FOR BHF USE

LL1

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

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0050732

Facility Name: Avenue Care Nursing & Rehab Center

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 12/22/09

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 01/01/11 to 12/31/11 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) Lisa M. Hanlon, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,575	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,575	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	44,406	640	2,007	47,053	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,406	640	2,007	47,053	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.17%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 02/01/1988

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 155 and days of care provided 1,988

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: 12/31/2011 Fiscal Year: 12/31/2011

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	199,403	41,216	8,843	249,462		249,462	(886)	248,576			1
2	Food Purchase		236,490		236,490		236,490	204	236,694			2
3	Housekeeping	130,830	31,301		162,131		162,131	585	162,716			3
4	Laundry	61,853	12,144		73,997		73,997	(173)	73,824			4
5	Heat and Other Utilities			143,006	143,006		143,006	1,027	144,033			5
6	Maintenance	122,370		170,898	293,268		293,268	(45,458)	247,810			6
7	Other (specify):*							2,576	2,576			7
8	TOTAL General Services	514,456	321,151	322,747	1,158,354		1,158,354	(42,125)	1,116,229			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,918,272	56,378	23,967	1,998,617		1,998,617	35,073	2,033,690			10
10a	Therapy	80,666			80,666		80,666		80,666			10a
11	Activities	83,446	8,694	2,308	94,448		94,448		94,448			11
12	Social Services	155,061	1,739	1,774	158,574		158,574	5,668	164,242			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							9,701	9,701			15
16	TOTAL Health Care and Programs	2,237,445	66,811	46,049	2,350,305		2,350,305	50,442	2,400,747			16
	C. General Administration											
17	Administrative	169,749			169,749		169,749	44,831	214,580			17
18	Directors Fees											18
19	Professional Services			450,889	450,889		450,889	(283,755)	167,134			19
20	Dues, Fees, Subscriptions & Promotions			27,044	27,044		27,044	32	27,076			20
21	Clerical & General Office Expenses	60,550	20,848	451,945	533,343		533,343	(255,621)	277,722			21
22	Employee Benefits & Payroll Taxes			572,992	572,992		572,992	(15,255)	557,737			22
23	Inservice Training & Education											23
24	Travel and Seminar			330	330		330	1,885	2,215			24
25	Other Admin. Staff Transportation			2,240	2,240		2,240	411	2,651			25
26	Insurance-Prop.Liab.Malpractice			88,599	88,599		88,599	688	89,287			26
27	Other (specify):*							27,811	27,811			27
28	TOTAL General Administration	230,299	20,848	1,594,039	1,845,186		1,845,186	(478,973)	1,366,213			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,982,200	408,810	1,962,835	5,353,845		5,353,845	(470,656)	4,883,189			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center #0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			7,232	7,232		7,232	181,342	188,574			30
31	Amortization of Pre-Op. & Org.			617	617		617	(617)				31
32	Interest			33,818	33,818		33,818	5,223	39,041			32
33	Real Estate Taxes							191,717	191,717			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			26,627	26,627		26,627	3,188	29,815			35
36	Other (specify):*											36
37	**TOTAL Ownership**			68,294	68,294		68,294	380,853	449,147			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		131,374	237,957	369,331		369,331	(9,134)	360,197			39
40	Barber and Beauty Shops			129	129		129		129			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			285,616	285,616		285,616		285,616			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		131,374	523,702	655,076		655,076	(9,134)	645,942			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,982,200	540,184	2,554,831	6,077,215		6,077,215	(98,938)	5,978,277			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Refer-ence	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	58,257	30		9
10	Interest and Other Investment Income	(2,340)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,586)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(32)	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	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(326,351)	21		24
25	Fund Raising, Advertising and Promotional	(2,033)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(12,494)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(87,663)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (377,742)		$	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)	278,805		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 278,805		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (98,938)		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

Avenue Care Nursing & Rehab Center

ID# 0050732

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income - Medical Records	$ (25)	10	1
2	Other Income - Hartford Fire Insurance Check	(225)	26	2
3	Patient Clothing	(243)	10	3
4	Collection Expense	(2,476)	21	4
5	Annual Report	(250)	20	5
6	Bldg. Co. - Loan Fee	(3,500)	21	6
7	Annual Corp. Report	(250)	20	7
8	Non-Allowable Legal	(7,079)	19	8
9	Amortization	(617)	31	9
10	Jury Duty	(17)	10	10
11	Additional R&M	2,430	06	11
12	Rental Income - Parking	(9,185)	06	12
13	Capitalized R&M	(47,833)	06	13
14	Prior Year Professional Fee Refund	(15,526)	21	14
15	Back Taxes	(2,867)	21	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(87,663)		49

Avenue Care Nursing & Rehab Center

ID# 0050732

Report Period Beginning: 01/01/11

Ending: 12/31/11

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

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Avenue Care Nursing & Rehab Center **#** 0050732 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			245		6,853		(7,984)					(886)	1
2	Food Purchase	(32)		236									204	2
3	Housekeeping			496		89							585	3
4	Laundry								(173)				(173)	4
5	Heat and Other Utilities			871		156							1,027	5
6	Maintenance	(54,588)		2,501	6,620	32			(23)				(45,458)	6
7	Other (specify):*				1,422	1,154							2,576	7
8	**TOTAL General Services**	(54,620)		4,349	8,042	8,284		(7,984)	(196)				(42,125)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(285)				38,241			(2,883)				35,073	10
10a	Therapy													10a
11	Activities													11
12	Social Services					5,668							5,668	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,391	2,310						9,701	15
16	**TOTAL Health Care and Programs**	(285)				51,300	2,310		(2,883)				50,442	16
	C. General Administration													
17	Administrative			2,613	8,897	33,321							44,831	17
18	Directors Fees													18
19	Professional Services	(7,079)		(219,179)		(57,497)							(283,755)	19
20	Fees, Subscriptions & Promotions	(3,033)		2,925		140							32	20
21	Clerical & General Office Expenses	(367,800)	3,500	10,836	90,949	6,894							(255,621)	21
22	Employee Benefits & Payroll Taxes				(12,945)		(2,310)						(15,255)	22
23	Inservice Training & Education													23
24	Travel and Seminar			162		1,723							1,885	24
25	Other Admin. Staff Transportation			411									411	25
26	Insurance-Prop.Liab.Malpractice	(225)		778		135							688	26
27	Other (specify):*				21,469	6,342							27,811	27
28	**TOTAL General Administration**	(378,137)	3,500	(201,454)	108,370	(8,942)	(2,310)						(478,973)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(433,042)	3,500	(197,105)	116,412	50,642		(7,984)	(3,079)				(470,656)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Avenue Care Nursing & Rehab Center** **#** **0050732** **Report Period Beginning:** **01/01/11** **Ending:** **12/31/11**

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	58,257	113,385	8,411		1,289							181,342	30
31	Amortization of Pre-Op. & Org.	(617)											(617)	31
32	Interest	(2,340)		7,154		409							5,223	32
33	Real Estate Taxes		190,195	1,290		232							191,717	33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles			3,188									3,188	35
36	Other (specify):*													36
37	**TOTAL Ownership**	55,300	303,580	20,043		1,930							380,853	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(1,303)	(346)	(1,108)	(6,278)	(100)	(9,134)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**							(1,303)	(346)	(1,108)	(6,278)	(100)	(9,134)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(377,742)	307,080	(177,062)	116,412	52,572		(9,287)	(3,425)	(1,108)	(6,278)	(100)	(98,938)	45

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Please See Page 6-Supplemental		Please See Page 6-Supplemental		Please See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	33	Real Estate Expense	$	Avenue Associates, LLC	100.00%	$ 190,195	$ 190,195	1
2	V	21	Loan Fee		Avenue Associates, LLC	100.00%	3,500	3,500	2
3	V	30	Depreciation		Avenue Associates, LLC	100.00%	113,385	113,385	3
4	V								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			$			$ 307,080	$ * 307,080	14

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	$ 245	$ 245	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	236	236	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	496	496	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	871	871	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,501	2,501	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,613	2,613	20
21	V	19	Professional Fees	224,155	Extended Care Consulting, LLC	100.00%	4,885	(219,179)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,925	2,925	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	10,836	10,836	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	162	162	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	411	411	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	778	778	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	8,411	8,411	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	7,154	7,154	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,290	1,290	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%			30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	3,188	3,188	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 224,155			$ 47,002	$ * (177,062)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	6,620	$ 6,620	15
16	V	06	Maintenance (Direct)	2,084	Extended Care Consulting, LLC	100.00%	2,084		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,187	1,187	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	235	235	18
19	V	12	Admission (Direct)		Extended Care Consulting, LLC	100.00%			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%	8,897	8,897	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	90,949	90,949	22
23	V	21	Office and Clerical (Direct)	29,317	Extended Care Consulting, LLC	100.00%	29,317		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	17,180	17,180	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,289	4,289	25
26	V	22	Employee Benefits	12,945	Extended Care Consulting, LLC	100.00%		(12,945)	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			$ 44,346			$ 160,758	$ * 116,412	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	$ 89	$ 89	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	156	156	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	32	32	17
18	V	19	Professional Fees	74,688	Extended Care Clinical, LLC	100.00%	17,191	(57,497)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	140	140	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,541	2,541	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,723	1,723	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	135	135	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,289	1,289	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	409	409	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	232	232	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	6,853	6,853	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,154	1,154	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	38,241	38,241	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%			29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	5,668	5,668	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	7,391	7,391	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	33,321	33,321	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	4,353	4,353	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	6,342	6,342	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 74,688			$ 127,260	$ * 52,572	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 / Medical Record Salary	15,473	Extended Care Clinical, LLC	100.00%	15,473		17
18	V	12	Social Service / Admission Salary	1,774	Extended Care Clinical, LLC	100.00%	1,774		18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	2,310	2,310	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	2,310	Extended Care Clinical, LLC	100.00%		(2,310)	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			$ 19,557			$ 19,557	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 16,660	Care Centers Health Systems, Inc.	100.00%	$ 8,676	$ (7,984)	15
16	V	2	Food		Care Centers Health Systems, Inc.	100.00%			16
17	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			17
18	V	39	Ancillary Expense	2,719	Care Centers Health Systems, Inc.	100.00%	1,416	(1,303)	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			$ 19,378			$ 10,092	$ * (9,287)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Xcel Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping		Xcel Supply, LLC	100.00%			16
17	V	4	Laundry	2,855	Xcel Supply, LLC	100.00%	2,682	(173)	17
18	V	6	Repairs & Maintenance	381	Xcel Supply, LLC	100.00%	358	(23)	18
19	V	10	Nursing	47,548	Xcel Supply, LLC	100.00%	44,666	(2,883)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			22
23	V	30	Fixed Assets-Depreciation		Xcel Supply, LLC	100.00%			23
24	V	39	Ancillary	5,711	Xcel Supply, LLC	100.00%	5,365	(346)	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			$ 56,495			$ 53,070	$ * (3,425)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Ventilator Equipment	1,680	Vent Lease LLC	100.00%	572	(1,108)	15
16	V	39	Other Ancillary		Vent Lease LLC	100.00%			16
17	V	35	Matrix Leasing		Vent Lease LLC	100.00%			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	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 56,685	$ 56,685	26
27	V								27
28	V								28
29	V								29
30	V	22	Employee Health Insurance	56,685	CCS Employee Benefits Group	100.00%		(56,685)	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			$ 58,365			$ 57,257	$ * (1,108)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 230,071	TriCare Rehab	100.00%	$ 223,793	$ (6,278)	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			$ 230,071			$ 223,793	$ * (6,278)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	11,129	Reliable Medical of the Midwest, LLC	100.00%	11,030	(100)	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			$ 11,129			$ 11,030	$ * (100)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ROTHNER FAMILY GRANDCHILDREN TRUST	10.000%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	AVENUE ASSOCIATES, LLC	EVANSTON	BUILDING CO.	1
2	ERIC ROTHNER	90.000%	BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKI	2
3			BRIAR PLACE, LTD.	INDIAN HEAD	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPI	4
5			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CCS EMPLOYEE BENEFITS GR	EVANSTON	HEALTH INSURANCE	5
6			DYER NURSING & REHAB	DYER, IN	XCEL MEDICAL SUPPLY	EVANSTON	MEDICAL SUPPLIES	6
7			GRASMERE PLACE, LLC	CHICAGO	TRICARE REHAB	HILLSIDE	THERAPY	7
8			GOLDEN PLAINES	HUTCHINSON, OK	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLY	8
9			HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	9
10			HOMESTEAD NURSING & REAHB	LINCOLN, NE	VENTELEASE< LLC	EVANSTON	VENTALATOR RENT	10
11			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				11
12			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				12
13			LANCASTER MANOR	LINCOLN, NE				13
14			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				14
15			MCKINLEY HEALTH CARE CENTER	CANTON, OH				15
16			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				16
17			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				17
18			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				18
19			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				19
20			RAINBOW BEACH QOC, L.L.C.	CHICAGO				20
21			SEBOS NURSING & REHAB	HOBART, IN				21
22			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				22
23			SNOW VALLEY NURSING AND REHABILITATION CENTER, L.L.C.	LISLE				23
24			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				25
26			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				26
27			WHEATON CARE CENTER, LLC	WHEATON				27
28								28
29								29
30								30

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	G. Matt Silvers	Relative	Administrative	N/A	See Attached	0.18	0.45%	Alloc. Salary	$ 708	17-7	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	3.1	5.64%	Al Sal/Al Fees	10,143	17-7	2
3	Adam Vales	Relative	Clerical	N/A	See Attached	0.42	1.05%	Alloc. Salary	740	22-7	3
4											4
5											5
6											6
7	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered										7
8	allowable by the Il. Dept of HFS.										8
9											9
10											10
11											11
12											12
13								TOTAL	$ 11,591		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	1,332,501	31	$ 6,942	$	47,053	$ 245	1
2	02	Food	Patient Days	1,332,501	31	6,677		47,053	236	2
3	03	Housekeeping	Patient Days	1,332,501	31	14,059		47,053	496	3
4	05	Utilities	Patient Days	1,332,501	31	24,674		47,053	871	4
5	06	Maintenance	Patient Days	1,332,501	31	70,833		47,053	2,501	5
6	17	Administrative	Patient Days	1,332,501	31	74,000		47,053	2,613	6
7	19	Professional Fees	Patient Days	1,332,501	31	138,332		47,053	4,885	7
8	20	Dues and Subscriptions	Patient Days	1,332,501	31	82,842		47,053	2,925	8
9	21	Office and Clerical	Patient Days	1,332,501	31	306,863		47,053	10,836	9
10	24	Seminar and Travel	Patient Days	1,332,501	31	4,580		47,053	162	10
11	25	Other Staff Admin. Trans.	Patient Days	1,332,501	31	11,637		47,053	411	11
12	26	Insurance	Patient Days	1,332,501	31	22,043		47,053	778	12
13	30	Depreciation	Patient Days	1,332,501	31	238,204		47,053	8,411	13
14	32	Interest	Patient Days	1,332,501	31	202,602		47,053	7,154	14
15	33	Real Estate Taxes	Patient Days	1,332,501	31	36,524		47,053	1,290	15
16	34	Rent - Building	Patient Days	1,332,501	31			47,053		16
17	35	Rent - Equipment & Auto	Patient Days	1,332,501	31	90,286		47,053	3,188	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,331,096	$		$ 47,002	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	1,332,501	31	187,474	187,474	47,053	6,620	1
2	06	Maintenance (Direct)	Direct		31	122,603	122,603		2,084	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,332,501	31	33,619		47,053	1,187	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	16,441			235	4
5	12	Admission (Direct)	Direct		31					5
6	15	Emp. Ben. - Nursing (Direct)	Direct		31					6
7	17	Administrative (Pooled)	Patient Days	1,332,501	31	251,959	251,959	47,053	8,897	7
8	21	Office and Clerical (Pooled)	Patient Days	1,332,501	31	2,575,611	2,575,611	47,053	90,949	8
9	21	Office and Clerical (Direct)	Direct		31	545,076	545,076		29,317	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,332,501	31	486,522		47,053	17,180	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	78,893			4,289	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					$ 4,298,198	$ 3,682,723		$ 160,758	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	817,528	19	$ 1,549	$	47,053	$ 89	1
2	05	Utilities	Patient Days	817,528	19	2,718		47,053	156	2
3	06	Maintenance	Patient Days	817,528	19	557		47,053	32	3
4	19	Professional Fees	Patient Days	817,528	19	298,695		47,053	17,191	4
5	20	Dues and Subscriptions	Patient Days	817,528	19	2,426		47,053	140	5
6	21	Office & Clerical	Patient Days	817,528	19	44,146		47,053	2,541	6
7	24	Travel and Seminar	Patient Days	817,528	19	29,934		47,053	1,723	7
8	26	Insurance	Patient Days	817,528	19	2,346		47,053	135	8
9	30	Depreciation	Patient Days	817,528	19	22,389		47,053	1,289	9
10	32	Interest	Patient Days	817,528	19	7,100		47,053	409	10
11	33	Real Estate Taxes	Patient Days	817,528	19	4,024		47,053	232	11
12	01	Dietary Salary	Patient Days	817,528	19	119,073	119,073	47,053	6,853	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	817,528	19	20,044		47,053	1,154	13
14	10	Nursing Salary	Patient Days	817,528	19	664,429	664,429	47,053	38,241	14
15	10a	Rehab Salary	Patient Days	817,528	19			47,053		15
16	12	Social Service Salary	Patient Days	817,528	19	98,474	98,474	47,053	5,668	16
17	15	Emp. Ben. - Healthcare	Patient Days	817,528	19	128,421		47,053	7,391	17
18	17	Administration Salary	Patient Days	817,528	19	578,938	578,938	47,053	33,321	18
19	21	Office Salary	Patient Days	817,528	19	75,625	75,625	47,053	4,353	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	817,528	19	110,184		47,053	6,342	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,211,073	$ 1,536,540		$ 127,260	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$		$	1
2	07	Emp. Ben. - General	Direct Allocation							2
3	10	Nursing / Medical Record Salary	Direct Allocation			344,209	344,209		15,473	3
4	12	Social Service / Admission Salary	Direct Allocation			174,668	174,668		1,774	4
5	15	Emp. Ben. - Healthcare	Direct Allocation			61,656			2,310	5
6	17	Administration Salary	Direct Allocation							6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation							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					$ 580,533	$ 518,877		$ 19,557	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$		$ 8,676	1
2	2	Food	Direct Allocation							2
3	10	Nursing Supplies	Direct Allocation							3
4	39	Ancillary Expense	Direct Allocation						1,416	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					$	$		$ 10,092	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			$	$		$	1
2	3	Housekeeping	Direct Allocation							2
3	4	Laundry	Direct Allocation						2,682	3
4	6	Repairs & Maintenance	Direct Allocation						358	4
5	10	Nursing	Direct Allocation						44,666	5
6	11	Activities	Direct Allocation							6
7	21	Office And Clerical	Direct Allocation							7
8	22	Employee Benefits	Direct Allocation							8
9	30	Fixed Assets-Depreciation	Direct Allocation							9
10	39	Ancillary	Direct Allocation						5,365	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					$	$		$ 53,070	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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: Vent Lease, LLC / CCS Employee Ben. Group, In
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180 / (847)905-4000
Fax Number: (847) 673-7741 / (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ventilator Equipment	Direct Allocation						572	1
2	39	Other Ancillary	Direct Allocation							2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12	22	Employee Health Insurance	Direct Allocation			$	$		$ 56,685	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					$	$		$ 57,257	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$		$ 223,793	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					$	$		$ 223,793	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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						11,030	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					$	$		$ 11,030	25

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Pacific Mutual		X	Mortgage		12/95	$ 4,657,452	$ 3,540,289			$	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	First Bank/HFG		X	LOC							27,208	6
7	Medicare Interest		X								6,610	7
8	See Supplemental Schedule										7,563	8
9	TOTAL Facility Related						$ 4,657,452	$ 3,540,289			$ 41,381	9
	B. Non-Facility Related*											
10	National Government		X	Late Fees							(2)	10
11	HFG Interest										(2,338)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (2,340)	14
15	TOTALS (line 9+line14)						$ 4,657,452	$ 3,540,289			$ 39,041	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Alloc. from Ext. Care Conslt.		X				$	$			$ 7,154	8
9	Alloc. from Ext. Care Clinical		X								409	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										7,563	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 169,029	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.)		$ 176,754	2
3. Under or (over) accrual (line 2 minus line 1).		$ 7,725	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 183,993	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.		$ 191,718	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	174,753	8
	2007	172,887	9
	2008	174,622	10
	2009	167,921	11
	2010	175,232	12

Beginning Accrual Adjusted
2011 Accrual =2010 R/E Tax=$175,232 x 1.05 = $183,993
Alloc from Extended Care Consulting 2201 Main LLC $1,290
Alloc from Extended Care Clinical 2201 Main LLC $232

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avenue Care Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050732

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-02-312-001-0000	Nursing Home	$ 175,231.66	$ 175,231.66
2.	See Attached	Alloc From 2201 Main	$ 126,481.18	$ 2,123.90
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 301,712.84	$ 177,355.56

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avenue Care Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050732

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	51,736	1995	$ 100,000	1
2	Allocated from ECConsulting/ECClinical 2201 Main LLC			13,770	2
3	TOTALS	51,736		$ 113,770	3

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	155			1970	$ 4,046,250	$ 113,385	39	$ 103,746	$ (9,639)	$ 1,750,855	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1988	5,400		20	216	216	5,094	9
10	Various			1989	1,035		20			1,035	10
11	Various			1990	5,400		20			5,400	11
12	Various			1991	14,414		20	354	354	14,414	12
13	Various			1992	40,065		20	1,288	1,288	26,297	13
14	Various			1993	17,484		20	431	431	9,999	14
15	Various			1994	25,290		20	882	882	15,503	15
16	Various			1995	48,214		20	1,144	1,144	22,238	16
17	Various			1996	14,555		20	373	373	5,743	17
18	Various			1997	81,665		20	2,094	2,094	30,348	18
19	Various			1998	77,656		20	4,170	4,170	56,389	19
20	Various			1999	57,028		20	1,462	1,462	18,335	20
21	Various			2000	13,093		20	476	476	5,307	21
22	Various			2001	75,231		20	3,225	3,225	34,956	22
23	Various			2002	3,877		20	141	141	1,361	23
24	Various			2003	28,341		20	1,099	1,099	9,413	24
25	Various			2004	16,990		20	618	618	4,415	25
26	Various			2005	15,280		20	1,727	1,727	8,237	26
27	Various			2006	76,699		20	3,704	3,704	21,308	27
28	Various			2007	400,627		20	15,693	15,693	83,100	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)								67
68	Related Party Allocations (Pages 12H & 12I)		55,761	3,790		3,790		30,235	68
69	Financial Statement Depreciation			7,232			(7,232)		69
70	TOTAL (lines 4 thru 69)		$ 5,120,355	$ 124,407		$ 146,633	$ 22,226	$ 2,159,982	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 5,120,355	$ 124,407		$ 146,633	$ 22,226	$ 2,159,982	1
2	Install New Elevator Traveling Cables	2008	3,320		20	121	121	469	2
3	New Circuits & Outlets	2008	3,500		20	127	127	418	3
4	Toilets,Sink,Faucets,Locks,Tile,Plumbing,Paint,Dry Wall,Electric	2008	51,225		20	1,863	1,863	6,598	4
5	New Piping & Drain System - 1St & 2Nd Floor	2008	22,975		20	835	835	2,957	5
6	Passenger Elevator - Changed Seals & Packing	2008	4,863		20	177	177	627	6
7	Replaced Car Sills In Freight Elevator	2008	6,400		20	233	233	709	7
8	Installed & Programed Elevator Phone	2009	10,271		20	514	514	1,322	8
9	Fire Alarm Panel Replacement	2009	26,447		20	1,322	1,322	3,326	9
10	Replaced Cable, Adjust Elevator Door Operator	2009	3,534		20	177	177	434	10
11	Wall Air Conditioners	2009	3,659		20	183	183	2,560	11
12	Installed Fire Dampers	2009	3,367		20	168	168	393	12
13	Installed 5 Ton A/C Condensing Unit	2009	2,455		20	123	123	1,720	13
14	Tuckpointing	2009	5,850		20	150	150	306	14
15	Elevator	2010	4,800		20	240	240	480	15
16	Water Cooler Dispensor	2010	4,222		20	422	422	2,850	16
17	Sprinklers	2010	3,640		20	182	182	303	17
18	Windows Treatments	2010	11,507		20	575	575	815	18
19	Ac	2010	4,289		20	357	357	477	19
20	Annunciator	2011	3,184		20	584	584	584	20
21	Smoke Room Fan	2011	2,500		20	375	375	375	21
22	Elevator Valve & Hydraulic Oil	2011	9,775		20	81	81	81	22
23	Plumbing 9 Bath Tubs & 3 Showers	2011	29,090		20	1,455	1,455	1,455	23
24	Painting Labor	2011	11,031		20	552	552	552	24
25	Painting Labor	2011	7,712		20	386	386	386	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,359,972	$ 124,407		$ 157,834	$ 33,427	$ 2,190,177	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 5,359,972	$ 124,407		$ 157,834	$ 33,427	$ 2,190,177	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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21									21
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)		$ 5,359,972	$ 124,407		$ 157,834	$ 33,427	$ 2,190,177	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 5,359,972	$ 124,407		$ 157,834	$ 33,427	$ 2,190,177	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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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,359,972	$ 124,407		$ 157,834	$ 33,427	$ 2,190,177	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 5,359,972	$ 124,407		$ 157,834	$ 33,427	$ 2,190,177	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,359,972	$ 124,407		$ 157,834	$ 33,427	$ 2,190,177	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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
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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)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 Consulting, 2201 Main LLC	2002	16,087	412	39	412		3,833	3
4	Allocated from Extended Care Clinical, 2201 Main LLC	2002	2,889	74	39	74		688	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, 2201 Main LLC	2002	13,289	1,214	20	1,214		9,727	9
10	Allocated from Extended Care Consulting, 2201 Main LLC	2003	15,660	1,431	20	1,431		11,463	10
11	Allocated from Extended Care Consulting, 2201 Main LLC	2005	778	83	20	83		446	11
12	Allocated from Extended Care Consulting, 2201 Main LLC	2009	140	7	20	7		21	12
13									13
14									14
15	Allocated from Extended Care Consulting, LLC	2007	162	8	20	8		41	15
16	Allocated from Extended Care Consulting, LLC	2009	97	5	20	5		15	16
17	Allocated from Extended Care Consulting, LLC	2010	953	48	20	48		95	17
18	Allocated from Extended Care Consulting, LLC	2011	343	17	20	17		17	18
19									19
20									20
21	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	2,386	218	20	218		1,747	21
22	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2003	2,812	257	20	257		2,058	22
23	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2005	140	15	20	15		80	23
24	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2009	25	1	20	1		4	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 55,761	$ 3,790		$ 3,790	$	$ 30,235	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 271,321	$ 5,077	$ 28,060	$ 22,983	10	$ 197,549	71
72	Current Year Purchases	16,448	12	1,858	1,846	10	1,858	72
73	Fully Depreciated Assets	405,054				10	405,054	73
74								74
75	TOTALS	$ 692,823	$ 5,089	$ 29,918	$ 24,829		$ 604,461	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Alloc. From EC Clinical	2011	$ 3,217	$ 643	$ 643	$	5	$ 2,145	76
77		Alloc. From ECC	2011	11,355	177	177		5	11,178	77
78										78
79										79
80	TOTALS			$ 14,572	$ 820	$ 820	$		$ 13,323	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,181,136	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 130,316	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 188,573	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 58,257	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,807,962	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			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.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 21,734 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2006 Ford E35C	$ 626.25	$ 8,081	17
18	Administrative	2006 Buick	756.16		18
19					19
20					20
21	TOTAL		$ 1,382.41	$ 8,081	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$		$ 108,754	$		$ 108,754	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			21,663			21,663	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			99,654			99,654	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				100,090		100,090	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					7,886	31,284		39,170	13
14	TOTAL			$		$ 237,957	$ 131,374		$ 369,331	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Avenue Care Nursing & Rehab Center **#** 0050732 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/11 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 4,164	1
2	Cash-Patient Deposits	52,354	52,354	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,369,461	1,369,461	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	236,191	236,191	6
7	Other Prepaid Expenses	5,393	5,393	7
8	Accounts Receivable (owners or related parties)	393,872	393,872	8
9	Other(specify): See Attached Schedule	731,709	894,489	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,788,980	$ 2,955,924	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		4,046,250	14
15	Leasehold Improvements, at Historical Cost	39,791	39,791	15
16	Equipment, at Historical Cost	31,365	186,365	16
17	Accumulated Depreciation (book methods)	(10,392)	(3,006,927)	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	7,500	7,500	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 68,264	$ 1,372,979	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,857,244	$ 4,328,903	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,859,640	$ 1,859,639	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,863	29,863	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	129,649	129,649	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,096	4,096	31
32	Accrued Real Estate Taxes(Sch.IX-B)	176,317	183,993	32
33	Accrued Interest Payable		157,863	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	185,234	665,751	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,384,799	$ 3,030,854	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,540,289	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,540,289	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,384,799	$ 6,571,143	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 472,445	$ (2,242,240)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,857,244	$ 4,328,903	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 79,364	1
2	Restatements (describe):		2
3	**Bad Debt**	(100,000)	3
4	**Depreciation**	(2,495)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (23,131)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	495,576	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 495,576	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)**	$ 472,445	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,441,446	1
2	Discounts and Allowances for all Levels	(866,452)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,574,994	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	871,956	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 871,956	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	9,185	16
17	Sale of Drugs	71,898	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,644	19
20	Radiology and X-Ray		20
21	Other Medical Services	659	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 84,386	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,340	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,340	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	39,115	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 39,115	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,572,791	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,158,354	31
32	Health Care	2,350,305	32
33	General Administration	1,845,186	33
	B. Capital Expense		
34	Ownership	68,294	34
	C. Ancillary Expense		
35	Special Cost Centers	369,460	35
36	Provider Participation Fee	285,616	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,077,215	40
41	**Income before Income Taxes (line 30 minus line 40)****	495,576	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 495,576	43

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

****** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

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

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

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,525	1,612	$ 67,454	$ 41.84	1
2	Assistant Director of Nursing	1,707	1,821	62,893	34.54	2
3	Registered Nurses	8,519	9,698	277,895	28.65	3
4	Licensed Practical Nurses	31,717	33,860	812,083	23.98	4
5	CNAs & Orderlies	62,523	67,852	675,928	9.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,992	5,525	80,666	14.60	8
9	Activity Director	1,490	1,755	19,484	11.10	9
10	Activity Assistants	6,831	7,104	63,962	9.00	10
11	Social Service Workers	7,735	8,541	155,061	18.15	11
12	Dietician					12
13	Food Service Supervisor	2,030	2,149	39,269	18.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,666	8,420	78,587	9.33	15
16	Dishwashers	8,535	9,338	81,547	8.73	16
17	Maintenance Workers	10,207	10,800	122,370	11.33	17
18	Housekeepers	13,929	14,905	130,830	8.78	18
19	Laundry	5,248	5,774	61,853	10.71	19
20	Administrator	2,034	2,171	104,779	48.27	20
21	Assistant Administrator	1,794	2,007	64,970	32.37	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,877	4,261	60,550	14.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,687	1,823	22,019	12.08	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	184,045	199,417	$ 2,982,200 *	$ 14.95	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	177	$ 8,843	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,494	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	2,308	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	Please See Attached		17,246		48
49	TOTAL (lines 35 - 48)	221	$ 54,891		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joeann Brew	Administrator	0	$ 104,779
Mila J Jeffery	Asst. Administrator	0	64,970
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 169,749

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	$ 53,968
Personnel Planners	Unemployment Consult.	4,435
Ext. Care Consulting	Home Office Expenses	224,064
Ext. Care Clinical	Other Professional Fees	74,688
National Datacare Corp	Data Processing	5,974
Paycor	Payroll Processing	10,528
eHealth Data Solutions	MDS Software	6,566
Medifax	Software	335
See Attached	Legal	12,819
Denise Carnes	Accounting	900
Nebo Systems	Software	104
See Supplemetal Schedule		56,509
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 450,890

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 82,511
Unemployment Compensation Insurance	97,357
FICA Taxes	225,922
Employee Health Insurance	117,910
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physical	216
Pension Expenses	24,605
Other Employee Welfare	6,072
Chicago City Tax	3,144
TOTAL (agree to Schedule V, line 22, col.8)	$ 557,737

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 487)	10,281
Patient Background Checks	
Dues & Subscription	12,173
Licenses & Fees	1,557
Alloc from Ext Care Consult.	2,925
Alloc from Ext Care Clinical	140
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,076

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	330
Alloc from Ext Care Consult	162
Alloc from Ext Care Clinical	1,723
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,215

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center # 0050732 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Paint/Decorating	07/06	$ 8,150	3Yrs	$ 2,716	$ 2,716	$ 1,359	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 8,150		$ 2,716	$ 2,716	$ 1,359	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nursing & Rehab Center **#** 0050732 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $11,963**

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **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. $ **308** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **285,616**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.

SEE ACCOUNTANTS' COMPILATION REPORT