FOR BHF USE

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

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.

I. IDPH License ID Number: 0046201

Facility Name: Lemont Nursing & Rehab Center

Address: 12450 Walker Road (Number) Lemont (City) 60539 (Zip Code)

County: Cook

Telephone Number: (630) 243-0400 **Fax #** (630) 243-5063

HFS ID Number:

Date of Initial License for Current Owners: 02/01/2003

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 Lemont Nursing & Rehab Center # 0046201 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	158	Skilled (SNF)	158	57,670	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	158	TOTALS	158	57,670	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	21,649	9,787	18,126	49,562	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,649	9,787	18,126	49,562	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.94%

D. How many bed-hold days during this year were paid by the Department?
1 (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 02/01/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 158 and days of care provided 17,631

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: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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	285,134	63,994	26,435	375,563		375,563	(4,151)	371,412			1
2	Food Purchase		282,683		282,683		282,683	(199)	282,484			2
3	Housekeeping	188,053	41,351		229,404		229,404	(2,360)	227,044			3
4	Laundry	58,512	37,537		96,049		96,049	(1,078)	94,971			4
5	Heat and Other Utilities			181,667	181,667		181,667	1,153	182,820			5
6	Maintenance	112,120		222,166	334,286		334,286	6,536	340,822			6
7	Other (specify):*							1,682	1,682			7
8	TOTAL General Services	643,819	425,565	430,268	1,499,652		1,499,652	1,582	1,501,234			8
	B. Health Care and Programs											
9	Medical Director			39,000	39,000		39,000		39,000			9
10	Nursing and Medical Records	3,392,983	207,481	118,103	3,718,567		3,718,567	18,636	3,737,203			10
10a	Therapy	223,598			223,598		223,598	3,544	227,142			10a
11	Activities	167,401	35,962		203,363		203,363		203,363			11
12	Social Services	189,250		7,081	196,331		196,331	(10,441)	185,890			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,925	6,925			15
16	TOTAL Health Care and Programs	3,973,232	243,443	164,184	4,380,859		4,380,859	18,664	4,399,523			16
	C. General Administration											
17	Administrative	159,194			159,194		159,194	45,482	204,676			17
18	Directors Fees											18
19	Professional Services			574,287	574,287		574,287	(470,855)	103,432			19
20	Dues, Fees, Subscriptions & Promotions			37,503	37,503		37,503	(6,601)	30,902			20
21	Clerical & General Office Expenses	138,848	38,983	129,657	307,488		307,488	80,843	388,331			21
22	Employee Benefits & Payroll Taxes			716,272	716,272		716,272	(12,548)	703,724			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,550	8,550		8,550	1,345	9,895			24
25	Other Admin. Staff Transportation			750	750		750	655	1,405			25
26	Insurance-Prop.Liab.Malpractice			373,524	373,524		373,524	(31,366)	342,158			26
27	Other (specify):*							25,075	25,075			27
28	TOTAL General Administration	298,042	38,983	1,840,543	2,177,568		2,177,568	(367,970)	1,809,598			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,915,093	707,991	2,434,995	8,058,079		8,058,079	(347,724)	7,710,355			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 Lemont Nursing & Rehab Center #0046201 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			35,657	35,657		35,657	249,230	284,887			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							350,455	350,455			32
33	Real Estate Taxes			380,921	380,921		380,921	(8,714)	372,207			33
34	Rent-Facility & Grounds			519,030	519,030		519,030	(517,996)	1,034			34
35	Rent-Equipment & Vehicles			23,245	23,245		23,245	(5,457)	17,788			35
36	Other (specify):*											36
37	**TOTAL Ownership**			958,853	958,853		958,853	67,518	1,026,371			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,111,642	1,644,696	2,756,338		2,756,338	(315,006)	2,441,332			39
40	Barber and Beauty Shops			794	794		794	(794)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			86,505	86,505		86,505		86,505			42
43	Other (specify):*			134,278	134,278		134,278	(134,278)				43
44	**TOTAL Special Cost Centers**		1,111,642	1,866,273	2,977,915		2,977,915	(450,078)	2,527,837			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,915,093	1,819,633	5,260,121	11,994,847		11,994,847	(730,284)	11,264,563			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 Lemont Nursing & Rehab Center # 0046201 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	106,414	30		9
10	Interest and Other Investment Income	(139,343)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(558)	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				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	(41,386)	21		24
25	Fund Raising, Advertising and Promotional	(9,204)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(500)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(231,277)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (315,855)		$	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)	(414,429)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (414,429)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (730,284)		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

Lemont Nursing & Rehab Center

ID# 0046201

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Clothing	$ (269)	10	1
2	Barber and Beauty Shop	(794)	40	2
3	Prior Period Adjustment- Medical Supplies & Tests	(6,364)	39	3
4	Prior Period Adjustment- Radiology	(7,486)	39	4
5	Theft Loss	(3,677)	21	5
6	Collection Expenses	(5,808)	21	6
7	Annual Report	(250)	20	7
8	Capitalized R&M	(2,907)	06	8
9	Non-Allowable Legal	(21,297)	19	9
10	Prior Period R/E Taxes	(10,385)	33	10
11	Non-Allowable Expenses	(134,278)	43	11
12	Jury Duty	(86)	21	12
13	Misc. Income - Misc Deduction Dietary	(32)	01	13
14	Misc. Income - Insurance	(32,223)	26	14
15	Misc. Income - Computer Refund	(21)	21	15
16	Non-Allowable PY Professional Fee	(5,400)	19	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**	(231,277)		49

Lemont Nursing & Rehab Center

ID# 0046201

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 Lemont Nursing & Rehab Center # 0046201 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	(32)		129		3,809		(8,045)			(12)		(4,151)	1
2	Food Purchase	(558)		359									(199)	2
3	Housekeeping			461		51					(2,872)		(2,360)	3
4	Laundry										(1,078)		(1,078)	4
5	Heat and Other Utilities			1,046		107							1,153	5
6	Maintenance	(2,907)		3,007	6,450	106					(120)		6,536	6
7	Other (specify):*				1,148	534							1,682	7
8	**TOTAL General Services**	(3,498)		5,002	7,598	4,607		(8,045)			(4,082)		1,582	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(269)				24,510					(5,605)		18,636	10
10a	Therapy					3,544							3,544	10a
11	Activities													11
12	Social Services				(12,977)	2,536							(10,441)	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					4,287	2,638						6,925	15
16	**TOTAL Health Care and Programs**	(269)			(12,977)	34,877	2,638				(5,605)		18,664	16
	C. General Administration													
17	Administrative			2,130	8,274	35,078							45,482	17
18	Directors Fees													18
19	Professional Services	(26,697)		(358,571)		(85,587)							(470,855)	19
20	Fees, Subscriptions & Promotions	(9,454)		2,701		152							(6,601)	20
21	Clerical & General Office Expenses	(51,478)		12,620	113,259	6,442							80,843	21
22	Employee Benefits & Payroll Taxes				(9,698)		(2,638)				(212)		(12,548)	22
23	Inservice Training & Education													23
24	Travel and Seminar			132		1,213							1,345	24
25	Other Admin. Staff Transportation			655									655	25
26	Insurance-Prop.Liab.Malpractice	(32,223)		719		138							(31,366)	26
27	Other (specify):*				19,455	5,620							25,075	27
28	**TOTAL General Administration**	(119,852)		(339,614)	131,290	(36,944)	(2,638)				(212)		(367,970)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(123,619)		(334,612)	125,911	2,540		(8,045)			(9,899)		(347,724)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lemont Nursing & Rehab Center **#** 0046201 **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	106,414	138,198	3,884		734							249,230	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(139,343)	468,386	7,412		14,000							350,455	32
33	Real Estate Taxes	(10,385)		1,505		166							(8,714)	33
34	Rent-Facility & Grounds		(519,030)	1,034									(517,996)	34
35	Rent-Equipment & Vehicles			1,854								(7,311)	(5,457)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(43,314)	87,554	15,689		14,900						(7,311)	67,518	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(13,850)						(4,422)	(262,951)	(6,050)	(10,871)	(16,862)	(315,006)	39
40	Barber and Beauty Shops	(794)											(794)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(134,278)											(134,278)	43
44	**TOTAL Special Cost Centers**	(148,922)						(4,422)	(262,951)	(6,050)	(10,871)	(16,862)	(450,078)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(315,855)	87,554	(318,923)	125,911	17,440		(12,466)	(262,951)	(6,050)	(20,771)	(24,173)	(730,284)	45

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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
See Attached		See Attached			See Attached	
					Lemont Property LLC	Building Co.

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	Rental Income	$ 519,030	Lemont Property, LLC		$	$ (519,030)	1
2	V	33	Real Estate Tax Expense	380,921	Lemont Property, LLC		380,921		2
3	V	30	Depreciation Expense		Lemont Property, LLC		138,198	138,198	3
4	V	32	Interest Expenses- Business Partners		Lemont Property, LLC		468,386	468,386	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 899,951			$ 987,505	$ * 87,554	14

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

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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%	$ 129	$ 129	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	359	359	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	461	461	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,046	1,046	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,007	3,007	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,130	2,130	20
21	V	19	Professional Fees	367,453	Extended Care Consulting, LLC	100.00%	8,882	(358,571)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,701	2,701	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	12,620	12,620	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	132	132	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	655	655	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	719	719	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	3,884	3,884	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	7,412	7,412	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,505	1,505	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%	1,034	1,034	30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,854	1,854	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 367,453			$ 48,530	$ * (318,923)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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%	6,450	$ 6,450	15
16	V	06	Maintenance (Direct)	688	Extended Care Consulting, LLC	100.00%	688		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,078	1,078	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	70	70	18
19	V	12	Admission (Direct)		Extended Care Consulting, LLC	100.00%		(12,977)	19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%			20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	8,274	8,274	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	100,282	100,282	22
23	V	21	Office and Clerical (Direct)	12,977	Extended Care Consulting, LLC	100.00%	12,977	12,977	23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	18,140	18,140	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,315	1,315	25
26	V	22	Employee Benefits	9,698	Extended Care Consulting, LLC	100.00%		(9,698)	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			$ 23,363			$ 149,274	$ * 125,911	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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%	$ 51	$ 51	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	107	107	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	106	106	17
18	V	19	Professional Fees	91,539	Extended Care Clinical, LLC	100.00%	5,952	(85,587)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	152	152	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,421	1,421	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,213	1,213	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	138	138	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	734	734	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	14,000	14,000	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	166	166	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	3,809	3,809	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	534	534	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	24,510	24,510	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%	3,544	3,544	29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	2,536	2,536	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	4,287	4,287	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	35,078	35,078	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	5,021	5,021	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	5,620	5,620	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 91,539			$ 108,979	$ * 17,440	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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	26,550	Extended Care Clinical, LLC	100.00%	26,550		17
18	V	12	Social Service Salary	6,066	Extended Care Clinical, LLC	100.00%	6,066		18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	2,638	2,638	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	2,638	Extended Care Clinical, LLC	100.00%		(2,638)	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			$ 35,254			$ 35,254	$ *	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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	$ 18,110	Care Centers Health Systems, Inc.	100.00%	$ 10,065	$ (8,045)	15
16	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			16
17	V	39	Ancillary Expense	9,954	Care Centers Health Systems, Inc.	100.00%	5,532	(4,422)	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			$ 28,063			$ 15,597	$ * (12,466)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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	$ 1,569,220	TriCare Rehab	100.00%	$ 1,306,269	$ (262,951)	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			$ 1,569,220			$ 1,306,269	$ * (262,951)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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	77,174	Reliable Medical of the Midwest, LLC	100.00%	71,124	(6,050)	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			$ 77,174			$ 71,124	$ * (6,050)	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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	$ 176	Xcel Supply, LLC	100.00%	$ 164	$ (12)	15
16	V	3	Housekeeping	43,103	Xcel Supply, LLC	100.00%	40,231	(2,872)	16
17	V	4	Laundry	16,181	Xcel Supply, LLC	100.00%	15,103	(1,078)	17
18	V	6	Repairs & Maintenance	1,797	Xcel Supply, LLC	100.00%	1,678	(120)	18
19	V	10	Nursing	84,113	Xcel Supply, LLC	100.00%	78,508	(5,605)	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	3,189	Xcel Supply, LLC	100.00%	2,977	(212)	24
25	V	24	Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39	Ancillary	163,138	Xcel Supply, LLC	100.00%	152,267	(10,871)	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			$ 311,698			$ 290,927	$ * (20,771)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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%	$ 171,479	$ 171,479	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	171,479	CCS Employee Benefits Group	100.00%		(171,479)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	35	Matrix Leasing	$ 13,604	Vent Lease LLC	100.00%	$ 6,293	$ (7,311)	26
27	V	39	Ventilator Equipment	28,940	Vent Lease LLC	100.00%	13,387	(16,862)	27
28	V	39	Other Ancillary		Vent Lease LLC	100.00%			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			$ 214,023			$ 191,159	$ * (24,173)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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	1.00%	See Attached	1.23	2.65%		$		1
2	Adam Vales	Relative	Clerical	N/A	See Attached	0.90	2.25%	Alloc. Salary	1,575	22-7	2
3	Mark Steinberg	Relative	Administrative	N/A	See Attached	1.80	3.27%	Alloc. Salary	5,240	17-7	3
4	G. Matt Silvers	Relative	Administrative	N/A	See Attached	0.55	2.47%	Alloc. Salary	1,853	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 8,668		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 Lemont Nursing & Rehab Center # 0046201 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 Lemont Nursing & Rehab Center # 0046201 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	$	49,562	$ 129	1
2	02	Food	Patient Days	1,512,273	34	10,940		49,562	359	2
3	03	Housekeeping	Patient Days	1,512,273	34	14,059		49,562	461	3
4	05	Utilities	Patient Days	1,512,273	34	31,923		49,562	1,046	4
5	06	Maintenance	Patient Days	1,512,273	34	91,744		49,562	3,007	5
6	17	Administrative	Patient Days	1,512,273	34	65,000		49,562	2,130	6
7	19	Professional Fees	Patient Days	1,512,273	34	271,007		49,562	8,882	7
8	20	Dues and Subscriptions	Patient Days	1,512,273	34	82,419		49,562	2,701	8
9	21	Office and Clerical	Patient Days	1,512,273	34	385,083		49,562	12,620	9
10	24	Seminar and Travel	Patient Days	1,512,273	34	4,022		49,562	132	10
11	25	Other Staff Admin. Trans.	Patient Days	1,512,273	34	19,982		49,562	655	11
12	26	Insurance	Patient Days	1,512,273	34	21,934		49,562	719	12
13	30	Depreciation	Patient Days	1,512,273	34	118,510		49,562	3,884	13
14	32	Interest	Patient Days	1,512,273	34	226,162		49,562	7,412	14
15	33	Real Estate Taxes	Patient Days	1,512,273	34	45,910		49,562	1,505	15
16	34	Rent - Building	Patient Days	1,512,273	34	31,555		49,562	1,034	16
17	35	Rent - Equipment & Auto	Patient Days	1,512,273	34	56,569		49,562	1,854	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,480,749	$		$ 48,530	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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	49,562	6,450	1
2	06	Maintenance (Direct)	Direct		34	32,478	32,478		688	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,512,273	34	32,885		49,562	1,078	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		34	3,607			70	4
5	12	Admission (Direct)	Direct		34	52,036	52,036			5
6	15	Emp. Ben. - Nursing (Direct)	Direct		34	5,270				6
7	17	Administrative (Pooled)	Patient Days	1,512,273	34	252,448	252,448	49,562	8,274	7
8	21	Office and Clerical (Pooled)	Patient Days	1,512,273	34	3,059,876	3,059,876	49,562	100,282	8
9	21	Office and Clerical (Direct)	Direct		34	771,063	771,063		12,977	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,512,273	34	553,505		49,562	18,140	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		34	94,865			1,315	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		$ 149,274	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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	$	49,562	$ 51	1
2	05	Utilities	Patient Days	1,512,273	34	3,268		49,562	107	2
3	06	Maintenance	Patient Days	1,512,273	34	3,240		49,562	106	3
4	19	Professional Fees	Patient Days	1,512,273	34	181,624		49,562	5,952	4
5	20	Dues and Subscriptions	Patient Days	1,512,273	34	4,624		49,562	152	5
6	21	Office & Clerical	Patient Days	1,512,273	34	43,370		49,562	1,421	6
7	24	Travel and Seminar	Patient Days	1,512,273	34	37,025		49,562	1,213	7
8	26	Insurance	Patient Days	1,512,273	34	4,213		49,562	138	8
9	30	Depreciation	Patient Days	1,512,273	34	22,389		49,562	734	9
10	32	Interest	Patient Days	1,512,273	34	427,165		49,562	14,000	10
11	33	Real Estate Taxes	Patient Days	1,512,273	34	5,058		49,562	166	11
12	01	Dietary Salary	Patient Days	1,512,273	34	116,221	116,221	49,562	3,809	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,512,273	34	16,288		49,562	534	13
14	10	Nursing Salary	Patient Days	1,512,273	34	747,870	747,870	49,562	24,510	14
15	10a	Rehab Salary	Patient Days	1,512,273	34	108,151	108,151	49,562	3,544	15
16	12	Social Service Salary	Patient Days	1,512,273	34	77,377	77,377	49,562	2,536	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,512,273	34	130,816		49,562	4,287	17
18	17	Administration Salary	Patient Days	1,512,273	34	1,070,339	1,070,339	49,562	35,078	18
19	21	Office Salary	Patient Days	1,512,273	34	153,206	153,206	49,562	5,021	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,512,273	34	171,480		49,562	5,620	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,325,274	$ 2,273,164		$ 108,979	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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		26,550	3
4	12	Social Service Salary	Direct Allocation			274,597	274,597		6,066	4
5	15	Emp. Ben. - Healthcare	Direct Allocation			94,697			2,638	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		$ 35,254	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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			$	$		$ 10,065	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						5,532	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					$	$		$ 15,597	25

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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			$	$		$ 1,306,269	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					$	$		$ 1,306,269	25

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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						71,124	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					$	$		$ 71,124	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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			$	$		$ 164	1
2	3	Housekeeping	Direct Allocation						40,231	2
3	4	Laundry	Direct Allocation						15,103	3
4	6	Repairs & Maintenance	Direct Allocation						1,678	4
5	10	Nursing	Direct Allocation						78,508	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						2,977	10
11	24	Seminars & Education	Direct Allocation							11
12	39	Ancillary	Direct Allocation						152,267	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					$	$		$ 290,927	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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 Emp. Ben. Group / Vent Lease LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000 / (847) 674-1180
Fax Number: (847)905-4040 / (847) 673-7741

	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			$	$		$ 171,479	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11	35	Matrix Leasing	Direct Allocation			$	$		$ 6,293	11
12	39	Ventilator Equipment	Direct Allocation						13,387	12
13	39	Other Ancillary	Direct Allocation							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					$	$		$ 191,159	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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	National City Bank		X	Note Payable			$	$ 7,696,143			$ 468,386	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Alloc from Ext Care Cnsult		X								7,412	6
7	Alloc from Ext Care Clinical		X								14,000	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 7,696,143			$ 489,798	9
	B. Non-Facility Related*											
10	Interest Income		X								(139,343)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (139,343)	14
15	TOTALS (line 9+line14)						$	$ 7,696,143			$ 350,455	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 Lemont Nursing & Rehab Center # 0046201 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							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											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 Lemont Nursing & Rehab Center **#** 0046201 **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.	$	330,375	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.)	$	343,579	2
3. Under or (over) accrual (line 2 minus line 1).	$	13,204	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	359,003	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	372,207	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	240,050	8
2006	236,542	9
2007	242,783	10
2008	314,643	11
2009	341,908	12

2010 R/E Accrual 2009 Taxes $341,908 X 1.05% = $359,003
Alloc from Extended Care Consulting 2201 Main LLC $1,539
Alloc from Extended Care Clinical 2201 Main LLC $170

	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 Lemont Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

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.	22-27-300-076-0000	Long Term Care Property	$ 322,848.78	$ 322,848.78
2.	22-27-300-077-0000	Long Term Care Property	$ 19,058.90	$ 19,058.90
3.	See Attached	Alloc from 2201 Main LLC	$ 116,500.56	$ 1,709.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 458,408.24	$ 343,616.68

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 Lemont Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

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 Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,000 B. General Construction Type: Exterior Brick Frame Masonary & Steel Number of Stories 1

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. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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	Facility		2003	$ 823,094	1
2	Allocated from ECC			12,028	2
3	TOTALS			$ 835,122	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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			2003	48,664		20	2,296	2,296	22,793	9
10	Various			2004	35,166		20	1,922	1,922	15,781	10
11	Various			2005	7,375		20	369	369	2,182	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

*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 Lemont Nursing & Rehab Center # 0046201 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)		5,391,421	138,198		252,705	114,507	2,334,382	67
68	Related Party Allocations (Pages 12H & 12I)		48,474	3,300		3,300		23,103	68
69	Financial Statement Depreciation			35,657			(35,657)		69
70	TOTAL (lines 4 thru 69)		$ 5,531,100	$ 177,155		$ 260,592	$ 83,437	$ 2,398,241	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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		$ 5,531,100	$ 177,155		$ 260,592	$ 83,437	$ 2,398,241	1
2	Replaced Heat Exchangers	2007	16,500		20	1,100	1,100	4,400	2
3	Painting (Transfer Expense From Home Office)	2007	4,792		20			4,792	3
4	Painting (Transfer Expense From Home Office)	2007	5,091		20			5,091	4
5	Painting (Transfer Expense From Home Office)	2007	19,331		20			19,331	5
6	Roof Repair	2007	2,500		20	125	125	427	6
7	Air Unit, Supply Duct & Registers	2007	4,475		20	224	224	746	7
8	Dorr Wreck Repair	2007	7,200		20	360	360	1,140	8
9	Repair A/C	2008	4,475		20	224	224	671	9
10	Install New Smoke Dampers	2008	14,039		20	702	702	2,047	10
11	Additions & Alterations	2008	9,341		20	467	467	1,207	11
12	Heating/Ac Unit Repairs	2008	5,250		20	263	263	656	12
13	Dining Room Remodeling	2008	3,600		20	180	180	420	13
14	Replace Heat Exchangers	2008	6,500		20	325	325	731	14
15	Additions & Alterations	2008	3,520		20	176	176	381	15
16	Sprinkler Repairs	2008	6,104		20	305	305	636	16
17	Sprinkler Repairs	2008	3,311		20	166	166	345	17
18	Fire Pipe Replacement	2008	3,177		20	159	159	384	18
19	Kitchen Vent	2009	2,625		20	525	525	1,050	19
20	Kitchen Roof Top Unit #7	2010	2,625		20	131	131	131	20
21	Exhaust Fan	2010	2,350		20	69	69	69	21
22	Exhaust Fan	2010	2,350		20	69	69	69	22
23	Fire System	2010	2,573		20	32	32	32	23
24	Walls & Flooring	2010	36,450		20	304	304	304	24
25	Rooftop A/C Unit	2010	16,850		20	70	70	70	25
26	Fire System	2010	7,628		20	32	32	32	26
27	Security Cameras	2010	5,302		20	88	88	88	27
28	Fire System	2010	18,990		20	79	79	79	28
29	Fire System	2010	19,225		20	80	80	80	29
30	Fire System	2010	8,998		20	37	37	37	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,776,271	$ 177,155		$ 266,883	$ 89,728	$ 2,443,688	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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		$ 5,776,271	$ 177,155		$ 266,883	$ 89,728	$ 2,443,688	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
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22									22
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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)		$ 5,776,271	$ 177,155		$ 266,883	$ 89,728	$ 2,443,688	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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		$ 5,776,271	$ 177,155		$ 266,883	$ 89,728	$ 2,443,688	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
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19									19
20									20
21									21
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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)		$ 5,776,271	$ 177,155		$ 266,883	$ 89,728	$ 2,443,688	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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		$ 5,776,271	$ 177,155		$ 266,883	$ 89,728	$ 2,443,688	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
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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)		$ 5,776,271	$ 177,155		$ 266,883	$ 89,728	$ 2,443,688	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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	115 Bed Facility	1995	4,683,421		Various	197,159	197,159	1,880,476	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Land Improvements	2003	708,000		Various	55,546	55,546	453,906	9
10									10
11	Building Company Information			138,198			(138,198)		11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
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24									24
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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 Lemont Nursing & Rehab Center # 0046201 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
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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)		$ 5,391,421	$ 138,198		$ 252,705	$ 114,507	$ 2,334,382	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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, Inc. 2201 Main LLC	2002	1,645	42	39	42		350	3
4	Allocated from Extended Care Consulting, 2201 Main LLC	2002	14,930	383	39	383		3,174	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from Extended Care Consulting, 2201 Main LLC	2002	12,333	1,127	20	1,127		7,901	10
11	Allocated from Extended Care Consulting, 2201 Main LLC	2003	14,535	1,328	20	1,328		9,311	11
12	Allocated from Extended Care Consulting, 2201 Main LLC	2005	722	77	20	77		337	12
13	Allocated from Extended Care Consulting, 2201 Main LLC	2009	130	7	20	7		13	13
14									14
15									15
16	Allocated from Extended Care Consulting, LLC	2007	151	8	20	8		30	16
17	Allocated from Extended Care Consulting, LLC	2009	90	5	20	5		9	17
18	Allocated from Extended Care Consulting, LLC	2010	884	44	20	44		44	18
19									19
20	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	1,359	124	20	124		870	20
21	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2003	1,601	146	20	146		1,026	21
22	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2005	80	8	20	8		37	22
23	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2009	14	1	20	1		1	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 Lemont Nursing & Rehab Center # 0046201 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
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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)		$ 48,474	$ 3,300		$ 3,300	$	$ 23,103	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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	$ 117,535	$ 739	$ 15,661	$ 14,922	10	$ 80,659	71
72	Current Year Purchases	21,098	48	1,812	1,764	10	1,812	72
73	Fully Depreciated Assets	358,044				10	358,044	73
74								74
75	TOTALS	$ 496,677	$ 787	$ 17,473	$ 16,686		$ 440,515	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	$ 1,832	$ 366	$ 366	$	5	$ 855	76
77		Alloc. From ECC	2010	10,539	165	165		5	10,209	77
78										78
79										79
80	TOTALS			$ 12,371	$ 531	$ 531	$		$ 11,064	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)	$ 7,120,442	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 178,473	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 284,887	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 106,414	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,895,267	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 Lemont Nursing & Rehab Center # 0046201 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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Extended Care Consulting.				1,034			5
6								6
7	TOTAL				$ 1,034 **			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: $ 17,788 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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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 Lemont Nursing & Rehab Center # 0046201 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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 651,435	$		$ 651,435	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			125,960			125,960	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			789,825			789,825	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				820,268		820,268	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					77,476	291,374		368,850	13
14	TOTAL			$		$ 1,644,696	$ 1,111,642		$ 2,756,338	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 Lemont Nursing & Rehab Center # 0046201 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	$ 377,221	$ 443,699	1
2	Cash-Patient Deposits	33,195	33,195	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	852,994	852,994	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	391,999	391,999	6
7	Other Prepaid Expenses	9,530	9,530	7
8	Accounts Receivable (owners or related parties)	4,313,845	5,857,501	8
9	Other(specify): See Attached Schedule	3,447,901	3,447,901	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 9,426,685	$ 11,036,819	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		823,094	13
14	Buildings, at Historical Cost		5,590,504	14
15	Leasehold Improvements, at Historical Cost	312,982	312,982	15
16	Equipment, at Historical Cost	229,265	229,265	16
17	Accumulated Depreciation (book methods)	(262,689)	(2,500,760)	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	2,400	17,450	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 281,958	$ 4,472,535	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,708,643	$ 15,509,354	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,701,050	$ 1,701,051	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,690	26,690	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	258,946	258,946	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,889	11,889	31
32	Accrued Real Estate Taxes(Sch.IX-B)	359,003	359,003	32
33	Accrued Interest Payable		21,845	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule		4,482	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,357,578	$ 2,383,906	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		7,696,143	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		178,561	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 7,874,704	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,357,578	$ 10,258,610	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,351,065	$ 5,250,744	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,708,643	$ 15,509,354	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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**	$ 8,597,099	1
2	Restatements (describe):		2
3	**Dividends**	(419,681)	3
4	**Income Adjustment**	(42)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,177,376	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,068,943	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	(2,895,254)	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)**	$ (826,311)	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)**	$ 7,351,065	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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	$ 13,678,474	1
2	Discounts and Allowances for all Levels	(7,120,693)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,557,781	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,172,919	6
7	Oxygen	713	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,173,632	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	1,909	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	826,084	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	146,782	19
20	Radiology and X-Ray	31,360	20
21	Other Medical Services	149,131	21
22	Laundry	5,406	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,160,672	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	139,343	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 139,343	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	32,362	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 32,362	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,063,790	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,499,652	31
32	Health Care	4,380,859	32
33	General Administration	2,177,568	33
	B. Capital Expense		
34	Ownership	958,853	34
	C. Ancillary Expense		
35	Special Cost Centers	2,891,410	35
36	Provider Participation Fee	86,505	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,994,847	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,068,943	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,068,943	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 Lemont Nursing & Rehab Center # 0046201 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	2,059	2,212	$ 100,691	$ 45.52	1
2	Assistant Director of Nursing	1,749	1,967	72,413	36.81	2
3	Registered Nurses	25,458	28,413	936,547	32.96	3
4	Licensed Practical Nurses	32,706	35,771	940,450	26.29	4
5	CNAs & Orderlies	93,350	102,154	1,264,806	12.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,044	13,243	223,598	16.88	8
9	Activity Director	1,931	2,171	41,927	19.31	9
10	Activity Assistants	12,655	13,492	125,474	9.30	10
11	Social Service Workers	9,047	9,940	189,250	19.04	11
12	Dietician	860	881	15,728	17.85	12
13	Food Service Supervisor	1,569	1,760	44,824	25.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,528	8,140	109,782	13.49	15
16	Dishwashers	12,266	13,468	114,800	8.52	16
17	Maintenance Workers	5,558	6,064	112,120	18.49	17
18	Housekeepers	18,617	20,387	188,053	9.22	18
19	Laundry	6,129	6,777	58,512	8.63	19
20	Administrator	1,933	2,136	108,524	50.81	20
21	Assistant Administrator	1,964	2,095	50,670	24.19	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,952	8,594	138,848	16.16	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	2,989	3,436	48,757	14.19	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,713	1,935	29,319	15.15	33
34	TOTAL (lines 1 - 33)	260,077	285,036	$ 4,915,093 *	$ 17.24	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	491	$ 26,435	01-03	35
36	Medical Director	Monthly	39,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,988	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				44
45	Social Service Consultant	18	1,015	12-03	45
46	Other(specify)				46
47	See Attached		6,066		47
48	See Attached		26,549		48
49	TOTAL (lines 35 - 48)	509	$ 107,053		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	286	$ 17,435	10-03	50
51	Licensed Practical Nurses	972	43,957	10-03	51
52	Certified Nurse Assistants/Aides	868	22,174	10-03	52
53	TOTAL (lines 50 - 52)	2,126	$ 83,566		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Wendy Janulis	Administrator		$ 108,524
Lisa Hardaman	Asst. Admin.		50,670
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 159,194

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
Frost, Ruttenberg& Rothblatt	Accounting	$ 25,457
Personnel Planners	Unemployment Consult	4,425
Vision Share	Computer Services	1,756
Paycor	Payroll Services	12,634
E-Health Data Solutions	Billing Program System	3,180
National Datacare Corp	Data Processing	1,593
Extended Care Consulting, Inc	Home Office Expenses	363,253
Extended Care Clinical	Home Office Expenses	91,539
Prospect Resources	Natural Gas Procurement	700
Pinnacle Consulting	Customer Satisfaction Surv	476
See Attached	Legal	31,897
See Supplemetal Schedule		37,376
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 574,286

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 149,762
Unemployment Compensation Insurance	71,101
FICA Taxes	366,208
Employee Health Insurance	90,254
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physical	12,087
Other Employee Welfare	11,062
Holiday Expenses	3,250
TOTAL (agree to Schedule V, line 22, col.8)	$ 703,724

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	$ 2,400
Advertising: Employee Recruitment	11,223
Health Care Worker Background Check	
(Indicate # of checks performed 749)	9,286
Patient Background Checks	
Dues,Subscriptions	3,966
Licenses & Permits	1,174
Alloc from Ext Care Consult.	2,701
Alloc from Ext Care Clinical	152
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,902

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,780
Inservice Expenses	6,770
Alloc from Ext Care Consult	132
Alloc from Ext Care Clinical	1,213
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,895

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

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

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **87,147** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **86,505**
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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

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