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: 0046201

Facility Name: Lemont Nursing & Rehab Center, Llc

Address: 12450 Walker Road (Number) Lemont (City) 60439 (Zip Code)

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 02/01/03

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 Lemont Nursing & Rehab Center, Llc # 0046201 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	158	Skilled (SNF)	158	57,670	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	158	TOTALS	158	57,670	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,354	10,009	17,782	50,145	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,354	10,009	17,782	50,145	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.95%

D. How many bed-hold days during this year were paid by the Department?
5 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 02/01/2003

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 158 and days of care provided 17,278

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: 12/31/11 Fiscal Year: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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	308,993	69,020	15,889	393,902		393,902	7,286	401,188			1
2	Food Purchase		304,358		304,358		304,358	(357)	304,001			2
3	Housekeeping	201,406	48,906		250,312		250,312	(1,963)	248,349			3
4	Laundry	53,635	30,407		84,042		84,042	(1,273)	82,769			4
5	Heat and Other Utilities			162,634	162,634		162,634	1,096	163,730			5
6	Maintenance	119,226		276,571	395,797		395,797	(30,525)	365,272			6
7	Other (specify):*							3,154	3,154			7
8	TOTAL General Services	683,260	452,691	455,094	1,591,045		1,591,045	(22,582)	1,568,463			8
	B. Health Care and Programs											
9	Medical Director			39,000	39,000		39,000		39,000			9
10	Nursing and Medical Records	3,329,700	184,838	197,695	3,712,233		3,712,233	20,852	3,733,085			10
10a	Therapy	237,891			237,891		237,891		237,891			10a
11	Activities	170,174	39,398		209,572		209,572		209,572			11
12	Social Services	214,119	394	294	214,807		214,807	6,040	220,847			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							9,186	9,186			15
16	TOTAL Health Care and Programs	3,951,884	224,630	236,989	4,413,503		4,413,503	36,078	4,449,581			16
	C. General Administration											
17	Administrative	169,659			169,659		169,659	47,778	217,437			17
18	Directors Fees											18
19	Professional Services			826,305	826,305		826,305	(671,214)	155,091			19
20	Dues, Fees, Subscriptions & Promotions			53,466	53,466		53,466	(5,931)	47,535			20
21	Clerical & General Office Expenses	141,944	39,987	111,263	293,194		293,194	100,120	393,314			21
22	Employee Benefits & Payroll Taxes			834,037	834,037		834,037	(12,867)	821,170			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,042	4,042		4,042	2,008	6,050			24
25	Other Admin. Staff Transportation			1,780	1,780		1,780	438	2,218			25
26	Insurance-Prop.Liab.Malpractice			219,409	219,409		219,409	974	220,383			26
27	Other (specify):*							26,818	26,818			27
28	TOTAL General Administration	311,603	39,987	2,050,302	2,401,892		2,401,892	(511,876)	1,890,016			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,946,747	717,308	2,742,385	8,406,440		8,406,440	(498,380)	7,908,060			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc #0046201 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			62,150	62,150		62,150	246,482	308,632			30
31	Amortization of Pre-Op. & Org.							(0)	(0)			31
32	Interest							739,338	739,338			32
33	Real Estate Taxes			364,493	364,493		364,493	1,621	366,114			33
34	Rent-Facility & Grounds			519,030	519,030		519,030	(519,030)				34
35	Rent-Equipment & Vehicles			10,798	10,798		10,798	(1,409)	9,389			35
36	Other (specify):*											36
37	TOTAL Ownership			956,471	956,471		956,471	467,001	1,423,472			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,070,857	1,739,525	2,810,382		2,810,382	(201,638)	2,608,744			39
40	Barber and Beauty Shops			740	740		740	(740)	1			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			241,448	241,448		241,448		241,448			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,070,857	1,981,713	3,052,570		3,052,570	(202,377)	2,850,193			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,946,747	1,788,165	5,680,569	12,415,481		12,415,481	(233,756)	12,181,725			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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	100,147	30		9
10	Interest and Other Investment Income	(24,987)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(608)	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	(750)	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	(6,643)	21		24
25	Fund Raising, Advertising and Promotional	(8,448)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(263,595)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (204,884)		$	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)	(28,872)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (28,872)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (233,756)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lemont Nursing & Rehab Center, Llc

ID# 0046201

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Additional R&M	$ 5,703	6	1
2	Capitalized R&M	(45,974)	6	2
3	Misc. Income - Misc. Office Rev	(17)	21	3
4	Theft Loss	(865)	21	4
5	Non-allowable Legal Expenses	(143,277)	19	5
6	Barber and Beauty Shop	(740)	40	6
7	Patient Clothing	(2,992)	10	7
8	Collection Expense	(2,823)	21	8
9	Non-Allowable Expense	(5,303)	21	9
10	Non-allowable Professional Expenses	(520)	19	10
11	Jury Duty	(49)	21	11
12	Bldg Co. - Amortization	(22,879)	31	12
13	Bldg Co. - Legal	(760)	19	13
14	Bldg Co. - Bank Charges	(1,949)	21	14
15	Bldg Co. - Filing Fees	(250)	20	15
16	Bldg Co. - Loan Fee	(40,000)	21	16
17	Professional Fee Refund	(900)	19	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**	(263,595)		49

Lemont Nursing & Rehab Center, Llc

ID# 0046201

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 Lemont Nursing & Rehab Center, Llc # 0046201 **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			261		7,304		(265)	(14)				7,286	1
2	Food Purchase	(608)		251									(357)	2
3	Housekeeping			529		95			(2,587)				(1,963)	3
4	Laundry								(1,273)				(1,273)	4
5	Heat and Other Utilities			929		167							1,096	5
6	Maintenance	(40,271)		2,666	7,055	34						(9)	(30,525)	6
7	Other (specify):*				1,925	1,229							3,154	7
8	**TOTAL General Services**	(40,879)		4,636	8,980	8,829		(265)	(3,874)			(9)	(22,582)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,992)				40,754		(10,464)	(6,446)				20,852	10
10a	Therapy													10a
11	Activities													11
12	Social Services					6,040							6,040	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,877	1,309						9,186	15
16	**TOTAL Health Care and Programs**	(2,992)				54,671	1,309	(10,464)	(6,446)				36,078	16
	C. General Administration													
17	Administrative			2,785	9,482	35,511							47,778	17
18	Directors Fees													18
19	Professional Services	(145,457)	760	(407,330)		(119,187)							(671,214)	19
20	Fees, Subscriptions & Promotions	(9,448)	250	3,118		149							(5,931)	20
21	Clerical & General Office Expenses	(57,649)	41,949	11,548	96,926	7,347			(1)				100,120	21
22	Employee Benefits & Payroll Taxes				(11,428)		(1,309)		(130)				(12,867)	22
23	Inservice Training & Education													23
24	Travel and Seminar			172		1,836							2,008	24
25	Other Admin. Staff Transportation			438									438	25
26	Insurance-Prop.Liab.Malpractice			830		144							974	26
27	Other (specify):*				20,060	6,758							26,818	27
28	**TOTAL General Administration**	(212,555)	42,959	(388,439)	115,040	(67,442)	(1,309)		(130)				(511,876)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(256,425)	42,959	(383,803)	124,020	(3,942)		(10,729)	(10,450)			(9)	(498,380)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Lemont Nursing & Rehab Center, Llc** **#** **0046201** **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	100,147	138,266	8,964		1,373			(2,268)				246,482	30
31	Amortization of Pre-Op. & Org.	(22,879)	22,879										(0)	31
32	Interest	(24,987)	756,265	7,624		436							739,338	32
33	Real Estate Taxes			1,374		247							1,621	33
34	Rent-Facility & Grounds		(519,030)										(519,030)	34
35	Rent-Equipment & Vehicles			3,398						(4,807)			(1,409)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	52,281	398,380	21,360		2,056			(2,268)	(4,807)			467,001	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(2,126)	(6,757)	(18,947)	(173,318)	(490)	(201,638)	39
40	Barber and Beauty Shops	(740)											(740)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(740)						(2,126)	(6,757)	(18,947)	(173,318)	(490)	(202,377)	44
45	**GRAND TOTAL COST** **(sum of lines 29, 37 & 44)**	(204,884)	441,339	(362,443)	124,020	(1,886)		(12,855)	(19,476)	(23,754)	(173,318)	(499)	(233,756)	45

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 519,030	Lemont Property, LLC	100.00%	$	$ (519,030)	1
2	V	33	Real Estate Tax Expense	364,493	Lemont Property, LLC	100.00%	364,493		2
3	V	30	Depreciation Expense		Lemont Property, LLC	100.00%	138,266	138,266	3
4	V	32	Interest Expenses- Business Partners		Lemont Property, LLC	100.00%	756,265	756,265	4
5	V	31	Amortization		Lemont Property, LLC	100.00%	22,879	22,879	5
6	V	19	Legal		Lemont Property, LLC	100.00%	760	760	6
7	V	21	Bank Charges		Lemont Property, LLC	100.00%	1,949	1,949	7
8	V	20	Filing Fees		Lemont Property, LLC	100.00%	250	250	8
9	V	21	Loan Fee		Lemont Property, LLC	100.00%	40,000	40,000	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 883,523			$ 1,324,862	$ * 441,339	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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%	$ 261	$ 261	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	251	251	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	529	529	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	929	929	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,666	2,666	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,785	2,785	20
21	V	19	Professional Fees	415,145	Extended Care Consulting, LLC	100.00%	5,206	(407,330)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,118	3,118	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	11,548	11,548	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	172	172	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	438	438	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	830	830	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	8,964	8,964	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	7,624	7,624	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,374	1,374	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%	3,398	3,398	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 415,145			$ 50,093	$ * (362,443)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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%	7,055	$ 7,055	15
16	V	06	Maintenance (Direct)	3,603	Extended Care Consulting, LLC	100.00%	3,603		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,265	1,265	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	660	660	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%	9,482	9,482	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	96,926	96,926	22
23	V	21	Office and Clerical (Direct)	14,298	Extended Care Consulting, LLC	100.00%	14,298		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	18,309	18,309	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,751	1,751	25
26	V	22	Employee Benefits	11,428	Extended Care Consulting, LLC	100.00%		(11,428)	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			$ 29,329			$ 153,349	$ * 124,020	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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%	$ 95	$ 95	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	167	167	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	34	34	17
18	V	19	Professional Fees	137,508	Extended Care Clinical, LLC	100.00%	18,321	(119,187)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	149	149	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,708	2,708	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,836	1,836	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	144	144	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,373	1,373	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	436	436	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	247	247	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	7,304	7,304	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,229	1,229	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	40,754	40,754	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%	6,040	6,040	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	7,877	7,877	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	35,511	35,511	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	4,639	4,639	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	6,758	6,758	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 137,508			$ 135,622	$ * (1,886)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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	12,901	Extended Care Clinical, LLC	100.00%	12,901		17
18	V	12	Social Service / Admission Salary	294	Extended Care Clinical, LLC	100.00%	294		18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	1,309	1,309	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	1,309	Extended Care Clinical, LLC	100.00%		(1,309)	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			$ 14,504			$ 14,504	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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	$ 554	Care Centers Health Systems, Inc.	100.00%	$ 288	$ (265)	15
16	V	2	Food		Care Centers Health Systems, Inc.	100.00%			16
17	V	10	Nursing Supplies	21,834	Care Centers Health Systems, Inc.	100.00%	11,370	(10,464)	17
18	V	39	Ancillary Expense	4,436	Care Centers Health Systems, Inc.	100.00%	2,310	(2,126)	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			$ 26,823			$ 13,969	$ * (12,855)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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	$ 233	Xcel Supply, LLC	100.00%	$ 219	$ (14)	15
16	V	3	Housekeeping	42,669	Xcel Supply, LLC	100.00%	40,082	(2,587)	16
17	V	4	Laundry	21,000	Xcel Supply, LLC	100.00%	19,726	(1,273)	17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	106,331	Xcel Supply, LLC	100.00%	99,885	(6,446)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical	14	Xcel Supply, LLC	100.00%	13	(1)	21
22	V	22	Employee Benefits	2,137	Xcel Supply, LLC	100.00%	2,007	(130)	22
23	V	30	Fixed Assets-Depreciation	37,418	Xcel Supply, LLC	100.00%	35,149	(2,268)	23
24	V	39	Ancillary	111,459	Xcel Supply, LLC	100.00%	104,702	(6,757)	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			$ 321,259			$ 301,784	$ * (19,476)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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	28,740	Vent Lease LLC	100.00%	9,793	(18,947)	15
16	V	39	Other Ancillary		Vent Lease LLC	100.00%			16
17	V	35	Matrix Leasing	4,807	Vent Lease LLC	100.00%		(4,807)	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	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 180,956	$ 180,956	27
28	V								28
29	V								29
30	V								30
31	V	22	Employee Health Insurance	180,956	CCS Employee Benefits Group	100.00%		(180,956)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 214,503			$ 190,749	$ * (23,754)	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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	$ 1,664,975	TriCare Rehab	100.00%	$ 1,491,657	$ (173,318)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,664,975			$ 1,491,657	$ * (173,318)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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	$ 1,004	Reliable Medical of the Midwest, LLC	100.00%	$ 995	$ (9)	15
16	V	10	Nursing Supplies		Reliable Medical of the Midwest, LLC	100.00%			16
17	V	39	Ancillary Expense	54,823	Reliable Medical of the Midwest, LLC	100.00%	54,333	(490)	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			$ 55,827			$ 55,328	$ * (499)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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	ERIC ROTHNER	1.000%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	LEMONT PROPERTY, LLC		BUILDING CO.	1
2	ROTHNER HEALTH VENTURES G II, LLC	99.000%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKI	2
3			BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4			BRIAR PLACE, LTD.	INDIAN HEAD	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPI	4
5			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	CCS EMPLOYEE BENEFITS GR	EVANSTON	HEALTH INSURANCE	5
6			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	XCEL MEDICAL SUPPLY	EVANSTON	MEDICAL SUPPLIES	6
7			DYER NURSING & REHAB	DYER, IN	VENTLEASE, LLC	EVANSTON	VENTALATOR RENTAL	7
8			GRASMERE PLACE, LLC	CHICAGO	TRICARE REHAB	HILLSIDE	THERAPY	8
9			GOLDEN PLAINES	HUTCHINSON, OK	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLY	9
10			HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	10
11			HOMESTEAD NURSING & REAHB	LINCOLN, NE				11
12			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				12
13			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				13
14			LANCASTER MANOR	LINCOLN, NE				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	HOLBART, 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 Lemont Nursing & Rehab Center, Llc # 0046201 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 Lemont Nursing & Rehab Center, Llc # 0046201 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: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Mark Steinberg	Relative	Administrative	N/A	See Attached	3.30	6.00%	Alloc. Salary	$ 10,810	17-7	1
2	Adam Vales	Relative	Clerical	N/A	See Attached	1.33	3.33%	Alloc. Salary	2,361	22-7	2
3	G. Matt Silvers	Relative	Administrative	N/A	See Attached	1.02	2.55%	Alloc. Salary	4,028	17-7	3
4											4
5											5
6	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered										6
7	allowable by the Il. Dept of HFS.										7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 17,199		13

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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 Lemont Nursing & Rehab Center, Llc # 0046201 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	$	50,145	$ 261	1
2	02	Food	Patient Days	1,332,501	31	6,677		50,145	251	2
3	03	Housekeeping	Patient Days	1,332,501	31	14,059		50,145	529	3
4	05	Utilities	Patient Days	1,332,501	31	24,674		50,145	929	4
5	06	Maintenance	Patient Days	1,332,501	31	70,833		50,145	2,666	5
6	17	Administrative	Patient Days	1,332,501	31	74,000		50,145	2,785	6
7	19	Professional Fees	Patient Days	1,332,501	31	138,332		50,145	5,206	7
8	20	Dues and Subscriptions	Patient Days	1,332,501	31	82,842		50,145	3,118	8
9	21	Office and Clerical	Patient Days	1,332,501	31	306,863		50,145	11,548	9
10	24	Seminar and Travel	Patient Days	1,332,501	31	4,580		50,145	172	10
11	25	Other Staff Admin. Trans.	Patient Days	1,332,501	31	11,637		50,145	438	11
12	26	Insurance	Patient Days	1,332,501	31	22,043		50,145	830	12
13	30	Depreciation	Patient Days	1,332,501	31	238,204		50,145	8,964	13
14	32	Interest	Patient Days	1,332,501	31	202,602		50,145	7,624	14
15	33	Real Estate Taxes	Patient Days	1,332,501	31	36,524		50,145	1,374	15
16	34	Rent - Building	Patient Days	1,332,501	31			50,145		16
17	35	Rent - Equipment & Auto	Patient Days	1,332,501	31	90,286		50,145	3,398	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,331,096	$		$ 50,093	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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	50,145	7,055	1
2	06	Maintenance (Direct)	Direct		31	122,603	122,603		3,603	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,332,501	31	33,619		50,145	1,265	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	16,441			660	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	50,145	9,482	7
8	21	Office and Clerical (Pooled)	Patient Days	1,332,501	31	2,575,611	2,575,611	50,145	96,926	8
9	21	Office and Clerical (Direct)	Direct		31	545,076	545,076		14,298	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,332,501	31	486,522		50,145	18,309	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	78,893			1,751	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		$ 153,349	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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	$	50,145	$ 95	1
2	05	Utilities	Patient Days	817,528	19	2,718		50,145	167	2
3	06	Maintenance	Patient Days	817,528	19	557		50,145	34	3
4	19	Professional Fees	Patient Days	817,528	19	298,695		50,145	18,321	4
5	20	Dues and Subscriptions	Patient Days	817,528	19	2,426		50,145	149	5
6	21	Office & Clerical	Patient Days	817,528	19	44,146		50,145	2,708	6
7	24	Travel and Seminar	Patient Days	817,528	19	29,934		50,145	1,836	7
8	26	Insurance	Patient Days	817,528	19	2,346		50,145	144	8
9	30	Depreciation	Patient Days	817,528	19	22,389		50,145	1,373	9
10	32	Interest	Patient Days	817,528	19	7,100		50,145	436	10
11	33	Real Estate Taxes	Patient Days	817,528	19	4,024		50,145	247	11
12	01	Dietary Salary	Patient Days	817,528	19	119,073	119,073	50,145	7,304	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	817,528	19	20,044		50,145	1,229	13
14	10	Nursing Salary	Patient Days	817,528	19	664,429	664,429	50,145	40,754	14
15	10a	Rehab Salary	Patient Days	817,528	19			50,145		15
16	12	Social Service Salary	Patient Days	817,528	19	98,474	98,474	50,145	6,040	16
17	15	Emp. Ben. - Healthcare	Patient Days	817,528	19	128,421		50,145	7,877	17
18	17	Administration Salary	Patient Days	817,528	19	578,938	578,938	50,145	35,511	18
19	21	Office Salary	Patient Days	817,528	19	75,625	75,625	50,145	4,639	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	817,528	19	110,184		50,145	6,758	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,211,073	$ 1,536,540		$ 135,622	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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		12,901	3
4	12	Social Service / Admission Salary	Direct Allocation			174,668	174,668		294	4
5	15	Emp. Ben. - Healthcare	Direct Allocation			61,656			1,309	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		$ 14,504	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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			$	$		$ 288	1
2	2	Food	Direct Allocation							2
3	10	Nursing Supplies	Direct Allocation						11,370	3
4	39	Ancillary Expense	Direct Allocation						2,310	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					$	$		$ 13,969	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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			$	$		$ 219	1
2	3	Housekeeping	Direct Allocation						40,082	2
3	4	Laundry	Direct Allocation						19,726	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						99,885	5
6	11	Activities	Direct Allocation							6
7	21	Office And Clerical	Direct Allocation						13	7
8	22	Employee Benefits	Direct Allocation						2,007	8
9	30	Fixed Assets-Depreciation	Direct Allocation						35,149	9
10	39	Ancillary	Direct Allocation						104,702	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					$	$		$ 301,784	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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						9,793	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										12
13	22	Employee Health Insurance	Direct Allocation			$	$		$ 180,956	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					$	$		$ 190,749	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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			$	$		$ 1,491,657	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,491,657	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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			$	$		$ 995	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						54,333	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					$	$		$ 55,328	25

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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	National City Bank		X	Note Payable			$	$			$ 498,722	1
2	Bassman		X	Note Payable		10/3/2011		5,000,000		20.0000	250,000	2
3	Cole Taylor Bank		X	Note Payable							872	3
4	Lake Forest Bank		X	Note Payable							6,670	4
5	See Supplemental Schedule											5
	Working Capital											
6	Alloc from Ext Care Cnsult		X								7,624	6
7	Alloc from Ext Care Clinical		X								436	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 5,000,000			$ 764,324	9
	B. Non-Facility Related*											
10	Interest Income		X								(24,987)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (24,987)	14
15	TOTALS (line 9+line14)						$	$ 5,000,000			$ 739,337	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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** 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							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc **#** 0046201 **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.**	$ 359,003	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.)		$ 354,546	2
3. Under or (over) accrual (line 2 minus line 1).		$ (4,457)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 370,571	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.		$ 366,114	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	236,542	8
	2007	242,783	9
	2008	314,643	10
	2009	341,908	11
	2010	352,925	12

2011 R/E Accrual 2010 Taxes $352,924 X 1.05% = $370,571
Alloc from Extended Care Consulting 2201 Main LLC $1374
Alloc from Extended Care Clinical 2201 Main LLC $247

	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 Lemont Nursing & Rehab Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 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.	22-27-300-076-0000	Long Term Care Property	$ 333,251.68	$ 333,251.68
2.	22-27-300-077-0000	Long Term Care Property	$ 19,673.06	$ 19,673.06
3.	See Attached	Alloc from 2201 Main LLC	$ 126,481.18	$ 2,263.47
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 479,405.92	$ 355,188.21

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 Lemont Nursing & Rehab Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

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 Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2003	$ 823,094	1
2	Allocated from Extended Care Consulting			14,675	2
3	TOTALS			$ 837,769	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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	115		2003	1995	$ 5,391,423	$ 138,266	Various	$ 252,705	$ 114,439	$ 2,592,633	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	48,664		20	2,045	2,045	24,839	9
10	Various			2004	35,166		20	1,898	1,898	17,678	10
11	Various			2005	7,375		20	369	369	2,551	11
12	Various			2007	59,889		20	1,809	1,809	37,736	12
13											13
14											14
15											15
16											16
17											17
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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
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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)		59,425	4,039		4,039		31,819	68
69	Financial Statement Depreciation			59,882			(59,882)		69
70	TOTAL (lines 4 thru 69)		$ 5,601,942	$ 202,187		$ 262,864	$ 60,677	$ 2,707,255	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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		$ 5,601,942	$ 202,187		$ 262,864	$ 60,677	$ 2,707,255	1
2	Repair A/C	2008	4,475		20	224	224	895	2
3	Install New Smoke Dampers	2008	14,039		20	702	702	2,749	3
4	Additions & Alterations	2008	9,341		20	467	467	1,674	4
5	Heating/Ac Unit Repairs	2008	5,250		20	263	263	919	5
6	Dining Room Remodeling	2008	3,600		20	180	180	600	6
7	Replace Heat Exchangers	2008	6,500		20	325	325	1,056	7
8	Additions & Alterations	2008	3,520		20	176	176	557	8
9	Sprinkler Repairs	2008	6,104		20	305	305	941	9
10	Sprinkler Repairs	2008	3,311		20	166	166	510	10
11	Fire Pipe Replacement	2008	3,177		20	159	159	543	11
12	Kitchen Vent	2009	2,625		20	525	525	1,575	12
13	Kitchen Roof Top Unit #7	2010	2,625		20	131	131	263	13
14	Exhaust Fan	2010	2,350		20	118	118	186	14
15	Exhaust Fan	2010	2,350		20	118	118	186	15
16	Fire System	2010	2,573		20	129	129	161	16
17	Improvements	2010	36,450		20	1,823	1,823	2,126	17
18	Rooftop A/C Unit	2010	16,850		20	843	843	913	18
19	Fire System	2010	7,628		20	381	381	413	19
20	Security Cameras	2010	5,302		20	530	530	574	20
21	Fire System	2010	18,990		20	950	950	1,029	21
22	Fire System	2010	19,225		20	961	961	1,041	22
23	Fire System	2010	8,998		20	450	450	487	23
24	Sprinkler System Repair	2011	2,745		20	137	137	137	24
25	Dry System Repair	2011	5,710		20	262	262	262	25
26	Custom Oak Trim	2011	18,156		20	454	454	454	26
27	Flooring & Trim Renovation	2011	35,000		20	729	729	729	27
28	Blinds	2011	9,834		20	1,147	1,147	1,147	28
29	Flooring & Trim Renovation	2011	35,000		20	583	583	583	29
30	Flooring & Trim Renovations	2011	25,000		20	417	417	417	30
31	Flooring & Trim Renovations	2011	35,000		20	438	438	438	31
32	Flooring & Trim Renovations	2011	80,000		20	1,000	1,000	1,000	32
33	Fuel Injection Pump	2011	5,895		20	25	25	25	33
34	TOTAL (lines 1 thru 33)		$ 6,039,565	$ 202,187		$ 277,979	$ 75,792	$ 2,731,845	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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		$ 6,039,565	$ 202,187		$ 277,979	$ 75,792	$ 2,731,845	1
2	Pipe Repair - Fire Alarm System	2011	3,372		20	112	112	112	2
3	Fire Sprinkler System Repair	2011	6,285		20	210	210	210	3
4	Painting	2011	5,547		20	139	139	139	4
5	Painting	2011	6,688		20	139	139	139	5
6	Painting	2011	12,721		20	212	212	212	6
7	Painting	2011	4,439		20	55	55	55	7
8	Painting	2011	3,660		20	31	31	31	8
9	Painting	2011	3,262		20	14	14	14	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,085,539	$ 202,187		$ 278,890	$ 76,703	$ 2,732,757	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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		$ 6,085,539	$ 202,187		$ 278,890	$ 76,703	$ 2,732,757	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,085,539	$ 202,187		$ 278,890	$ 76,703	$ 2,732,757	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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		$ 6,085,539	$ 202,187		$ 278,890	$ 76,703	$ 2,732,757	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,085,539	$ 202,187		$ 278,890	$ 76,703	$ 2,732,757	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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
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16									16
17									17
18									18
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32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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
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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 Lemont Nursing & Rehab Center, Llc # 0046201 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 Clinical, Inc. 2201 Main LLC	2002	17,144	440	39	440		4,084	3
4	Allocated from Extended Care Consulting, 2201 Main LLC	2002	3,078	79	39	79		733	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, 2201 Main LLC	2002	14,162	1,294	20	1,294		10,367	9
10	Allocated from Extended Care Consulting, 2201 Main LLC	2003	16,690	1,525	20	1,525		12,217	10
11	Allocated from Extended Care Consulting, 2201 Main LLC	2005	829	88	20	88		88	11
12	Allocated from Extended Care Consulting, 2201 Main LLC	2009	150	7	20	7		7	12
13									13
14									14
15	Allocated from Extended Care Consulting, LLC	2007	173	9	20	9		43	15
16	Allocated from Extended Care Consulting, LLC	2009	103	5	20	5		16	16
17	Allocated from Extended Care Consulting, LLC	2010	1,015	51	20	51		102	17
18	Allocated from Extended Care Consulting, LLC	2011	365	18	20	18		18	18
19									19
20	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	2,543	232	20	232		1,861	20
21	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2003	2,997	274	20	274		2,194	21
22	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2005	149	16	20	16		85	22
23	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2009	27	1	20	1		4	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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
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30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 59,425	$ 4,039		$ 4,039	$	$ 31,819	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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	$ 137,513	$ 4,936	$ 19,842	$ 14,906	10	$ 92,841	71
72	Current Year Purchases	84,641	487	9,025	8,538	10	12,768	72
73	Fully Depreciated Assets	409,998				10	409,998	73
74								74
75	TOTALS	$ 632,152	$ 5,423	$ 28,867	$ 23,444		$ 515,608	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	$ 3,428	$ 686	$ 686	$	5	$ 2,286	76
77		Alloc. From ECC	2011	12,101	189	189		5	11,912	77
78										78
79										79
80	TOTALS			$ 15,529	$ 875	$ 875	$		$ 14,198	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,570,990	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 208,485	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 308,632	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 100,147	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,262,563	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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: $ 9,389 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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 Lemont Nursing & Rehab Center, Llc # 0046201 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	$		$ 738,933	$		$ 738,933	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			120,936			120,936	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			805,106			805,106	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				766,171		766,171	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					74,550	304,686		379,236	13
14	TOTAL			$		$ 1,739,525	$ 1,070,857		$ 2,810,382	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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	$	$ 66,033	1
2	Cash-Patient Deposits	41,757	41,757	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,122,903	2,122,903	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	335,750	335,750	6
7	Other Prepaid Expenses	26,758	26,758	7
8	Accounts Receivable (owners or related parties)	3,960,625	5,960,625	8
9	Other(specify): See Attached Schedule	6,535,937	6,535,937	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 13,023,730	$ 15,089,763	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		823,094	13
14	Buildings, at Historical Cost		5,590,504	14
15	Leasehold Improvements, at Historical Cost	556,874	556,874	15
16	Equipment, at Historical Cost	323,188	323,188	16
17	Accumulated Depreciation (book methods)	(324,795)	(2,701,132)	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	22,400	387,766	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 577,667	$ 4,980,294	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 13,601,397	$ 20,070,057	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,310,201	$ 2,310,202	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,226	36,226	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	292,949	292,949	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,094	16,094	31
32	Accrued Real Estate Taxes(Sch.IX-B)	370,571	370,571	32
33	Accrued Interest Payable		91,667	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule		4,482	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,026,041	$ 3,122,191	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		3,914,171	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,914,171	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,026,041	$ 12,036,362	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,575,356	$ 8,033,695	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 13,601,397	$ 20,070,057	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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**	$ 7,351,066	1
2	Restatements (describe):		2
3	**Dividends**	1,000,000	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,351,066	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,167,050	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	(942,760)	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)**	$ 2,224,290	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)**	$ 10,575,356	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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	$ 15,283,148	1
2	Discounts and Allowances for all Levels	(7,891,042)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,392,106	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,968,547	6
7	Oxygen	1,135	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,969,682	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,708	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	779,116	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	189,224	19
20	Radiology and X-Ray	25,060	20
21	Other Medical Services	186,706	21
22	Laundry	5,743	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,187,557	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24,987	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 24,987	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	8,199	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,199	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,582,531	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,591,045	31
32	Health Care	4,413,503	32
33	General Administration	2,401,892	33
	B. Capital Expense		
34	Ownership	956,471	34
	C. Ancillary Expense		
35	Special Cost Centers	2,811,122	35
36	Provider Participation Fee	241,448	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,415,481	40
41	**Income before Income Taxes (line 30 minus line 40)****	3,167,050	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 3,167,050	43

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

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

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

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

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 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	2,066	2,231	$ 104,825	$ 46.99	1
2	Assistant Director of Nursing	1,936	2,171	71,763	33.06	2
3	Registered Nurses	25,593	29,003	983,434	33.91	3
4	Licensed Practical Nurses	29,366	32,992	891,663	27.03	4
5	CNAs & Orderlies	87,730	95,315	1,201,039	12.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,860	13,475	237,891	17.65	8
9	Activity Director	1,861	2,113	41,965	19.86	9
10	Activity Assistants	13,656	14,728	128,209	8.71	10
11	Social Service Workers	10,020	11,099	214,119	19.29	11
12	Dietician	568	626	10,939	17.47	12
13	Food Service Supervisor	1,847	2,081	55,703	26.77	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,694	8,620	120,566	13.99	15
16	Dishwashers	12,881	13,910	121,785	8.76	16
17	Maintenance Workers	5,691	6,531	119,226	18.26	17
18	Housekeepers	20,021	22,172	201,406	9.08	18
19	Laundry	5,243	6,007	53,635	8.93	19
20	Administrator	1,888	2,143	115,343	53.82	20
21	Assistant Administrator	1,921	2,178	54,316	24.94	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,777	8,707	141,944	16.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,898	3,318	48,304	14.56	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,806	2,013	28,672	14.24	33
34	TOTAL (lines 1 - 33)	254,323	281,433	$ 4,946,747 *	$ 17.58	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	316	$ 15,889	01-03	35
36	Medical Director	Montly	39,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,757	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	See Attached		13,195		48
49	TOTAL (lines 35 - 48)	316	$ 77,841		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,406	$ 84,469	10-03	50
51	Licensed Practical Nurses	1,226	53,210	10-03	51
52	Certified Nurse Assistants/Aides	1,512	37,358	10-03	52
53	TOTAL (lines 50 - 52)	4,144	$ 175,037		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Wendy Janulis	Administrator		$ 115,343
Lisa Hardaman	Asst. Admin.		54,316
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 169,659

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg& Rothblatt	Accounting	$ 25,100
Personnel Planners	Unemployment Consult	4,140
See Attached	Legal	202,791
Paycor	Payroll Services	13,070
E-Health Data Solutions	Billing Program System	2,650
National Datacare Corp	Data Processing	1,581
Extended Care Consulting, Inc	Home Office Expenses	412,536
Extended Care Clinical	Home Office Expenses	137,508
Prospect Resources	Natural Gas Procurement	700
Pinnacle Consulting	Customer Satisfaction Surv	2,048
Legat Architects	Professional Fees	2,425
See Supplemetal Schedule		21,756
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 826,305

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 227,181
Unemployment Compensation Insurance	123,321
FICA Taxes	358,872
Employee Health Insurance	89,678
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physical	12,160
Other Employee Welfare	9,958
TOTAL (agree to Schedule V, line 22, col.8)	$ 821,170

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	13,999
Health Care Worker Background Check	
(Indicate # of checks performed 1149)	12,721
Patient Background Checks	
Dues,Subscriptions	14,397
Licenses & Permits	3,151
Alloc from Ext Care Consult.	3,118
Alloc from Ext Care Clinical	149
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 47,535

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,629
Inservice Expenses	2,413
Alloc from Ext Care Consult	172
Alloc from Ext Care Clinical	1,836
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,050

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc **#** 0046201 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XX. GENERAL INFORMATION:

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

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

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **62,724** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **241,448**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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