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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0050732

Facility Name: Avenue Care Nursing & Rehab Center

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Lisa M. Hanlon, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,730	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,730	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	39,907	592	4,300	44,799	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,907	592	4,300	44,799	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.97%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 155 and days of care provided 2,816

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	201,575	37,737	11,312	250,624		250,624	6,287	256,911			1
2	Food Purchase		266,532		266,532		266,532	411	266,943			2
3	Housekeeping	137,819	26,297		164,116		164,116	559	164,675			3
4	Laundry	62,293	14,252		76,545		76,545		76,545			4
5	Heat and Other Utilities			114,749	114,749		114,749	809	115,558			5
6	Maintenance	135,261		111,532	246,793		246,793	3,541	250,334			6
7	Other (specify):*							3,233	3,233			7
8	**TOTAL General Services**	536,948	344,818	237,593	1,119,359		1,119,359	14,840	1,134,199			8
	B. Health Care and Programs											
9	Medical Director			17,000	17,000		17,000		17,000			9
10	Nursing and Medical Records	2,001,236	65,906	9,013	2,076,155		2,076,155	48,778	2,124,933			10
10a	Therapy	74,477			74,477		74,477		74,477			10a
11	Activities	90,662	17,041	2,332	110,035		110,035		110,035			11
12	Social Services	179,717	1,637		181,354		181,354	21,020	202,374			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							12,171	12,171			15
16	**TOTAL Health Care and Programs**	2,346,092	84,584	28,345	2,459,021		2,459,021	81,969	2,540,990			16
	C. General Administration											
17	Administrative	148,959			148,959		148,959	80,957	229,916			17
18	Directors Fees											18
19	Professional Services			413,972	413,972	(10,831)	403,141	(304,016)	99,125			19
20	Dues, Fees, Subscriptions & Promotions			27,749	27,749		27,749	1,473	29,222			20
21	Clerical & General Office Expenses	69,565	19,467	220,042	309,074		309,074	(52,255)	256,819			21
22	Employee Benefits & Payroll Taxes			592,619	592,619		592,619	(5,749)	586,870			22
23	Inservice Training & Education											23
24	Travel and Seminar			45	45		45	1,618	1,663			24
25	Other Admin. Staff Transportation			1,301	1,301		1,301	772	2,073			25
26	Insurance-Prop.Liab.Malpractice			217,559	217,559		217,559	1,440	218,999			26
27	Other (specify):*							34,362	34,362			27
28	**TOTAL General Administration**	218,524	19,467	1,473,287	1,711,278	(10,831)	1,700,447	(241,398)	1,459,049			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,101,564	448,869	1,739,225	5,289,658	(10,831)	5,278,827	(144,589)	5,134,238			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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			17,018	17,018		17,018	175,698	192,716			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(15,037)	(15,037)		(15,037)	143,024	127,987			32
33	Real Estate Taxes			183,228	183,228	10,831	194,059	2,566	196,625			33
34	Rent-Facility & Grounds			137,277	137,277		137,277	(137,277)				34
35	Rent-Equipment & Vehicles			22,892	22,892		22,892	997	23,889			35
36	Other (specify):*											36
37	**TOTAL Ownership**			345,378	345,378	10,831	356,209	185,008	541,217			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		159,434	280,640	440,074		440,074	(2,176)	437,898			39
40	Barber and Beauty Shops			25	25		25		25			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			339,921	339,921		339,921		339,921			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		159,434	620,586	780,020		780,020	(2,176)	777,844			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,101,564	608,303	2,705,189	6,415,056		6,415,056	38,243	6,453,299			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	54,409	30		9
10	Interest and Other Investment Income	(13,661)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(35)	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	(715)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(144,218)	21		24
25	Fund Raising, Advertising and Promotional	(2,001)	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	(56,166)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (162,387)		$	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)	200,630		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 200,630		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 38,243		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Avenue Care Nursing & Rehab Center

ID# 0050732

Report Period Beginning: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (1,603)	21	1
2	Rental Income - Parking	(6,400)	06	2
3	Other Income	(9,757)	21	3
4	Jury Duty	(17)	21	4
5	Patient Clothing	(378)	10	5
6	Collection Expense	(2,351)	21	6
7	Additional R&M	1,370	06	7
8	Non-allowable Legal	(33,729)	19	8
9	PPA Nursing Supplies	(3,301)	10	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(56,166)		49

Avenue Care Nursing & Rehab Center

ID# 0050732

Report Period Beginning: 01/01/12

Ending: 12/31/12

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

STATE OF ILLINOIS **Summary A**

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

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			233		9,150	(3,096)						6,287	1
2	Food Purchase	(35)		446									411	2
3	Housekeeping			446		113							559	3
4	Laundry													4
5	Heat and Other Utilities			645		164							809	5
6	Maintenance	(5,030)		2,553	5,967	51							3,541	6
7	Other (specify):*				1,717	1,516							3,233	7
8	**TOTAL General Services**	(5,065)		4,323	7,684	10,994	(3,096)						14,840	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,679)				52,457							48,778	10
10a	Therapy													10a
11	Activities													11
12	Social Services					21,020							21,020	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					12,171							12,171	15
16	**TOTAL Health Care and Programs**	(3,679)				85,648							81,969	16
	C. General Administration													
17	Administrative			2,759	12,918	65,280							80,957	17
18	Directors Fees													18
19	Professional Services	(33,729)		(181,440)		(88,847)							(304,016)	19
20	Fees, Subscriptions & Promotions	(2,001)		3,382		92							1,473	20
21	Clerical & General Office Expenses	(158,661)	(2,759)	11,544	91,566	6,055							(52,255)	21
22	Employee Benefits & Payroll Taxes				(5,749)								(5,749)	22
23	Inservice Training & Education													23
24	Travel and Seminar			207		1,411							1,618	24
25	Other Admin. Staff Transportation			772									772	25
26	Insurance-Prop.Liab.Malpractice			911		529							1,440	26
27	Other (specify):*				22,881	11,481							34,362	27
28	**TOTAL General Administration**	(194,391)	(2,759)	(161,865)	121,616	(3,999)							(241,398)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(203,135)	(2,759)	(157,542)	129,300	92,643	(3,096)						(144,589)	29

STATE OF ILLINOIS **Summary B**

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

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	54,409	113,385	6,483		1,421							175,698	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(13,661)	126,000	4,032		26,653							143,024	32
33	Real Estate Taxes			2,045		521							2,566	33
34	Rent-Facility & Grounds		(137,277)										(137,277)	34
35	Rent-Equipment & Vehicles			997									997	35
36	Other (specify):*													36
37	**TOTAL Ownership**	40,748	102,108	13,557		28,595							185,008	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(729)	(905)	(483)		(59)		(2,176)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(729)	(905)	(483)		(59)		(2,176)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(162,387)	99,349	(143,985)	129,300	121,238	(3,825)	(905)	(483)		(59)		38,243	45

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

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 6-Supplemental		See 6-Supplemental		See 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	$ 137,277	Avenue Associates, LLC	100.00%	$	$ (137,277)	1
2	V	21	Adjustment Prior Year	2,759	Avenue Associates, LLC	100.00%		(2,759)	2
3	V	32	Interest Expense		Avenue Associates, LLC	100.00%	126,000	126,000	3
4	V	30	Depreciation		Avenue Associates, LLC	100.00%	113,385	113,385	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 140,036			$ 239,385	$ * 99,349	14

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

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

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%	$ 233	$ 233	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	446	446	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	446	446	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	645	645	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,553	2,553	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,759	2,759	20
21	V	19	Professional Fees	185,340	Extended Care Consulting, LLC	100.00%	3,900	(181,440)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,382	3,382	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	11,544	11,544	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	207	207	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	772	772	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	911	911	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	6,483	6,483	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	4,032	4,032	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,045	2,045	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%	997	997	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 185,340			$ 41,355	$ * (143,985)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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%	5,967	$ 5,967	15
16	V	06	Maintenance (Direct)	2,787	Extended Care Consulting, LLC	100.00%	2,787		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,096	1,096	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	621	621	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	12,918	12,918	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	90,673	90,673	22
23	V	21	Office and Clerical (Direct)	16,375	Extended Care Consulting, LLC	100.00%	17,268	893	23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	19,033	19,033	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	3,848	3,848	25
26	V	22	Employee Benefits	5,749	Extended Care Consulting, LLC	100.00%		(5,749)	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			$ 24,911			$ 154,211	$ * 129,300	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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%	$ 113	$ 113	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	164	164	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	51	51	17
18	V	19	Professional Fees	91,284	Extended Care Clinical, LLC	100.00%	2,437	(88,847)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	92	92	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,025	2,025	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,411	1,411	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	529	529	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,421	1,421	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	26,653	26,653	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	521	521	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	9,150	9,150	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,516	1,516	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	52,457	52,457	28
29	V								29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	21,020	21,020	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	12,171	12,171	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	65,280	65,280	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	4,030	4,030	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	11,481	11,481	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 91,284			$ 212,522	$ * 121,238	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	$ 11,058	Care Centers Health Systems, Inc.	100.00%	$ 7,962	$ (3,096)	15
16	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			16
17	V	39	Ancillary Expense	2,604	Care Centers Health Systems, Inc.	100.00%	1,875	(729)	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			$ 13,662			$ 9,837	$ * (3,825)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ventilator Equipment	1,590	Vent Lease LLC	100.00%	685	$ (905)	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			$ 1,590			$ 685	$ * (905)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	$ 276,730	Tri Care Rehab	100.00%	$ 276,248	$ (483)	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			$ 276,730			$ 276,248	$ * (483)	39

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

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 82,207	$ 82,207	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	82,207	CCS Employee Benefits Group	100.00%		(82,207)	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			$ 82,207			$ 82,207	$ *	39

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

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

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	Ancillary Expense	6,645	Reliable Medical of the Midwest, LLC	100.00%	6,586	$ (59)	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			$ 6,645			$ 6,586	$ * (59)	39

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

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

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	B&Z GRANDCHILREN ACCUMULATION TRUST	10.000%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	AVENUE ASSOCIATES, LLC	EVANSTON	BUILDING CO.	1
2	ERIC ROTHNER	90.000%	BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKI	2
3			BRIAR PLACE LTD	INDIAN HEAD PARK	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPI	4
5			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6			DEVON GABLES REHABILITATION CENTER	ARIZONA	ROTHNER VENTS LLC	EVANSTON	VENTALATOR RENTAL	6
7			DYER NURSING & REHAB	DYER, IN	TRICARE REHAB	HILLSIDE	THERAPY	7
8			FOOTHILLS REHABILITATION CENTER LLC	ARIZONA	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLY	8
9			GOLDEN PLAINES REHABILITATION CENTER	KANSAS	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	9
10			GRASMERE PLACE, LLC	CHICAGO				10
11			HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET				11
12			HOMESTEAD NURSING & REAHB	LINCOLN, NE				12
13			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				13
14			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				14
15			LANCASTER MANOR	LINCOLN, NE				15
16			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				16
17			MCKINLEY HEALTH CARE CENTER	CANTON, OH				17
18			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				18
19			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				19
20			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				20
21			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				21
22			RAINBOW BEACH QOC, L.L.C.	CHICAGO				22
23			SEBOS NURSING & REHAB	HOLBART, IN				23
24			SHEFFIELD MANOR	DYER, IN				24
25			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				25
26			SNOW VALLEY NURSING AND REHABILITATION CENTER, L.L.C.	LISLE				26
27			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				27
28			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				28
29			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				29
30			WHEATON CARE CENTER	WHEATON				30

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

VII. RELATED PARTIES

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

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

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

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Adam Vales	Relative	Clerical	N/A	See Attached	0.71	1.78%	Alloc. Salary	$ 1,289	22-7	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	2.96	5.38%	Alloc. Salary	10,285	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 11,574		13

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	1,364,178	31	$ 7,101	$	44,799	$ 233	1
2	02	Food	Patient Days	1,364,178	31	13,586		44,799	446	2
3	03	Housekeeping	Patient Days	1,364,178	31	13,573		44,799	446	3
4	05	Utilities	Patient Days	1,364,178	31	19,636		44,799	645	4
5	06	Maintenance	Patient Days	1,364,178	31	77,756		44,799	2,553	5
6	17	Administrative	Patient Days	1,364,178	31	84,000		44,799	2,759	6
7	19	Professional Fees	Patient Days	1,364,178	31	118,750		44,799	3,900	7
8	20	Dues and Subscriptions	Patient Days	1,364,178	31	102,984		44,799	3,382	8
9	21	Office and Clerical	Patient Days	1,364,178	31	351,528		44,799	11,544	9
10	24	Seminar and Travel	Patient Days	1,364,178	31	6,315		44,799	207	10
11	25	Other Staff Admin. Trans.	Patient Days	1,364,178	31	23,506		44,799	772	11
12	26	Insurance	Patient Days	1,364,178	31	27,741		44,799	911	12
13	30	Depreciation	Patient Days	1,364,178	31	197,424		44,799	6,483	13
14	32	Interest	Patient Days	1,364,178	31	122,765		44,799	4,032	14
15	33	Real Estate Taxes	Patient Days	1,364,178	31	62,275		44,799	2,045	15
16	34	Rent - Building	Patient Days	1,364,178	31			44,799		16
17	35	Rent - Equipment & Auto	Patient Days	1,364,178	31	30,363		44,799	997	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,259,303	$		$ 41,355	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	1,364,178	31	181,713	181,713	44,799	5,967	1
2	06	Maintenance (Direct)	Direct		31	256,754	256,754		2,787	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,364,178	31	33,386		44,799	1,096	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	40,137			621	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,364,178	31	393,362	393,362	44,799	12,918	7
8	21	Office and Clerical (Pooled)	Patient Days	1,364,178	31	2,761,089	2,761,089	44,799	90,673	8
9	21	Office and Clerical (Direct)	Direct		31	368,461	368,461		17,268	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,364,178	31	579,570		44,799	19,033	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	65,039			3,848	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					$ 4,679,511	$ 3,961,379		$ 154,211	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	611,520	14	$ 1,549	$	44,799	$ 113	1
2	05	Utilities	Patient Days	611,520	14	2,241		44,799	164	2
3	06	Maintenance	Patient Days	611,520	14	691		44,799	51	3
4	19	Professional Fees	Patient Days	611,520	14	33,266		44,799	2,437	4
5	20	Dues and Subscriptions	Patient Days	611,520	14	1,249		44,799	92	5
6	21	Office & Clerical	Patient Days	611,520	14	27,644		44,799	2,025	6
7	24	Travel and Seminar	Patient Days	611,520	14	19,257		44,799	1,411	7
8	26	Insurance	Patient Days	611,520	14	7,216		44,799	529	8
9	30	Depreciation	Patient Days	611,520	14	19,393		44,799	1,421	9
10	32	Interest	Patient Days	611,520	14	363,826		44,799	26,653	10
11	33	Real Estate Taxes	Patient Days	611,520	14	7,106		44,799	521	11
12	01	Dietary Salary	Patient Days	611,520	14	124,907	124,907	44,799	9,150	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	611,520	14	20,691		44,799	1,516	13
14	10	Nursing Salary	Patient Days	611,520	14	716,058	716,058	44,799	52,457	14
15										15
16	12	Social Service Salary	Patient Days	611,520		286,925	286,925	44,799	21,020	16
17	15	Emp. Ben. - Healthcare	Patient Days	611,520		166,142		44,799	12,171	17
18	17	Administration Salary	Patient Days	611,520		891,091	891,091	44,799	65,280	18
19	21	Office Salary	Patient Days	611,520		55,009	55,009	44,799	4,030	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	611,520		156,720		44,799	11,481	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,900,982	$ 2,073,990		$ 212,522	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			$	$		$ 7,962	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						1,875	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					$	$		$ 9,837	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ventilator Equipment	Direct Allocation						685	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					$	$		$ 685	25

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

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			$	$		$ 276,248	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					$	$		$ 276,248	25

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 82,207	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					$	$		$ 82,207	25

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

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	39	Ancillary Expense	Direct Allocation						6,586	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					$	$		$ 6,586	25

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Pacific Mutual		X	Mortgage		12/95	$ 4,657,452	$ 3,068,700			$ 126,000	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	First Bank/ HFG		X	LOC				2,818,837			7,008	6
7												7
8	See Supplemental Schedule										30,685	8
9	TOTAL Facility Related						$ 4,657,452	$ 5,887,538			$ 163,693	9
	B. Non-Facility Related*											
10	Interest Income		X								(13,661)	10
11	Interest Income PY		X								(22,045)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (35,706)	14
15	TOTALS (line 9+line14)						$ 4,657,452	$ 5,887,538			$ 127,987	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Alloc. Ext. Care Conslt.	X					$	$			$ 4,032	8
9	Alloc. Ext Care Clinical	X									26,653	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										30,685	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 174,503	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.)		$ 177,069	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,566	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 183,228	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.**		$ 10,831	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.		$ 196,625	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	172,887	8
	2008	174,622	9
	2009	167,921	10
	2010	175,232	11
	2011	174,503	12

2012 Accural = $174,503 x 1.05 =$183,228
Allocated from Extended Care Consulting = $2,045
Allocated from Extended Care Clinical = $521
Beginning Accural Adjusted

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avenue Care Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050732

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-02-312-001-0000	Long Term Care	$ 174,502.89	$ 174,502.89
2.	See Attached	Alloc From 2201 Main	$ 127,119.67	$ 2,038.44
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 301,622.56	$ 176,541.33

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 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avenue Care Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050732

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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	Nursing Home	51,736	1995	$ 100,000	1
2	Alloc. From EC Consulting/Clinical			13,149	2
3	TOTALS	51,736		$ 113,149	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155			1970	$ 4,046,250	$ 113,385	39	$ 103,746	$ (9,639)	$ 1,854,601	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1988	5,400		20	216	216	5,310	9
10	Various			1989	1,035		20			1,035	10
11	Various			1990	5,400		20			5,400	11
12	Various			1991	14,414		20			14,414	12
13	Various			1992	40,065		20	1,288	1,288	27,585	13
14	Various			1993	17,484		20	431	431	10,430	14
15	Various			1994	25,290		20	882	882	16,385	15
16	Various			1995	48,214		20	1,144	1,144	23,382	16
17	Various			1996	14,555		20	373	373	6,116	17
18	Various			1997	81,665		20	2,094	2,094	32,442	18
19	Various			1998	77,656		20	4,170	4,170	60,559	19
20	Various			1999	57,028		20	1,462	1,462	19,797	20
21	Various			2000	13,093		20	476	476	5,783	21
22	Various			2001	75,231		20	3,225	3,225	38,181	22
23	Various			2002	3,877		20	141	141	1,502	23
24	Various			2003	28,341		20	1,099	1,099	10,512	24
25	Various			2004	16,990		20	618	618	5,033	25
26	Various			2005	15,280		20	1,727	1,727	9,964	26
27	Various			2006	76,699		20	3,704	3,704	25,012	27
28	Various			2007	400,627		20	13,882	13,882	96,982	28
29	Various			2008	92,283		20	3,356	3,356	15,134	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		53,314	3,623		3,623		32,490	68
69	Financial Statement Depreciation			17,018			(17,018)		69
70	TOTAL (lines 4 thru 69)		$ 5,210,191	$ 134,026		$ 147,657	$ 13,631	$ 2,318,049	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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		$ 5,210,191	$ 134,026		$ 147,657	$ 13,631	$ 2,318,049	1
2	Installed & Programed Elevator Phone	2009	10,271		20	514	514	1,836	2
3	Fire Alarm Panel Replacement	2009	26,447		20	1,322	1,322	4,648	3
4	Replaced Cable, Adjust Elevator Door Operator	2009	3,534		20	177	177	611	4
5	Wall Air Conditioners	2009	3,659		20	183	183	2,743	5
6	Installed Fire Dampers	2009	3,367		20	168	168	561	6
7	Installed 5 Ton A/C Condensing Unit	2009	2,455		20	123	123	1,842	7
8	Tuckpointing	2009	5,850		20	150	150	456	8
9	Elevator	2010	4,800		20	240	240	720	9
10	Water Cooler Dispensor	2010	4,222		20	422	422	3,272	10
11	Sprinklers	2010	3,640		20	182	182	485	11
12	Windows Treatments	2010	11,507		20	575	575	1,390	12
13	Ac	2010	4,289		20	357	357	834	13
14	Annunciator	2011	3,184		20	637	637	1,220	14
15	Smoke Room Fan	2011	2,500		20	500	500	875	15
16	Elevator Valve & Hydraulic Oil	2011	9,775		20	489	489	570	16
17	Plumbing - 9 Bath Tubs & 3 Showers	2011	29,090		20	1,455	1,455	1,697	17
18	Painting - Labor	2011	11,031		20	552	552	689	18
19	Painting - Labor	2011	7,712		20	386	386	450	19
20	155 Overhead Lights	2012	24,703		20	3,705	3,705	3,705	20
21	Wire Installation	2012	3,590		20	120	120	120	21
22	Light Fixtures	2012	5,250		20	613	613	613	22
23	Replace Two Doors	2012	4,891		20	61	61	61	23
24	80 Sconces	2012	6,725		20	336	336	336	24
25	Dishwasher Room Remodel-Remove And Replace Doors, Wall & I	2012	10,150		20	211	211	211	25
26	Phone System Project	2012	6,200		20	103	103	103	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,419,034	$ 134,026		$ 161,238	$ 27,212	$ 2,348,100	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,419,034	$ 134,026		$ 161,238	$ 27,212	$ 2,348,100	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,419,034	$ 134,026		$ 161,238	$ 27,212	$ 2,348,100	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,419,034	$ 134,026		$ 161,238	$ 27,212	$ 2,348,100	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,419,034	$ 134,026		$ 161,238	$ 27,212	$ 2,348,100	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,419,034	$ 134,026		$ 161,238	$ 27,212	$ 2,348,100	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,419,034	$ 134,026		$ 161,238	$ 27,212	$ 2,348,100	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting 2201 Main LLC	2002	14,443	370	39	370		3,811	3
4	Allocated from Extended Care Clinical 2201 Main LLC	2002	3,677	94	39	94		970	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting LLC	2007	151	8	20	8		45	9
10	Allocated from Extended Care Consulting LLC	2009	90	5	20	5		18	10
11	Allocated from Extended Care Consulting LLC	2010	886	44	20	44		133	11
12	Allocated from Extended Care Consulting LLC	2011	319	16	20	16		32	12
13	Allocated from Extended Care Consulting LLC	2012	105	5	20	5		5	13
14									14
15	Allocated from Extended Care Consulting 2201 Main LLC	2002	11,931	1,090	20	1,090		9,824	15
16	Allocated from Extended Care Consulting 2201 Main LLC	2003	14,061	1,285	20	1,285		11,577	16
17	Allocated from Extended Care Consulting 2201 Main LLC	2005	699	74	20	74		475	17
18	Allocated from Extended Care Consulting 2201 Main LLC	2009	126	6	20	6		25	18
19									19
20	Allocated from Extended Care Clinical 2201 Main LLC	2002	3,037	278	20	278		2,501	20
21	Allocated from Extended Care Clinical 2201 Main LLC	2003	3,579	327	20	327		2,947	21
22	Allocated from Extended Care Clinical 2201 Main LLC	2005	178	19	20	19		121	22
23	Allocated from Extended Care Clinical 2201 Main LLC	2009	32	2	20	2		6	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 53,314	$ 3,623		$ 3,623	$	$ 32,490	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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	$ 284,629	$ 2,664	$ 28,914	$ 26,250	10	$ 225,654	71
72	Current Year Purchases	20,432		948	948	10	948	72
73	Fully Depreciated Assets	398,047				10	398,047	73
74								74
75	TOTALS	$ 703,108	$ 2,664	$ 29,861	$ 27,197		$ 624,649	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Extended Care Cc	2011	$ 5,089	$ 1,018	$ 1,018	$	5	$ 5,089	76
77		Allocated from Extended Care Cl	2011	3,764	599	599		5	360	77
78										78
79										79
80	TOTALS			$ 8,853	$ 1,617	$ 1,617	$		$ 5,449	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	6,244,144	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	138,307	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	192,716	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	54,409	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	2,978,198	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	A/C Units	$ 3,000	92
93			93
94			94
95		$ 3,000	95

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 19,672 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2006 Ford E35C	$ 626.25	$ 4,218	17
18					18
19					19
20					20
21	TOTAL		$ 626.25	$ 4,218	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	$		$ 87,651	$		$ 87,651	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			10,134			10,134	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			178,945			178,945	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				121,821		121,821	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					3,910	37,613		41,523	13
14	TOTAL			$		$ 280,640	$ 159,434		$ 440,074	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,429	$ 8,593	1
2	Cash-Patient Deposits	64,958	64,958	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,408,480	1,408,480	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	78,902	78,902	6
7	Other Prepaid Expenses	50,047	50,047	7
8	Accounts Receivable (owners or related parties)	103,605	103,605	8
9	Other(specify): See Attached Schedule	2,961,273	3,033,273	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,671,694	$ 4,747,858	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		4,046,250	14
15	Leasehold Improvements, at Historical Cost	58,423	213,423	15
16	Equipment, at Historical Cost	96,045	96,045	16
17	Accumulated Depreciation (book methods)	(27,411)	(3,023,946)	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	10,500	10,500	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 137,557	$ 1,442,272	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,809,251	$ 6,190,130	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,310,822	$ 1,310,821	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,639	30,639	28
29	Short-Term Notes Payable	2,818,837	2,818,837	29
30	Accrued Salaries Payable	152,351	152,351	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,937	5,937	31
32	Accrued Real Estate Taxes(Sch.IX-B)	183,228	183,228	32
33	Accrued Interest Payable		72,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	388,013	868,530	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,889,827	$ 5,442,343	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,068,700	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,068,700	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,889,827	$ 8,511,043	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (80,576)	$ (2,320,913)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,809,251	$ 6,190,130	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 472,445	1
2	Restatements (describe):		2
3	**Interest Income**	25,365	3
4	**Rounding**	(6)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 497,804	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	421,620	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	(1,000,000)	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)**	$ (578,380)	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)**	$ (80,576)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,765,959	1
2	Discounts and Allowances for all Levels	(1,249,511)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,516,448	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,184,189	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,184,189	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	6,400	16
17	Sale of Drugs	100,870	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,489	19
20	Radiology and X-Ray		20
21	Other Medical Services	242	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 111,001	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,661	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,661	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	11,377	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,377	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,836,676	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,119,359	31
32	Health Care	2,459,021	32
33	General Administration	1,711,278	33
	B. Capital Expense		
34	Ownership	345,378	34
	C. Ancillary Expense		
35	Special Cost Centers	440,099	35
36	Provider Participation Fee	339,921	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,415,056	40
41	**Income before Income Taxes (line 30 minus line 40)****	421,620	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 421,620	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,173,052	44
45	Private Pay - Net Inpatient Revenue	85,194	45
46	Medicare - Net Inpatient Revenue	73,585	46
47	Other-(specify) Hospice	177,967	47
48	Other-(specify) Insurance	6,650	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,516,448	49

* 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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	2,000	2,121	$ 89,659	$ 42.27	1
2	Assistant Director of Nursing	1,968	2,252	85,713	38.06	2
3	Registered Nurses	7,706	9,482	269,059	28.38	3
4	Licensed Practical Nurses	31,917	34,186	826,841	24.19	4
5	CNAs & Orderlies	65,064	71,067	703,184	9.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,460	5,080	74,477	14.66	8
9	Activity Director	1,902	2,102	23,330	11.10	9
10	Activity Assistants	6,969	7,640	67,332	8.81	10
11	Social Service Workers	8,420	9,448	179,717	19.02	11
12	Dietician					12
13	Food Service Supervisor	1,982	2,179	39,719	18.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,594	8,196	76,679	9.36	15
16	Dishwashers	8,756	9,746	85,177	8.74	16
17	Maintenance Workers	58,180	12,064	135,261	11.21	17
18	Housekeepers	14,432	15,515	137,819	8.88	18
19	Laundry	5,149	5,793	62,293	10.75	19
20	Administrator	1,968	2,332	110,949	47.58	20
21	Assistant Administrator	1,059	1,225	38,010	31.03	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,877	4,347	69,565	16.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,879	2,058	26,780	13.01	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	235,282	206,833	$ 3,101,564 *	$ 15.00	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	226	$ 11,312	01-03	35
36	Medical Director	Monthly	17,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,013	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,332	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	270	$ 39,657		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joeann Brew	Administrator	0	$ 110,949
Mila Jeffery	Asst. Administrator	0	38,010
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 148,959

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
Ext. Care Consulting	Home Office Allocation	$ 185,340
Ext. Care Clinical	Home Office Allocation	91,284
Personnel Planners	Unemployment Tax Cons.	2,238
FR&R	Accounting	6,616
Paycor	Payroll Processing	5,716
Pro Payroll Solutions	Payroll Consulting	11,821
American Data	Data Processing	4,502
Nebo Systems	Software	53
Medifax	Software	616
eHealth Data Solutions	MDS Software	4,302
HFG	Line of Credit	13,789
See Supplemetal Schedule		87,693
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 413,971

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,186
Unemployment Compensation Insurance	93,532
FICA Taxes	234,148
Employee Health Insurance	134,422
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Chicago City Tax	1,256
Employee Physical	708
Pension Expense	26,908
Other Employee Welfare	1,685
Holiday Expense	2,025
TOTAL (agree to Schedule V, line 22, col.8)	$ 586,869

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	$ 1,658
Advertising: Employee Recruitment	
Health Care Worker Background Check	5,175
(Indicate # of checks performed 207)	
Patient Background Checks	
ICLTC	14,725
Licenses & Fees	4,190
Allocated - Ext. Care Consulting	3,382
Allocated - Ext. Care Clinical	92
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,222

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	45
Allocated - Ext. Care Clinical	1,411
Allocated - Ext. Care Consulting	207
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,663

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $14,725.00**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **293** 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 **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Avenue Care Center, Inc #0033340 11/01/09

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **339,921**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(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? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

SEE ACCOUNTANTS' COMPILATION REPORT