



Facility Name & ID Number Claremont Hanover Park

# 0049957 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	150	Skilled (SNF)	150	54,750	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	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	4 Other	5 Total	
8	SNF	995	2,998	28,388	32,381	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	995	2,998	28,388	32,381	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.14%

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 1/11/11

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

YES  Date 1/11/11 NO

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

YES  NO  If YES, enter number of beds certified 150 and days of care provided 22,551

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year?

YES  NO

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Claremont Hanover Park # 0049957 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

**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	354,567	31,111	48,600	434,278		434,278		434,278		1
2	Food Purchase		268,296		268,296		268,296	(50)	268,246		2
3	Housekeeping	135,940	62,218		198,158		198,158		198,158		3
4	Laundry	60,232	38,640		98,872		98,872	(601)	98,271		4
5	Heat and Other Utilities			515,585	515,585		515,585	1,970	517,555		5
6	Maintenance	84,533	25,491	119,278	229,302		229,302	26,845	256,147		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	635,272	425,756	683,463	1,744,491		1,744,491	28,164	1,772,655		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			(1,000)	(1,000)		(1,000)		(1,000)		9
10	Nursing and Medical Records	3,247,664	281,924	117,832	3,647,420		3,647,420	67,921	3,715,341		10
10a	Therapy										10a
11	Activities	111,623	11,969	1,980	125,572		125,572		125,572		11
12	Social Services	106,828		(2,185)	104,643		104,643		104,643		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Home Office Benefit</b>							1,179	1,179		15
16	<b>TOTAL Health Care and Programs</b>	3,466,115	293,893	116,627	3,876,635		3,876,635	69,100	3,945,735		16
	<b>C. General Administration</b>										
17	Administrative	166,699		828,343	995,042		995,042	(787,109)	207,933		17
18	Directors Fees										18
19	Professional Services			211,945	211,945		211,945	(41,009)	170,936		19
20	Dues, Fees, Subscriptions & Promotions			36,417	36,417		36,417	(358)	36,059		20
21	Clerical & General Office Expenses	585,201	42,701	385,947	1,013,849		1,013,849	(103,669)	910,180		21
22	Employee Benefits & Payroll Taxes			770,659	770,659		770,659		770,659		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,024	9,024		9,024	870	9,894		24
25	Other Admin. Staff Transportation			(212)	(212)		(212)	3,936	3,724		25
26	Insurance-Prop.Liab.Malpractice			80,904	80,904		80,904	111,639	192,543		26
27	Other (specify):* <b>Home Office Benefit</b>							13,849	13,849		27
28	<b>TOTAL General Administration</b>	751,900	42,701	2,323,027	3,117,628		3,117,628	(801,851)	2,315,777		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,853,287	762,350	3,123,117	8,738,754		8,738,754	(704,587)	8,034,167		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 &amp; ID Number

Claremont Hanover Park

#0049957

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

## 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			88,179	88,179		88,179	607,930	696,109			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,772	49,772		49,772	1,194,544	1,244,316			32
33	Real Estate Taxes							256,769	256,769			33
34	Rent-Facility & Grounds			2,400,000	2,400,000		2,400,000	(2,399,700)	300			34
35	Rent-Equipment & Vehicles			95,769	95,769		95,769	1,844	97,613			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,633,720	2,633,720		2,633,720	(338,613)	2,295,107			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,046,891	2,675,635	3,722,526		3,722,526	(21,438)	3,701,088			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			141,423	141,423		141,423		141,423			42
43	Other (specify):* <b>Non-Allowable Cos</b>			373,691	373,691		373,691	(373,691)				43
44	<b>TOTAL Special Cost Centers</b>		1,046,891	3,190,749	4,237,640		4,237,640	(395,129)	3,842,511			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,853,287	1,809,241	8,947,586	15,610,114		15,610,114	(1,438,329)	14,171,785			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(50)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,463)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(601)	4		8
9	Non-Straightline Depreciation	29,778	30		9
10	Interest and Other Investment Income	(22,083)	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	(2,073)	43		18
19	Entertainment	(637)	43		19
20	Contributions	(5,499)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(360)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(90,000)	43		24
25	Fund Raising, Advertising and Promotional	(73,764)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(364,935)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (532,687)		\$	30

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(905,642)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (905,642)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,438,329)		37

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

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

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

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

Claremont Hanover Park

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Report Period Beginning: 01/01/2014

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Salary	\$ (164,814)	43	1
2	X-Rays - Part A	(79,685)	43	2
3	Labs - Part A	(96,083)	43	3
4	Misc. Income	(742)	21	4
5	Reclass LHI to repairs and maintenance	1,500	6	5
6	Valet Parking	(23,487)	43	6
7	Lobbying expense	(1,624)	20	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
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31				31
32				32
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(364,935)		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
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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	19 Professional Fees	\$	Church Street Station Properties, LLC	100.00%	\$ 20,259	\$ 20,259	1
2	V	20 Dues, Fees, Subs. & Promotions		Church Street Station Properties, LLC	100.00%	250	250	2
3	V	26 Insurance		Church Street Station Properties, LLC	100.00%	111,190	111,190	3
4	V	30 Depreciation		Church Street Station Properties, LLC	100.00%	570,180	570,180	4
5	V	32 Amortization		Church Street Station Properties, LLC	100.00%	10,801	10,801	5
6	V	32 Interest	200	Church Street Station Properties, LLC	100.00%	1,204,421	1,204,221	6
7	V	33 Real Estate Taxes		Church Street Station Properties, LLC	100.00%	405,747	405,747	7
8	V	34 Rent	2,400,000	Church Street Station Properties, LLC	100.00%		(2,400,000)	8
9	V	43 TIF Revenue	218,507	Church Street Station Properties, LLC	100.00%		(218,507)	9
10	V	21 Bank Charges		Church Street Station Properties, LLC	100.00%	104	104	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,618,707			\$ 2,322,952	\$ * (295,755)	14

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

Facility Name &amp; ID Number

Claremont Hanover Park

# 0049957

Report Period Beginning:

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12/31/2014

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 Utilities	\$	NuCare Services Corp.	70.00%	\$ 1,970	\$ 1,970
16	V	6 Repairs and Maintenance		NuCare Services Corp.	70.00%	9,308	9,308
17	V	6 Maintenance Emp. Ben.		NuCare Services Corp.	70.00%	283	283
18	V	10 Clinical Salaries		NuCare Services Corp.	70.00%	13,313	13,313
19	V	15 Clinical Employee Benefits		NuCare Services Corp.	70.00%	1,179	1,179
20	V	17 Management Fees	828,343	NuCare Services Corp.	70.00%	19,333	(809,010)
21	V	19 Professional Fees		NuCare Services Corp.	70.00%	5,977	5,977
22	V	20 Dues, Subscriptions		NuCare Services Corp.	70.00%	1,016	1,016
23	V	21 Office Expense		NuCare Services Corp.	70.00%	154,046	154,046
24	V	24 Education and Seminars		NuCare Services Corp.	70.00%	870	870
25	V	25 Other Admin Transportation		NuCare Services Corp.	70.00%	3,936	3,936
26	V	26 Insurance		NuCare Services Corp.	70.00%	449	449
27	V	27 Employee Benefits		NuCare Services Corp.	70.00%	13,849	13,849
28	V	30 Depreciation Expense		NuCare Services Corp.	70.00%	7,756	7,756
29	V	32 Interest & Amortization		NuCare Services Corp.	70.00%	1,605	1,605
30	V	33 Real Estate Taxes		NuCare Services Corp.	70.00%	2,644	2,644
31	V	34 Facility Rent		NuCare Services Corp.	70.00%	300	300
32	V	35 Auto Lease		NuCare Services Corp.	70.00%	1,844	1,844
33	V						
34	V	30 Depreciation Expense		NuCare Services Corp.	70.00%	216	216
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 828,343			\$ 239,894	\$ * (588,449)

\* 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	39 DME and Medical Supplies	\$ 160,469	Integra Healthcare Equipment		\$ 145,651	\$ (14,818)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
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		\$ 160,469			\$ 145,651	\$ * (14,818)

\* 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	39 Respirator	\$ 31,760	Integra Respiratory Service		\$ 25,140	\$ (6,620)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
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		\$ 31,760			\$ 25,140	\$ * (6,620)

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

Facility Name &amp; ID Number

Claremont Hanover Park

# 0049957

Report Period Beginning:

01/01/2014

Ending:

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## 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	Hartman Family Trust	40	Bronzeville Park	Chicago	Nucare Services	Lincolnwood	Bookeeping Mgmt	1
2	Rajchenbach Family Trust	25.5	California Gardens Corp.	Chicago	7257 N. Lincoln Ave, L	Lincolnwood	Building Rental	2
3	David Hartman	24.5	Claremont Rehab. & Living	Buffalo Grove	Diamond Insurance	Northbrook	Work Comp Ins.	3
4	Gerald Jenich	10	Claremont - Hanover Park	Hanover Park	Mapleleaf Insurance	Grand Cayman	Liability/Work Com	4
5			Claridge Imperial, LTD.	Chicago	Seasons Hospice	Park Ridge	Hospice *	5
6			Jackson Corp	Chicago	JLR Financial Svcs. C	Lincolnwood	Management Co.	6
7			Monroe Pavillion	Chicago	KFT Services, LLC	Lincolnwood	Management Co. **	7
8			Renaissance at 87th Street	Chicago	Drake Louis Enterpris	Lincolnwood	Management Co. **	8
9			Renaissance at Midway	Chicago	Integra Healthcare Eq	Elmhurst	DME & Med. Suppl	9
10			Renaissance at South Shore	Chicago	Lifeline Ambulance, L	Chicago	Ambulance	10
11			Renaissance Park South	Chicago	Integra Respiratory Se	Elmhurst	Respiratory Service	11
12			Aria Post Acute Care	Hillside				12
13			Seven Oaks	Glendale, WI				13
14			Renaissance East	Mesa, Arizona	* No expense paid by home to the related			14
15			Renaissance West	Mesa, Arizona	entity, therefore no page 6 or 8.			15
16			Renaissance Village IL	Mesa, Arizona	** No expense of this related business			16
17			Renaissance Village AL	Mesa, Arizona	allocated to homes			17
18								18
19								19
20								20
21								21
22								22
23			Symphony Aspen Ridge, LLC D/B/A Symphony Decatur		Symphony Healthcare	Lincolnwood	Sub Lessor	23
24			Symphony Countryside, LLC D/B/A Countrysid Aurora		Symphony M.L., LLC	Lincolnwood	Main Lessor	24
25			Symphony Crestwood, LLC D/B/A Symphony of Crestwood		Symphony HMG, LLC	Lincolnwood	Sub Lessor	25
26			Symphony Deerbrook, LLC D/B/A Symphony of Joliet		Symphony Financial S	Lincolnwood	Mgmt Co.	26
27			Symphony Maple Crest, LLC D/B/A Maple Cres Belvidere					27
28			Symphony Maple Ridge, LLC D/B/A Symphony Lincoln					28
29			Symphony McKinley, LLC D/B/A McKinley Coi Decatur					29
30			Symphony Northwoods, LLC D/B/A Northwood Belvidere					30

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VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A, no owners receive compensation from this facility.								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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 Claremont Hanover Park

# 0049957

Report Period Beginning:

01/01/2014

Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization NuCare Services Corp.  
 Street Address 7257 North Lincoln Avenue  
 City / State / Zip Code Lincolnwood, IL 60645  
 Phone Number (847) 933-2600  
 Fax Number (847) 933-2601

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities	Bed days available	1,239,904	14	\$ 44,608	\$ 54,750	\$ 1,970	1	
2	6	Repairs and Maintenance	Bed days available	1,239,904	14	210,802	72,310	54,750	9,308	2
3	6	Maintenance Benefits	Bed days available	1,239,904	14	6,405	54,750	283	3	
4	10	Clinical Salaries	Bed days available	1,239,904	14	301,506	301,506	54,750	13,313	4
5	15	Clinical Benefits	Bed days available	1,239,904	14	26,708	54,750	1,179	5	
6	17	Management Fees	Bed days available	1,239,904	14	437,828	437,828	54,750	19,333	6
7	19	Professional Fees	Bed days available	1,239,904	14	135,365	54,750	5,977	7	
8	20	Dues, Subscriptions	Bed days available	1,239,904	14	23,010	54,750	1,016	8	
9	21	Office Expense	Bed days available	1,239,904	14	3,488,631	2,938,655	54,750	154,046	9
10	24	Education and Seminars	Bed days available	1,239,904	14	19,695	54,750	870	10	
11	25	Other Admin Transportation	Bed days available	1,239,904	14	89,139	54,750	3,936	11	
12	26	Insurance	Bed days available	1,239,904	14	10,164	54,750	449	12	
13	27	Employee Benefits	Bed days available	1,239,904	14	313,624	54,750	13,849	13	
14	30	Depreciation Expense	Bed days available	1,239,904	14	175,648	54,750	7,756	14	
15	32	Interest & Amortization	Bed days available	1,239,904	14	36,349	54,750	1,605	15	
16	33	Real Estate Taxes	Bed days available	1,239,904	14	59,877	54,750	2,644	16	
17	34	Facility Rent	Bed days available	1,239,904	14	6,796	54,750	300	17	
18	35	Auto Lease	Bed days available	1,239,904	14	41,766	54,750	1,844	18	
19									19	
20	30	Depreciation Expense						216	20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 5,427,921	\$ 3,750,299	\$ 239,894	25	

Facility Name & ID Number Claremont Hanover Park

# 0049957 Report Period Beginning: 01/01/2014

Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Integra Healthcare Equipment, LLC  
 Street Address 747 Church Road  
 City / State / Zip Code Elmhurst, IL 60126  
 Phone Number ( 630) 834-3700  
 Fax Number ( 630) 834-1500

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	39	DME and Medical Supplies	Direct Allocation		\$	\$		\$ 145,651	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				\$	\$		\$ 145,651	25

Facility Name & ID Number Claremont Hanover Park

# 0049957

Report Period Beginning:

01/01/2014

Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Integra Respiratory Service

Street Address

747 Church Road

City / State / Zip Code

Elmhurst, IL 60126

Phone Number

( 630) 834-3700

Fax Number

( 630) 834-1500

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

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

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	39	Respiratory	Direct Allocation		\$	\$		\$ 25,140	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 25,140	25

Facility Name & ID Number Claremont Hanover Park

# 0049957

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

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

1	2	3	4	5	6	7	8	9	10											
										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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Greystone Servicing Corporatio		X	Mortgage	\$109,880.11		\$ 18,320,600	\$ 17,913,971		0.0670	\$ 1,204,421	1								
2	The Village of Hanover Park		X	Land	Variable	07/01/10	700,000	457,963		None		2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	The Private Bank and Trust Co		X	Line of Credit	Interest Only	11/1/12	1,000,000	985,000	10/31/13	Variable	33,125	6								
7	Finance Charges	X									16,647	7								
8												8								
9	<b>TOTAL Facility Related</b>				\$109,880.11		\$ 20,020,600	\$ 19,356,934			\$ 1,254,193	9								
<b>B. Non-Facility Related*</b>																				
10										Interest Income	(5,636)	10								
11										Management Company Allocation	1,605	11								
12										Amortization of loan costs	10,801	12								
13										Offset Finance Charges	(16,647)	13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (9,877)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 20,020,600	\$ 19,356,934			\$ 1,244,316	15								

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

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

\*\* 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 2013 report.			\$ <b>700,000</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.)	2013		\$ <b>539,389</b>	2																				
3. Under or (over) accrual (line 2 minus line 1).			\$ <b>(160,611)</b>	3																				
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ <b>116,768</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>			\$ <b>66,885</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.		Allocated from Management Co. TIF Revenue	2,644 <b>(218,507)</b>																					
<b>TOTAL REFUND \$ <u>449,590</u> For <u>2011</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$ <b>449,590</b>	6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ <b>256,769</b>	7																				
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2009		8	<table border="1" style="width: 100%;"> <tr> <td colspan="3" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2013	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
<b>FOR BHF USE ONLY</b>																								
13	FROM R. E. TAX STATEMENT FOR 2013	\$	13																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																					
15	LESS REFUND FROM LINE 6	\$	15																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
	2010	<b>90,714</b>	9																					
	2011	<b>722,904</b>	10																					
	2012	<b>421,096</b>	11																					
	2013	<b>539,389</b>	12																					
<b>Real estate taxes \$539,389 x 105%=\$566,358</b>																								

**NOTES:**

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

**2013 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Claremont Hanover Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049957

CONTACT PERSON REGARDING THIS REPORT Jay Flatt

TELEPHONE (847) 933-2600 x 23 FAX #: (847) 745-0915

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-36-407-021-0000</u>	<u>Land and Property</u>	\$ <u>531,399.33</u>	\$ <u>531,399.33</u>
2. <u>06-36-309-033-0000</u>	<u>Land and Property</u>	\$ <u>7,989.35</u>	\$ <u>7,989.35</u>
3. <u>10-27-319-028-0000</u>	<u>Land and Property Mgmt Co.</u>	\$ <u>89,368.57</u>	\$ <u>2,644.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>628,757.25</u></u>	\$ <u><u>542,032.68</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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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 Claremont Hanover Park

# 0049957

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 74,800 B. General Construction Type: Exterior Brick Frame Steel Number of Stories Two

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

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

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

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

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO

If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: 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>Land (Allocation)</u>		<u>2011</u>	<u>\$ 1,524,000</u>	<u>1</u>
2	<u>Alloc. from NuCare Services Corp.</u>			<u>4,734</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 1,528,734</b>	<b>3</b>

Facility Name &amp; ID Number Claremont Hanover Park

# 0049957

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

**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	Allocation		2011	\$ 17,410,854	\$	40	\$ 564,542	\$ 564,542	\$ 1,757,876	4
5										5
6										6
7	HO Allocation - NuCare	2004		42,601		35	1,218	1,218	13,540	7
8										8
	<b>Improvement Type**</b>									
9	Installation of PA System and Telephone Paging System		2011	14,840		20	742	742	2,597	9
10	Fabricate and Install Syringe Disposal Cabinets to Wall		2011	10,000		20	500	500	1,750	10
11	Install and Furnish Door Control along with Back Door		2011	6,227		20	311	311	1,090	11
12	Boiler #1 - Fireeye Flame Amplifier Module		2012	3,537		20	177	177	442	12
13	Paint 2nd Floor Hallway and 3rd floor dining room		2013	4,476		20	223	223	335	13
14	Starter for GENRAC-Install starter and rebuild starter		2013	5,112		20	256	256	384	14
15	Parts, materials to repair generator-Entire Facility		2014	26,993		20	675	675	675	15
16	Paint 2nd Floor hallway & dining room, 3rd floor dining room		2014	4,476		20	149	149	149	16
17	8 rooms on 2nd floor, 1st conf., 1st hallway, 1st dining.									17
18	Depreciation to tie to Financials				88,179			(88,179)		18
19										19
20										20
21	2013 Allocation from NuCare Services Corp.									21
22										22
23	Alarm System		2003	517		20	26	26	288	23
24	Buildout of Offices		2004	10,501		20	526	526	5,631	24
25	Security & Fire Alarm System		2004	847		20	42	42	445	25
26	Data Cables, Lights & Heat Exchanger		2005	623		20	31	31	307	26
27	Fire Alarm System		2005	3,884		20	246	246	2,324	27
28	Cooling Unit		2006	844		20	42	42	353	28
29	Asphalt & Carpet		2008	890		20	44	44	278	29
30	Landscaping, 2nd Floor Reconst. (including Phone, Sprinklers.		2009	14,325		20	716	716	4,018	30
31	Alarm Systems, Kitchen Remodel, Wallcoverings, etc.)									31
32	HVAC, Paint/Wallpaper, Electrical, Sprinkler, & Generator Repair		2010	2,201		20	110	110	496	32
33	Hot Water Heater		2011	119		20	6	6	23	33
34	Paint 2nd Floor Windows		2012	132		20	7	7	18	34
35	Elevator repair, sprinkler system repair, electrical HVAC		2014	1,656		20	50	50	50	35
36	repair, wiring for phone & workstations, carpet									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	<b>TOTAL (lines 4 thru 69)</b>	\$	\$ 17,565,655		\$ 570,639	\$ 482,460	\$ 1,793,069	70

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

Facility Name & ID Number Claremont Hanover Park

# 0049957

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	\$ 388,281	\$	\$ 115,342	\$ 115,342	5-10	\$ 370,430	71
72	Current Year Purchases	8,122		406	406		406	72
73	Fully Depreciated Assets							73
74	Sch 13A	1,410,563		9,644	9,644		545,251	74
75	TOTALS	\$ 1,806,966	\$	\$ 125,392	\$ 125,392		\$ 916,087	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	Allocated from NuCare Services Corp.			\$ 391	\$	\$ 78	\$ 78		\$ 346	76
77										77
78										78
79										79
80	TOTALS			\$ 391	\$	\$ 78	\$ 78		\$ 346	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)	\$ 20,901,746	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 88,179	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 696,109	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 607,930	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,709,502	85

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

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

G. Construction-in-Progress

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

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

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

**Facility Name:** Claremont Hanover Park  
**IDPH License ID Number:** 0049957  
**Fiscal Year End:** 12/31/2014

**Schedule 13A**

Category	Cost	Current Book	S.L.	Adjustments	Component Life	Acc. Dep.
Real Estate	1,341,366		4,814	4,814	5-10	505,106
NuCare	69,197		4,830	4,830		40,145
<b>Total</b>	<b>1,410,563</b>	-	<b>9,644</b>	9,644		<b>545,251</b>

Facility Name & ID Number Claremont Hanover Park

# 0049957

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

**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:				\$			3
4	Additions							4
5								5
6	Home Office				300			6
7	TOTAL				\$ 300			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.	_____ /2015	\$ _____
13.	_____ /2016	\$ _____
14.	_____ /2017	\$ _____

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: \$ 95,769 Description: \$13,627- Copy Machine; \$67,490 -Bed Rental; \$14,652- Med Equip.

(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	Home Office Allocation		\$	1,844	17
18					18
19					19
20					20
21	TOTAL		\$	1,844	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.

**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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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(3)	hrs	\$	12,807	\$ 922,077	\$	12,807	\$ 922,077	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,584	186,018		2,584	186,018	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		21,296	1,533,303		21,296	1,533,303	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 prescrpts				1,004,983		1,004,983	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	39(3)			408	22,740		408	22,740	12
13	Other (specify): <u>See Sch 16A</u>	39(2)(3)				4,877	27,090		31,967	13
14	<b>TOTAL</b>			\$	37,095	\$ 2,669,015	\$ 1,032,073	37,095	\$ 3,701,088	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: Claremont Hanover Park  
IDPH License ID Number: 0049957  
Fiscal Year End: 12/31/2014

**Schedule 16A**

**XIV. Special Services (Direct Cost)**

**Line 12 Other (specify)**

<u>Description</u>	<u>Line</u>	<u>Units</u>	<u>Costs</u>	<u>Supplies</u>
Oxygen	39(2)			27,090
Ambulance	39(3)		4,877	
<b>Total - Line 12</b>		<b>-</b>	<b>4,877</b>	<b>27,090</b>

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

As of **12/31/2014**

(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	\$ 119,012	\$ 593,285	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>249,257</u> )	2,520,562	3,048,508	3
4	Supply Inventory (priced at _____ )			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,453	79,623	6
7	Other Prepaid Expenses	1,933	173,933	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	115,082	436,677	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,760,042	\$ 4,332,026	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,528,734	13
14	Buildings, at Historical Cost		17,453,456	14
15	Leasehold Improvements, at Historical Cost	61,566	112,199	15
16	Equipment, at Historical Cost	744,166	1,807,357	16
17	Accumulated Depreciation (book methods)	(298,675)	(2,709,502)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe _____)			22
23	Other(specify): <u>See Schedule 17A</u>		388,818	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 507,057	\$ 18,581,062	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,267,099	\$ 22,913,088	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 714,493	\$ 689,382	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	390,661	390,661	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,536	30,536	31
32	Accrued Real Estate Taxes(Sch.IX-B)		116,768	32
33	Accrued Interest Payable	114,912	214,912	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	809,473	809,473	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,060,075	\$ 2,251,732	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	985,000	985,000	39
40	Mortgage Payable		17,913,971	40
41	Bonds Payable		457,963	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>	\$ 985,000	\$ 19,356,934	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,045,075	\$ 21,608,666	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 222,024	\$ 1,304,422	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,267,099	\$ 22,913,088	48

\*(See instructions.)

Facility Name: Claremont Hanover Park  
 IDPH License ID Number: 0049957  
 Fiscal Year End: 12/31/2014

**Schedule 17A**

**XV. Balance Sheet**

**Line 9 Current Assets Other (specify):**

<u>Description</u>	<b>After</b>	
	<b>Operating</b>	<b>Consolidation</b>
Replacement Reserve		321,595
Due to Maple Leaf	3,215	3,215
Due from Shareholders	11,913	11,913
Due to Renaissance at Midway Expe:	3,868	3,868
Due to Renaissance Park South Expe	3,868	3,868
Due to Partners	92,218	92,218
<b>Total - Line 9</b>	<b>115,082</b>	<b>436,677</b>

**XV. Balance Sheet**

**Line 23 Long-Term Assets Other (specify):**

<u>Description</u>	<b>After</b>	
	<b>Operating</b>	<b>Consolidation</b>
Cosing Costs		14,994
Deferred Loan Costs		417,028
Accumulated Amortization-Closing		(1,500)
Accumulated Amort-Loan Costs-HUD		(41,704)
<b>Total - Line 23</b>	<b>-</b>	<b>388,818</b>

**XV. Balance Sheet**

**Line 36 Other Current Liabilities (specify):**

<u>Description</u>	<b>After</b>	
	<b>Operating</b>	<b>Consolidation</b>
Accrued Accounts Payable	183,566	183,566
Professional Claims Liability	218,595	218,595
Accrued Insurance Premium	16,304	16,304
Accrued Utilities	42,679	42,679
Accrued Management Fees-NuCare	65,141	65,141
Due to NuCare Services Corp Expen	233,249	233,249
Due NuVision Holdings Expense	49,939	49,939
<b>Total - Line 36</b>	<b>809,473</b>	<b>809,473</b>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(432,655)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>	<b>6</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(432,649)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>654,673</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>654,673</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>222,024</b>	<b>24</b> *

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

Facility Name &amp; ID Number Claremont Hanover Park

# 0049957

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

**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**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,486,396	1
2	Discounts and Allowances for all Levels	(3,354,500)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,131,896	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,111,624	6
7	Oxygen	47,964	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 8,159,588	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	50	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	125	16
17	Sale of Drugs	2,407,544	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	178,552	19
20	Radiology and X-Ray	160,341	20
21	Other Medical Services	247,680	21
22	Laundry	601	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 2,994,893	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	5,436	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 5,436	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Prior Year Adjustment</b>	(27,026)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (27,026)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 16,264,787	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,744,491	31
32	Health Care	3,876,635	32
33	General Administration	3,117,628	33
<b>B. Capital Expense</b>			
34	Ownership	2,633,720	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	4,096,217	35
36	Provider Participation Fee	141,423	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 15,610,114	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	654,673	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 654,673	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 68,372	44
45	Private Pay - Net Inpatient Revenue	899,845	45
46	Medicare - Net Inpatient Revenue	3,928,136	46
47	Other-(specify) <u>Managed Care</u>	490,167	47
48	Other-(specify) <u>Hospice</u>	(254,624)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,131,896	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.

^ - This entity is a cash basis taxpayer"

Facility Name & ID Number Claremont Hanover Park

# 0049957

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

**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	2,256	2,400	\$ 100,057	\$ 41.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	43,311	45,093	1,343,003	29.78	3
4	Licensed Practical Nurses	20,921	22,256	540,099	24.27	4
5	CNAs & Orderlies	69,863	74,323	910,525	12.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,527	2,742	50,670	18.48	9
10	Activity Assistants	5,054	5,430	60,953	11.23	10
11	Social Service Workers	3,782	4,196	106,828	25.46	11
12	Dietician	2,087	2,321	59,135	25.48	12
13	Food Service Supervisor					13
14	Head Cook	7,595	8,090	135,440	16.74	14
15	Cook Helpers/Assistants	15,624	16,318	159,992	9.80	15
16	Dishwashers					16
17	Maintenance Workers	4,456	5,027	100,287	19.95	17
18	Housekeepers	12,295	13,158	135,940	10.33	18
19	Laundry	5,417	5,879	60,232	10.25	19
20	Administrator	1,991	2,336	132,066	56.54	20
21	Assistant Administrator	1,865	2,126	56,534	26.59	21
22	Other Administrative					22
23	Office Manager	3,331	3,544	71,049	20.05	23
24	Clerical	11,347	12,071	257,075	21.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,750	3,989	54,681	13.71	31
32	Other Health C: Care Plan Coord.	6,044	6,430	208,294	32.39	32
33	Other(specify) <u>Sch 20A</u>	7,521	7,783	310,427	39.89	33
34	TOTAL (lines 1 - 33)	231,037	245,512	\$ 4,853,287 *	\$ 19.77	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	602	\$ 28,300	1(3)	35
36	Medical Director	Monthly	(1,000)	9(3)	36
37	Medical Records Consultant	116	17,353	10(3)	37
38	Nurse Consultant	12	644	10(3)	38
39	Pharmacist Consultant	Monthly	7,257	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,980	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	766	\$ 54,534		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	441	\$ 22,876	10(3)	50
51	Licensed Practical Nurses	1,084	47,972	10(3)	51
52	Certified Nurse Assistants/Aides	770	14,190	10(3)	52
53	TOTAL (lines 50 - 52)	2,295	\$ 85,038		53

**Facility Name:** Claremont Hanover Park  
**IDPH License ID Number:** 0049957  
**Fiscal Year End:** 12/31/2014

**Schedule 20A**

**XVIII. Staffing and Salary Costs**

**Line 33 Other (specify):**

<b>Description</b>	<b># of Hrs. Actually Worked</b>	<b># of Hrs. Paid and Accrued</b>	<b>Total Salaries</b>	<b>Average Hourly Wage</b>
Payroll Coordinator	4,098	4,360	145,613	\$ 33.40
Marketing	3,423	3,423	164,814	\$ 48.15
<b>Total - Line 33 Other (specify):</b>	<b>7,521</b>	<b>7,783</b>	<b>310,427</b>	<b>\$ 39.89</b>

Facility Name & ID Number **Claremont Hanover Park**

# **0049957**

Report Period Beginning: **01/01/2014**

Ending: **12/31/2014**

**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		
Lisa Ulm	Administrator	0	\$ 110,165	Workers' Compensation Insurance	\$ 174,559	IDPH License Fee	\$ 1,990		
Lisa Williams	Asst. Administrator	0	56,534	Unemployment Compensation Insurance		Advertising: Employee Recruitment	10,000		
				FICA Taxes	433,365	Health Care Worker Background Check (Indicate # of checks performed <u>353</u> )	2,528		
				Employee Health Insurance	142,522	Patient Background Checks <u>353</u>	2,528		
				Employee Meals		Miscellaneous Licenses & Fees	10,883		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	340		
				Other Employee Benefits	14,281	Schedule 21F	6,524		
				Employee Retirement	5,489	Allocated from Real Estate Entity	250		
				Employee Uniforms	443	Allocated from NuCare Services Corp.	1,016		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						Less: Public Relations Expense	( )		
						Non-allowable advertising	( )		
						Yellow page advertising	( )		
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 36,059		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)					
Description			Amount						
General and Administrative - Management Service (Eliminated on Sch. V, Col. 7)			\$ 828,343						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 828,343	E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
C. Professional Services				Description	Line #	Amount	G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount					Description	Amount	
McGladrey LLP	Accounting	\$ 23,965		N/A			Out-of-State Travel	\$	
Ability Network, Inc.	Computer Consulting	2,746							
CDW Government	Computer Consulting	388					In-State Travel		
Creative Technology Solutions	Computer Consulting	5,697							
EBS Master, LLC dba Emdeon	Computer Consulting	1,153					Seminar Expense	9,024	
Efax Corporate	Computer Consulting	6,124					Allocated from NuCare Services Corp.	870	
E-Health Data Solutions	Computer Consulting	4,917							
Formation Healthcare Group	Computer Consulting	1,005					Entertainment Expense	( )	
HDSI Health Data System	Computer Consulting	4,408					(agree to Sch. V, line 24, col. 8)		
It's Never 2 Late	Computer Consulting	3,400					TOTAL	\$ 9,894	
Kipp Computer Solutions	Computer Consulting	300							
See Sch. 21C	See Sch. 21C	157,842							
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 211,945	TOTAL			\$		

\* Attach copy of IMRF notifications

\*\*See instructions.

**Facility Name:** Claremont Hanover Park  
**IDPH License ID Number:** 0049957  
**Fiscal Year End:** 12/31/14

**Schedule 21A**

**XIX. SUPPORT SCHEDULES**

**A. Administrative Salaries**

<u>Name</u>	<u>Function</u>	<u>Ownership</u>	<u>Amount</u>
Administrator Salaries from Schedule XIX Section A			166,699
Reclassified from line 21 Clerical			21,901
Allocated from NuCare Services			19,333
<b>Total (agree to Schedule V, line 17, column 7)</b>			<u><u>207,933</u></u>

Facility Name: Claremont Hanover Park  
 IDPH License ID Number: 0049957  
 Fiscal Year End: 12/31/2014

**Schedule 21A**

**XIX. SUPPORT SCHEDULES**

**C. Professional Services**

<u>Vendor</u>	<u>Type</u>	<u>Amount</u>
Market Metrix of Delaware, LLC	Computer Consulting	1,627
Matrixcare/MDI Achieve, Inc.	Computer Consulting	21,162
Medifax-EDI, LLC	Computer Consulting	242
Moeo Interactive Product, Inc.	Computer Consulting	863
Officite, LLC	Computer Consulting	1,620
Providence Management & Development	Computer Consulting	126
Providigm-Citibusiness Card	Computer Consulting	2,080
Telemedicine Solutions, LLC	Computer Consulting	1,997
Tik Tek IT Solutions	Computer Consulting	6,343
Transworld Systems Inc.	Computer Consulting	325
Current Years Unallocated A/P Accrual	Computer Consulting	(7,945)
Comcast Fiber and Cable	Internet Expense	17,435
Illinois Health Information Exchange	Internet Expense	276
Officite Website-Business Card	Internet Expense	3,089
Paetec	Internet Expense	11,760
Point B Communications, Inc.	Internet Expense	16
Achieve Accreditation	Financial	7,847
Documentations Solutions	Financial	743
Pinnacle Quality Insight	Financial	600
M. Munter-IBEX	Financial	4,494
Marsh USA, Inc.	Financial	542
Mercer Health & Benefits LLC	Financial	217
Nitestar Health & Benefits LLC	Financial	51
Risk Management Services LLC	Financial	417
Symphony Financial Services	Financial	1,500
A/P Accrual	Financial	(5,000)
Personal Planners	Unemployment Consulting	1,517
Much Shelist	Legal	494
Stone, McGuire & Siegel	Legal	14,521
Stone, Pogrund & Korey LLC	Legal	276
U.S. Legal Support, Inc.	Legal	1,186
Ashman & Stein	Legal	2,460
IDEPO	Legal	52
Ricoh USA, Inc.	Legal	6
Allen A. Lefkowitz & Associates, PC	Legal	66,884
Accrual	Legal	(1,980)
<b>Total</b>		<b>157,842</b>

**Total Schedule V line 19 Col. 3** 211,945

Allocated from Real Estate Legal Fees	250
Allocated from Real Estate Accounting	20,009
Allocated from Management Company Legal Fees	4,350
Allocated from Management Company Professional Services	1,627
Less: Non-Allowable Legal Fees	(360)
Less: Reclass Real Estate Legal	(66,885)
<b>Total (agree to Schedule V, line 19, column 8)</b>	<b>170,936</b>

**Facility Name:** Claremont Hanover Park  
**IDPH License ID Number:** 0049957  
**Fiscal Year End:** 12/31/2014

**Schedule 21F**

**XIX. SUPPORT SCHEDULES**

**F. Dues, Fees, subscriptions and promotions**

<u>Name</u>	<u>Amount</u>
News paper subscription	3,228
Illinois Council and Long Term Care	4,920
Less Lobbying Expense	(1,624)
	<u>6,524</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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010
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 & ID Number Claremont Hanover Park# 0049957Report Period Beginning: 01/01/2014Ending: 12/31/2014**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Council Long Term Care-\$3,296
- (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? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 141,423  
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. \$ 50
- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees