FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0050732

Facility Name: Avenue Care Nursing & Rehab Center

Address: 4505 South Drexel Blvd (Number) Chicago (City) 60653 (Zip Code)

County: Cook

Telephone Number: (773) 285-0550 **Fax #** (773) 285-5618

HFS ID Number:

Date of Initial License for Current Owners: 11/01/2009

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) Andrew B. Cutler
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,575	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	155	TOTALS	155	56,575	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	43,445	688	2,587	46,720	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,445	688	2,587	46,720	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.58%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 02/01/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/08 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 42 and days of care provided 2,587

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	198,671	36,842	10,924	246,437		246,437	1,615	248,052			1
2	Food Purchase		221,006		221,006		221,006	305	221,311			2
3	Housekeeping	140,992	28,047		169,039		169,039	39	169,078			3
4	Laundry	64,425	11,621		76,046		76,046	(368)	75,678			4
5	Heat and Other Utilities			136,203	136,203		136,203	1,087	137,290			5
6	Maintenance	102,163		106,498	208,661		208,661	9,014	217,675			6
7	Other (specify):*							1,559	1,559			7
8	**TOTAL General Services**	506,251	297,516	253,625	1,057,392		1,057,392	13,252	1,070,644			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,863,290	47,611	18,807	1,929,708		1,929,708	20,856	1,950,564			10
10a	Therapy	70,107			70,107		70,107	3,341	73,448			10a
11	Activities	83,476	8,574	1,664	93,714		93,714		93,714			11
12	Social Services	166,570	4,906	6,605	178,081		178,081	8,705	186,786			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,197	6,197			15
16	**TOTAL Health Care and Programs**	2,183,443	61,091	36,076	2,280,610		2,280,610	39,099	2,319,709			16
	C. General Administration											
17	Administrative	186,116			186,116		186,116	36,559	222,675			17
18	Directors Fees											18
19	Professional Services			446,216	446,216	(7,581)	438,635	(334,376)	104,259			19
20	Dues, Fees, Subscriptions & Promotions			14,856	14,856		14,856	(3,485)	11,371			20
21	Clerical & General Office Expenses	60,810	16,750	296,503	374,063		374,063	(90,152)	283,911			21
22	Employee Benefits & Payroll Taxes			533,658	533,658		533,658	(16,592)	517,066			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,554	2,554		2,554	1,268	3,822			24
25	Other Admin. Staff Transportation			214	214		214	617	831			25
26	Insurance-Prop.Liab.Malpractice			111,482	111,482		111,482	808	112,290			26
27	Other (specify):*							28,564	28,564			27
28	**TOTAL General Administration**	246,926	16,750	1,405,483	1,669,159	(7,581)	1,661,578	(376,789)	1,284,789			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,936,620	375,357	1,695,184	5,007,161	(7,581)	4,999,580	(324,439)	4,675,141			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center #0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			888	888		888	178,752	179,640			30
31	Amortization of Pre-Op. & Org.			494	494		494	(494)				31
32	Interest			30,290	30,290		30,290	353,992	384,282			32
33	Real Estate Taxes			173,746	173,746	7,581	181,327	1,574	182,901			33
34	Rent-Facility & Grounds			637,774	637,774		637,774	(636,799)	975			34
35	Rent-Equipment & Vehicles			29,962	29,962		29,962	1,748	31,710			35
36	Other (specify):*											36
37	**TOTAL Ownership**			873,154	873,154	7,581	880,735	(101,227)	779,508			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		182,122	101,623	283,745		283,745	(8,128)	275,617			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,863	84,863		84,863		84,863			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		182,122	186,486	368,608		368,608	(8,128)	360,480			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,936,620	557,479	2,754,824	6,248,923		6,248,923	(433,794)	5,815,129			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	61,014	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(33)	02		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	(68,963)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(132,000)	21		24
25	Fund Raising, Advertising and Promotional	(5,574)	20		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	(52,136)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (197,692)		$	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 Amount	2 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)	(236,103)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (236,103)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (433,794)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Avenue Care Nursing & Rehab Center

ID# 0050732

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (1,239)	21	1
2	Patient Clothing	(152)	10	2
3	Collection Expense	(731)	21	3
4	Annual Report	(250)	20	4
5	Annual Report - Bldg. Co.	(250)	20	5
6	Annual Corp. Report	(100)	20	6
7	Non-Allowable Legal	(39,521)	19	7
8	Amortization	(494)	31	8
9	Rental Income - Parking	(9,398)	34	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(52,136)		49

Avenue Care Nursing & Rehab Center

ID# 0050732

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			121		3,591		(2,097)					1,615	1
2	Food Purchase	(33)		338									305	2
3	Housekeeping			434		48					(443)		39	3
4	Laundry										(368)		(368)	4
5	Heat and Other Utilities			986		101							1,087	5
6	Maintenance			2,834	6,080	100							9,014	6
7	Other (specify):*				1,056	503							1,559	7
8	**TOTAL General Services**	(33)		4,713	7,136	4,343		(2,097)			(811)		13,252	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(152)				23,105					(2,097)		20,856	10
10a	Therapy					3,341							3,341	10a
11	Activities													11
12	Social Services				6,315	2,390							8,705	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				914	4,041	1,242						6,197	15
16	**TOTAL Health Care and Programs**	(152)			7,229	32,877	1,242				(2,097)		39,099	16
	C. General Administration													
17	Administrative			2,008	1,484	33,067							36,559	17
18	Directors Fees													18
19	Professional Services	(39,521)		(215,566)		(79,289)							(334,376)	19
20	Fees, Subscriptions & Promotions	(6,174)		2,546		143							(3,485)	20
21	Clerical & General Office Expenses	(202,933)	280	11,897	94,531	6,073							(90,152)	21
22	Employee Benefits & Payroll Taxes				(15,278)		(1,242)				(72)		(16,592)	22
23	Inservice Training & Education													23
24	Travel and Seminar			124		1,144							1,268	24
25	Other Admin. Staff Transportation			617									617	25
26	Insurance-Prop.Liab.Malpractice			678		130							808	26
27	Other (specify):*				23,266	5,298							28,564	27
28	**TOTAL General Administration**	(248,628)	280	(197,696)	104,003	(33,434)	(1,242)				(72)		(376,789)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(248,813)	280	(192,983)	118,368	3,786		(2,097)			(2,980)		(324,439)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	61,014	113,385	3,661		692							178,752	30
31	Amortization of Pre-Op. & Org.	(494)											(494)	31
32	Interest		333,808	6,987		13,197							353,992	32
33	Real Estate Taxes			1,418		156							1,574	33
34	Rent-Facility & Grounds	(9,398)	(628,376)	975									(636,799)	34
35	Rent-Equipment & Vehicles			1,748									1,748	35
36	Other (specify):*													36
37	**TOTAL Ownership**	51,122	(181,183)	14,789		14,045							(101,227)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(1,044)	(4,827)	(614)	(1,644)		(8,128)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**							(1,044)	(4,827)	(614)	(1,644)		(8,128)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(197,692)	(180,903)	(178,194)	118,368	17,831		(3,140)	(4,827)	(614)	(4,624)		(433,794)	45

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Please See Attached		Please See Attached		Please See Attached		

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 628,376		100.00%	$	$ (628,376)	1
2	V	21	Office Expense			100.00%	150	150	2
3	V	21	Bank Service			100.00%	130	130	3
4	V	30	Depreciation			100.00%	113,385	113,385	4
5	V	32	Interest Expense			100.00%	333,808	333,808	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 628,376			$ 447,473	$ * (180,903)	14

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 121	$ 121	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	338	338	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	434	434	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	986	986	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,834	2,834	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,008	2,008	20
21	V	19	Professional Fees	223,938	Extended Care Consulting, LLC	100.00%	8,372	(215,566)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,546	2,546	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	11,897	11,897	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	124	124	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	617	617	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	678	678	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	3,661	3,661	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	6,987	6,987	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,418	1,418	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%	975	975	30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,748	1,748	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 223,938			$ 45,744	$ * (178,194)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	6,080	$ 6,080	15
16	V	06	Maintenance (Direct)	274	Extended Care Consulting, LLC	100.00%	274		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,016	1,016	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	40	40	18
19	V	12	Admission (Direct)	6,315	Extended Care Consulting, LLC	100.00%	6,315	6,315	19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%	914	914	20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	7,799	1,484	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	94,531	94,531	22
23	V	21	Office and Clerical (Direct)	42,606	Extended Care Consulting, LLC	100.00%	42,606		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	17,100	17,100	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	6,166	6,166	25
26	V	22	Employee Benefits	13,074	Extended Care Consulting, LLC	100.00%		(15,278)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 62,269			$ 182,841	$ * 118,368	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 48	$ 48	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	101	101	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	100	100	17
18	V	19	Professional Fees	69,848	Extended Care Clinical, LLC	100.00%	5,611	(79,289)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	143	143	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,340	1,340	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,144	1,144	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	130	130	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	692	692	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	13,197	13,197	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	156	156	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	3,591	3,591	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	503	503	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	23,105	23,105	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%	3,341	3,341	29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	2,390	2,390	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	4,041	4,041	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	33,067	33,067	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	4,733	4,733	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	5,298	5,298	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 69,848			$ 102,731	$ * 17,831	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$	Extended Care Clinical, LLC	100.00%	$	$	15
16	V	07	Emp. Ben. - General		Extended Care Clinical, LLC	100.00%			16
17	V	10	Nursing Salary	11,348	Extended Care Clinical, LLC	100.00%	11,348		17
18	V	12	Social Service Salary	290	Extended Care Clinical, LLC	100.00%	290		18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	1,242	1,242	19
20	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%			20
21	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%			21
22	V	22	Employee Benefits	3,446	Extended Care Clinical, LLC	100.00%		(1,242)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 15,084			$ 12,880	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Supplies, Supplements	$ 4,720	Care Centers Health Systems, Inc.	100.00%	$ 2,623	$ (2,097)	15
16	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			16
17	V	39	Ancillary Expense	2,349	Care Centers Health Systems, Inc.	100.00%	1,306	(1,044)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,069			$ 3,929	$ * (3,140)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	$ 116,035	TriCare Rehab	100.00%	$ 111,209	$ (4,827)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 116,035			$ 111,209	$ * (4,827)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	R&M - Equipment	$	Reliable Medical of the Midwest, LLC	100.00%	$	$	15
16	V	10	Nursing Supplies		Reliable Medical of the Midwest, LLC	100.00%			16
17	V	39	Ancillary Expense	7,826	Reliable Medical of the Midwest, LLC	100.00%	7,213	(614)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,826			$ 7,213	$ * (614)	39

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Xcel Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping	6,649	Xcel Supply, LLC	100.00%	6,206	(443)	16
17	V	4	Laundry	5,519	Xcel Supply, LLC	100.00%	5,151	(368)	17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	31,467	Xcel Supply, LLC	100.00%	29,370	(2,097)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	12	Social Service		Xcel Supply, LLC	100.00%			21
22	V	20	Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22	Employee Benefits	1,076	Xcel Supply, LLC	100.00%	1,004	(72)	24
25	V	24	Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39	Ancillary	24,677	Xcel Supply, LLC	100.00%	23,032	(1,644)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 69,387			$ 64,763	$ * (4,624)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 47,253	$ 47,253	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	47,253	CCS Employee Benefits Group	100.00%		(47,253)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 47,253			$ 47,253	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Shareholder	Administrative	90.00%	See Attached	1.16	3.87%		$		1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	1.7	3.09%	Alloc. Salary	4,939	17-7	2
3	Adam Vales	Relative	Clerical	N/A	See Attached	0.25	0.63%	Alloc. Salary	434	22-7	3
4	G. Matt Silvers	Relative	Administrative	N/A	See Attached	0.12	0.54%	Alloc. Salary	413	17-7	4
5											5
6											6
7	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered										7
8	allowable by the Il. Dept of HFS.										8
9											9
10											10
11											11
12											12
13								TOTAL	$ 5,786		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 Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	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						$	$		$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	01	Dietary	Patient Days	1,512,273	34	$ 3,931	$	46,720	$ 121	1
2	02	Food	Patient Days	1,512,273	34	10,940		46,720	338	2
3	03	Housekeeping	Patient Days	1,512,273	34	14,059		46,720	434	3
4	05	Utilities	Patient Days	1,512,273	34	31,923		46,720	986	4
5	06	Maintenance	Patient Days	1,512,273	34	91,744		46,720	2,834	5
6	17	Administrative	Patient Days	1,512,273	34	65,000		46,720	2,008	6
7	19	Professional Fees	Patient Days	1,512,273	34	271,007		46,720	8,372	7
8	20	Dues and Subscriptions	Patient Days	1,512,273	34	82,419		46,720	2,546	8
9	21	Office and Clerical	Patient Days	1,512,273	34	385,083		46,720	11,897	9
10	24	Seminar and Travel	Patient Days	1,512,273	34	4,022		46,720	124	10
11	25	Other Staff Admin. Trans.	Patient Days	1,512,273	34	19,982		46,720	617	11
12	26	Insurance	Patient Days	1,512,273	34	21,934		46,720	678	12
13	30	Depreciation	Patient Days	1,512,273	34	118,510		46,720	3,661	13
14	32	Interest	Patient Days	1,512,273	34	226,162		46,720	6,987	14
15	33	Real Estate Taxes	Patient Days	1,512,273	34	45,910		46,720	1,418	15
16	34	Rent - Building	Patient Days	1,512,273	34	31,555		46,720	975	16
17	35	Rent - Equipment & Auto	Patient Days	1,512,273	34	56,569		46,720	1,748	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,480,749	$		$ 45,744	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	06	Maintenance (Pooled)	Patient Days	1,512,273	34	196,794	196,794	46,720	6,080	1
2	06	Maintenance (Direct)	Direct		34	32,478	32,478		274	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,512,273	34	32,885		46,720	1,016	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		34	3,607			40	4
5	12	Admission (Direct)	Direct		34	52,036	52,036		6,315	5
6	15	Emp. Ben. - Nursing (Direct)	Direct		34	5,270			914	6
7	17	Administrative (Pooled)	Patient Days	1,512,273	34	252,448	252,448	46,720	7,799	7
8	21	Office and Clerical (Pooled)	Patient Days	1,512,273	34	3,059,876	3,059,876	46,720	94,531	8
9	21	Office and Clerical (Direct)	Direct		34	771,063	771,063		42,606	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,512,273	34	553,505		46,720	17,100	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		34	94,865			6,166	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					$ 5,054,827	$ 4,364,695		$ 182,841	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	03	Housekeeping	Patient Days	1,512,273	34	$ 1,549	$	46,720	$ 48	1
2	05	Utilities	Patient Days	1,512,273	34	3,268		46,720	101	2
3	06	Maintenance	Patient Days	1,512,273	34	3,240		46,720	100	3
4	19	Professional Fees	Patient Days	1,512,273	34	181,624		46,720	5,611	4
5	20	Dues and Subscriptions	Patient Days	1,512,273	34	4,624		46,720	143	5
6	21	Office & Clerical	Patient Days	1,512,273	34	43,370		46,720	1,340	6
7	24	Travel and Seminar	Patient Days	1,512,273	34	37,025		46,720	1,144	7
8	26	Insurance	Patient Days	1,512,273	34	4,213		46,720	130	8
9	30	Depreciation	Patient Days	1,512,273	34	22,389		46,720	692	9
10	32	Interest	Patient Days	1,512,273	34	427,165		46,720	13,197	10
11	33	Real Estate Taxes	Patient Days	1,512,273	34	5,058		46,720	156	11
12	01	Dietary Salary	Patient Days	1,512,273	34	116,221	116,221	46,720	3,591	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,512,273	34	16,288		46,720	503	13
14	10	Nursing Salary	Patient Days	1,512,273	34	747,870	747,870	46,720	23,105	14
15	10a	Rehab Salary	Patient Days	1,512,273	34	108,151	108,151	46,720	3,341	15
16	12	Social Service Salary	Patient Days	1,512,273	34	77,377	77,377	46,720	2,390	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,512,273	34	130,816		46,720	4,041	17
18	17	Administration Salary	Patient Days	1,512,273	34	1,070,339	1,070,339	46,720	33,067	18
19	21	Office Salary	Patient Days	1,512,273	34	153,206	153,206	46,720	4,733	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,512,273	34	171,480		46,720	5,298	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,325,274	$ 2,273,164		$ 102,731	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	01	Dietary Salary	Direct Allocation			$ 15,960	$ 15,960		$	1
2	07	Emp. Ben. - General	Direct Allocation			1,662				2
3	10	Nursing Salary	Direct Allocation			495,330	495,330		11,348	3
4	12	Social Service Salary	Direct Allocation			274,597	274,597		290	4
5	15	Emp. Ben. - Healthcare	Direct Allocation			94,697			1,242	5
6	17	Administration Salary	Direct Allocation			82,389	82,389			6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation			10,053				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					$ 974,688	$ 868,276		$ 12,880	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Care Centers Health Systems, Inc.
Street Address: 200 Howard
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: (224) 612-5662
Fax Number: (224) 612-5862

	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	1	Dietary Supplies, Supplements	Direct Allocation			$	$		$ 2,623	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						1,306	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					$	$		$ 3,929	25

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: TriCare Rehab
Street Address: 150 Fencl Lane
City / State / Zip Code: Hillside, IL 60162
Phone Number: (773) 449-9400
Fax Number: (773) 449-9700

	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	39	Therapy	Direct Allocation			$	$		$ 111,209	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					$	$		$ 111,209	25

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Reliable Medical of the Midwest, LLC
Street Address: 200 Howard Avenue
City / State / Zip Code: Des Plaines, Illinois 60018-5909
Phone Number: (847) 566-0800
Fax Number: ( )

	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	6	R&M - Equipment	Direct Allocation			$	$		$	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						7,213	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					$	$		$ 7,213	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Xcel Supply, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	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	1	Dietary	Direct Allocation			$	$		$	1
2	3	Housekeeping	Direct Allocation						6,206	2
3	4	Laundry	Direct Allocation						5,151	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						29,370	5
6	11	Activities	Direct Allocation							6
7	12	Social Service	Direct Allocation							7
8	20	Dues, Fees And Subscriptions	Direct Allocation							8
9	21	Office And Clerical	Direct Allocation							9
10	22	Employee Benefits	Direct Allocation						1,004	10
11	24	Seminars & Education	Direct Allocation							11
12	39	Ancillary	Direct Allocation						23,032	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					$	$		$ 64,763	25

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	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	22	Employee Health Insurance	Direct Allocation			$	$		$ 47,253	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					$	$		$ 47,253	25

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Pacific Mutual		X	Mortgage		12/95	$ 4,657,452	$ 3,356,078			$ 333,808	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	First Bank		X	LOC							28,879	6
7	Homewood Loan			LOC							4,416	7
8	See Supplemental Schedule										20,184	8
9	TOTAL Facility Related						$ 4,657,452	$ 3,356,078			$ 387,287	9
	B. Non-Facility Related*											
10	National Government		X	Late Fees							128	10
11	HFG Interest										(3,133)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (3,005)	14
15	TOTALS (line 9+line14)						$ 4,657,452	$ 3,356,078			$ 384,282	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Alloc. from Ext. Care Conslt.		X				$	$			$ 6,987	8
9	Alloc. from Ext. Care Clinical		X								13,197	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										20,184	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.	$	170,492	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.)	$	169,495	2
3. Under or (over) accrual (line 2 minus line 1).	$	(997)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	176,317	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	$	7,581	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	182,901	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	178,049	8
2006	174,753	9
2007	172,887	10
2008	174,622	11
2009	167,921	12

2009 Accrual=$167,921 x 1.05 = $176,317

Alloc from Extended Care Consulting 2201 Main LLC $1,418

Alloc from Extended Care Clinical 2201 Main LLC $156

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avenue Care Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050732

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-02-312-001-0000	Nursing Home	$ 167,921.37	$ 167,921.37
2.	See Attached	Alloc from 2201 Main	$ 116,500.56	$ 1,610.86
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 284,421.93	$ 169,532.23

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 & 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avenue Care Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050732

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,293 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (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 [X] NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	51,736	1995	$ 100,000	1
2	Allocated from CCI/ECC			11,338	2
3	TOTALS	51,736		$ 111,338	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1988	5,400		20	216	216	4,878	9
10	Various			1989	1,035		20			1,035	10
11	Various			1990	5,400		20	113	113	5,400	11
12	Various			1991	14,414		20	721	721	14,060	12
13	Various			1992	40,065		20	1,288	1,288	25,009	13
14	Various			1993	17,484		20	431	431	9,568	14
15	Various			1994	25,290		20	882	882	14,621	15
16	Various			1995	48,214		20	1,264	1,264	21,094	16
17	Various			1996	14,555		20	373	373	5,370	17
18	Various			1997	81,665		20	2,094	2,094	28,254	18
19	Various			1998	77,656		20	4,170	4,170	52,219	19
20	Various			1999	57,028		20	1,462	1,462	16,873	20
21	Various			2000	13,093		20	476	476	4,831	21
22	Various			2001	75,231		20	3,225	3,225	31,731	22
23	Various			2002	3,877		20	141	141	1,220	23
24	Various			2003	28,341		20	1,099	1,099	8,314	24
25	Various			2004	16,990		20	618	618	3,797	25
26	Various			2005	15,280		20	1,727	1,727	6,510	26
27	Various			2006	76,699		20	3,704	3,704	17,604	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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	Related Building Company (Pages 12F & 12G)		4,046,250	113,385		103,746	(9,639)	1,647,109	67
68	Related Party Allocations (Pages 12H & 12I)		45,694	3,111		3,111		21,779	68
69	Financial Statement Depreciation			888			(888)		69
70	TOTAL (lines 4 thru 69)		$ 4,709,661	$ 117,384		$ 130,861	$ 13,477	$ 1,941,276	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,709,661	$ 117,384		$ 130,861	$ 13,477	$ 1,941,276	1
2	Exhaust Fan For Smoking Room	2007	3,012		20	110	110	390	2
3	Toilets,Sink,Faucets,Locks,Tile,Plumbing,Paint,Dry Wall,Electric	2007	360,377		20	13,105	13,105	47,506	3
4	Custom Window Treatments & Cubicle Curtains	2007	18,883		20	3,626	3,626	17,072	4
5	Elevator Moderization	2007	12,800		20	465	465	1,724	5
6	Install New Stem Well	2007	2,656		20	97	97	343	6
7	Basement Dining A/C Unit	2007	2,899		20	105	105	372	7
8	Install New Elevator Traveling Cables	2008	3,320		20	121	121	348	8
9	New Circuits & Outlets	2008	3,500		20	127	127	291	9
10	Toilets,Sink,Faucets,Locks,Tile,Plumbing,Paint,Dry Wall,Electric	2008	51,225		20	1,863	1,863	4,735	10
11	New Piping & Drain System - 1St & 2Nd Floor	2008	22,975		20	835	835	2,122	11
12	Passenger Elevator - Changed Seals & Packing	2008	4,863		20	177	177	450	12
13	Replaced Car Sills In Freight Elevator	2008	6,400		20	233	233	476	13
14	Installed & Programed Elevator Phone	2009	10,271		20	514	514	809	14
15	Fire Alarm Panel Replacement	2009	26,447		20	1,322	1,322	2,003	15
16	Replaced Cable, Adjust Elevator Door Operator	2009	3,534		20	177	177	258	16
17	Wall Air Conditioners	2009	3,659		20	183	183	2,377	17
18	Installed Fire Dampers	2009	3,367		20	168	168	224	18
19	Installed 5 Ton A/C Condensing Unit	2009	2,455		20	123	123	1,597	19
20	Tuckpointing	2009	5,850		20	293	293	302	20
21	Long Elevator- Traveling Cable Replacement	2010	4,800		20	240	240	240	21
22	Water Cooled Dispensor	2010	4,222		20	211	211	211	22
23	Sprinkler Protection - Top & Bottom Of Elevator Shaft	2010	3,640		20	182	182	182	23
24	Window Treatments	2010	11,507		20	575	575	575	24
25	Thru-The-Wall Air Conditioner	2010	4,289		20	214	214	214	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,286,613	$ 117,384		$ 155,927	$ 38,543	$ 2,026,097	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,286,613	$ 117,384		$ 155,927	$ 38,543	$ 2,026,097	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,286,613	$ 117,384		$ 155,927	$ 38,543	$ 2,026,097	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,286,613	$ 117,384		$ 155,927	$ 38,543	$ 2,026,097	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,286,613	$ 117,384		$ 155,927	$ 38,543	$ 2,026,097	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,286,613	$ 117,384		$ 155,927	$ 38,543	$ 2,026,097	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,286,613	$ 117,384		$ 155,927	$ 38,543	$ 2,026,097	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	155 Bed Building	1970	4,046,250	113,385	39	103,746	(9,639)	1,647,109	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 4,046,250	$ 113,385		$ 103,746	$ (9,639)	$ 1,647,109	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Clinical, 2201 Main LLC	2002	1,550	40	39	40		330	3
4	Allocated from Extended Care Consulting, 2201 Main LLC	2002	14,074	361	39	361		2,992	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, 2201 Main LLC	2002	11,626	1,063	20	1,063		7,448	9
10	Allocated from Extended Care Consulting, 2201 Main LLC	2003	13,701	1,252	20	1,252		8,777	10
11	Allocated from Extended Care Consulting, 2201 Main LLC	2005	681	72	20	72		318	11
12	Allocated from Extended Care Consulting, 2201 Main LLC	2009	123	6	20	6		12	12
13									13
14									14
15	Allocated from Extended Care Consulting, LLC	2007	142	7	20	7		28	15
16	Allocated from Extended Care Consulting, LLC	2009	85	4	20	4		9	16
17	Allocated from Extended Care Consulting, LLC	2010	833	42	20	42		42	17
18									18
19	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	1,281	117	20	117		820	19
20	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2003	1,509	138	20	138		967	20
21	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2005	75	8	20	8		35	21
22	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2009	14	1	20	1		1	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								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
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19									19
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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	TOTAL (12H & 12I lines 1 thru 33)		$ 45,694	$ 3,111		$ 3,111	$	$ 21,779	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 231,673	$ 697	$ 23,168	$ 22,471	10	$ 137,652	71
72	Current Year Purchases	451	45	45		10	45	72
73	Fully Depreciated Assets	392,532				10	392,532	73
74								74
75	TOTALS	$ 624,656	$ 742	$ 23,213	$ 22,471		$ 530,229	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Alloc. From EC Clinical	2010	$ 1,727	$ 345	$ 345	$	5	$ 806	76
77		Alloc. From ECC	2010	9,934	155	155		5	9,624	77
78										78
79										79
80	TOTALS			$ 11,661	$ 500	$ 500	$		$ 10,430	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)	$ 6,034,268	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 118,626	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 179,640	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 61,014	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,566,756	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Extended Care Consulting				975			5
6								6
7	TOTAL				$ 975 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 31,710 Description: See Attached Schedule
(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	Facility	2006 Ford E35C	$ 626.25	$	17
18	Administrative	2006 Buick	756.16		18
19					19
20					20
21	TOTAL		$ 1,382.41	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 50,735	$		$ 50,735	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			4,533			4,533	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			46,255			46,255	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				124,129		124,129	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					100	57,993		58,093	13
14	TOTAL			$		$ 101,623	$ 182,122		$ 283,745	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 4,286	1
2	Cash-Patient Deposits	36,874	36,874	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	805,652	805,652	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,359	54,359	6
7	Other Prepaid Expenses	21,149	21,149	7
8	Accounts Receivable (owners or related parties)	388,821	388,821	8
9	Other(specify): See Attached Schedule	1,307,798	1,465,111	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,614,653	$ 2,776,252	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		4,046,250	14
15	Leasehold Improvements, at Historical Cost	14,290	169,290	15
16	Equipment, at Historical Cost	22,644	22,644	16
17	Accumulated Depreciation (book methods)	(888)	(1,812,636)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	3,949	3,949	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 39,995	$ 2,529,497	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,654,648	$ 5,305,749	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,060,066	$ 1,060,066	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,874	36,874	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	214,429	214,429	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,878	12,878	31
32	Accrued Real Estate Taxes(Sch.IX-B)	176,317	176,317	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,074,720	1,558,600	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,575,284	$ 3,059,164	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,356,078	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,356,078	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,575,284	$ 6,415,242	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 79,364	$ (1,109,493)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,654,648	$ 5,305,749	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 96,957	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	180	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 97,137	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(17,773)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (17,773)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 79,364	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,193,903	1
2	Discounts and Allowances for all Levels	(441,343)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,752,560	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	371,381	6
7	Oxygen	1,404	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 372,785	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	9,398	16
17	Sale of Drugs	90,721	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,862	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,532	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 104,513	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,292	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,292	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,231,150	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,057,392	31
32	Health Care	2,280,610	32
33	General Administration	1,669,159	33
	B. Capital Expense		
34	Ownership	873,154	34
	C. Ancillary Expense		
35	Special Cost Centers	283,745	35
36	Provider Participation Fee	84,863	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,248,923	40
41	**Income before Income Taxes (line 30 minus line 40)****	(17,773)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (17,773)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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. SEE ACCOUNTANTS' COMPILATION REPORT**

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,741	2,293	$ 87,840	$ 38.31	1
2	Assistant Director of Nursing	1,675	2,212	71,857	32.49	2
3	Registered Nurses	4,789	5,328	140,620	26.39	3
4	Licensed Practical Nurses	33,054	35,809	833,803	23.28	4
5	CNAs & Orderlies	68,619	75,982	710,154	9.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,952	4,447	70,107	15.77	8
9	Activity Director	1,744	1,944	21,156	10.88	9
10	Activity Assistants	5,546	6,524	62,320	9.55	10
11	Social Service Workers	5,456	6,235	166,570	26.72	11
12	Dietician					12
13	Food Service Supervisor	1,964	2,205	39,273	17.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,538	7,460	68,912	9.24	15
16	Dishwashers	9,639	10,581	90,486	8.55	16
17	Maintenance Workers	8,287	9,302	102,163	10.98	17
18	Housekeepers	14,553	15,924	140,992	8.85	18
19	Laundry	5,279	6,063	64,425	10.63	19
20	Administrator	1,984	2,572	116,064	45.13	20
21	Assistant Administrator	2,197	2,671	70,052	26.23	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,784	4,154	60,810	14.64	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	1,628	1,850	19,016	10.28	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	182,429	203,556	$ 2,936,620 *	$ 14.43	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 10,924	01-03	35
36	Medical Director	Monthly	9,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,459	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	1,664	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	Please See Attached		17,952		48
49	TOTAL (lines 35 - 48)	32	$ 46,999		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joeann Brew	Administrator	0	$ 116,065
Mila J Jeffery	Asst. Administrator	0	70,051
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 186,116

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Krupnick, Bokor, Kagda	Accounting	$ 29,850
Personnel Planners	Unemployment Consult.	2,141
Ext. Care Consulting	Home Office Expenses	223,938
Ext. Care Clinical	Other Professional Fees	69,848
AIS Assessment	MDS Training	1,427
Paycor	Payroll Processing	11,038
eHealth Data Solutions	MDS Software	3,283
Medifax	Software	55
Vision Share	Software	399
Denise Carnes	Accounting	1,883
Nebo Systems	Software	81
See Supplemetal Schedule		102,273
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 446,216

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,394
Unemployment Compensation Insurance	82,975
FICA Taxes	217,821
Employee Health Insurance	108,095
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physical	1,076
Pension Expenses	28,755
Other Employee Welfare	860
Holiday Expenses	2,050
Chicago City Tax	3,040
TOTAL (agree to Schedule V, line 22, col.8)	$ 517,066

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,454
Advertising: Employee Recruitment	844
Health Care Worker Background Check	
(Indicate # of checks performed 166)	2,274
Patient Background Checks	
Dues & Subscription	13
Licenses & Fees	3,097
Alloc from Ext Care Consult.	2,546
Alloc from Ext Care Clinical	143
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,371

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,554
Alloc from Ext Care Consult	124
Alloc from Ext Care Clinical	1,144
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,822

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Paint/Decorating	07/06	$ 8,150	3Yrs	$ 2,716	$ 2,716	$ 1,359	$	$	$	$	$	$
2													
3													
4													
5													
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16													
17													
18													
19													
20	TOTALS		$ 8,150		$ 2,716	$ 2,716	$ 1,359	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center **#** 0050732 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(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? **10Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **306** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Avenue Care Center Inc. #0033340 11/01/09

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **84,863**
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. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
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:

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.