<u>Avg Hrly Wage</u>
Line 32 - Other Health Care				
MDS Coordinator	1,923	2,170	60,743	27.99
Dementia Director	1,472	1,904	36,690	19.27
Restoratvie Services	7,790	8,583	150,591	17.55
Case Manager	264	320	15,551	48.60
	<u>11,449</u>	<u>12,977</u>	<u>263,575</u>	
Line 33 - Other				
Beautician	828	830	14,518	17.49
Marketing Wages	1,850	2,121	65,428	30.85
	<u>2,678</u>	<u>2,951</u>	<u>79,946</u>	

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Dalena Kemna-Kahn</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 108,368</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 138,058</u>	<u>IDPH License Fee</u>	<u>\$</u>	
				<u>Unemployment Compensation Insurance</u>	<u>49,411</u>	<u>Advertising: Employee Recruitment</u>	<u>584</u>	
				<u>FICA Taxes</u>	<u>274,992</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>156,284</u>	<u>(Indicate # of checks performed <u>4</u>)</u>	<u>42</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks <u>139</u></u>	<u>1,458</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses &amp; Fees</u>	<u>4,945</u>	
				<u>Uniform Expense</u>	<u>477</u>	<u>Miscellaneous Dues &amp; Subscriptions</u>	<u>1,475</u>	
				<u>Employee Physicals</u>	<u>5,652</u>	<u>IL Council on LTC</u>	<u>8,098</u>	
				<u>Other Employee Benefits</u>	<u>18,020</u>	<u>Dekalb Chamber of Commerce</u>	<u>902</u>	
						<u>Less : Chamber of Commerce</u>	<u>(902)</u>	
						<u>Less: Public Relations Expense</u>	<u>( )</u>	
						<u>Non-allowable advertising</u>	<u>( )</u>	
						<u>Yellow page advertising</u>	<u>( )</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 108,368</b>			<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	<b>\$ 16,602</b>	
<b>(List each licensed administrator separately.)</b>								
<b>B. Administrative - Other</b>				<b>TOTAL (agree to Schedule V, line 22, col.8)</b>				
					<b>\$ 642,894</b>			
<b>Description</b>			<b>Amount</b>	<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>				
<u>Mark Weldler, Admin - Guar. Pmts.</u>			<u>\$ 79,800</u>	<b>Description</b>	<b>Line #</b>	<b>Amount</b>	<b>G. Schedule of Travel and Seminar**</b>	
<u>Steve Jeremias, CFO - Guar. Pmts.</u>			<u>79,800</u>	<u>N/A</u>			<b>Description</b>	<b>Amount</b>
							<u>Out-of-State Travel</u>	<u>\$</u>
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ 159,600</b>				<u>In-State Travel</u>	
<b>(Attach a copy of any management service agreement)</b>								
<b>C. Professional Services</b>				<b>TOTAL</b>			<b>Seminar Expense</b>	
<b>Vendor/Payee</b>	<b>Type</b>		<b>Amount</b>					<u>1,814</u>
<u>Marilyn P. Dunn</u>	<u>Legal</u>		<u>\$ 275</u>				<u>Entertainment Expense</u>	<u>( )</u>
<u>Much Shelist</u>	<u>Legal</u>		<u>(630)</u>				<u>(agree to Sch. V, line 24, col. 8)</u>	
<u>Ashman &amp; Stein</u>	<u>Legal</u>		<u>110</u>				<b>TOTAL</b>	<b>\$ 1,814</b>
<u>Mcgladrey LLP</u>	<u>Accounting</u>		<u>55,604</u>					
<u>Paylocity</u>	<u>Payroll Fees</u>		<u>8,781</u>					
<u>Personal Planners</u>	<u>Professional Services</u>		<u>2,035</u>					
<u>MDI Achieve, Inc.</u>	<u>Software Maintenance</u>		<u>21,744</u>					
<u>Innovative LTC Solutions</u>	<u>Computer Services</u>		<u>1,601</u>					
<u>Corporate Cost Solutions Inc.</u>	<u>Workers' Compensation</u>		<u>4,203</u>					
<u>Singer Network</u>	<u>Computer Services</u>		<u>17,577</u>					
<u>Other Vendors</u>	<u>See SCH 21A</u>		<u>25,205</u>					
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 136,505</b>					
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>								

\* Attach copy of IMRF notifications

\*\*See instructions.

**Pine Acres Rehab & Living Center, LLC**  
**Provider #: 0047720**  
**01/01/12 - 12/31/12**

Schedule 21A

XIX.C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Holland & Knight LLP	Legal	2,339.00
Foote Meyers Mielke & Flowers LLC	Legal	2,492.00
Medifax-EDI	Computer Services	1,090.00
Coms Interactive, LLC	Computer Services	16,308.00
Information Controls, Inc.	Computer Services	2,280.00
Vivian	Computer Services	696.00
		<u>25,205</u> To PG21
Total for Page 3, Line 19, Column 3		136,505
Disallowed Legal Fees		<u>(296)</u>
Total for Page 3, Line 19, Column 8		<u>136,209</u>

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									N/A			
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Pine Acres Rehab &amp; Living Center

# 0047720

Report Period Beginning:

01/01/12

Ending:

12/31/12

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Council on Long Term Care \$8,098
- (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 \$3,826
- (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? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 46,840 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. \$ 228,206  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,315
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.