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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0050732

Facility Name: Avenue Care Nrsg & Rehab Ctr

Address: 4505 S 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: 12/22/2009

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/13 to 12/31/13 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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	37,876	925	7,293	46,094	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,876	925	7,293	46,094	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.47%

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 02/01/08

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 6,994

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: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	208,700	36,080	10,116	254,896		254,896	6,349	261,245			1
2	Food Purchase		276,423		276,423		276,423	476	276,899			2
3	Housekeeping	157,577	35,256	1,064	193,897		193,897	641	194,538			3
4	Laundry	66,632	33,594		100,226		100,226		100,226			4
5	Heat and Other Utilities			131,043	131,043		131,043	847	131,890			5
6	Maintenance	146,814	2,921	296,359	446,094		446,094	13,474	459,568			6
7	Other (specify):*							13,128	13,128			7
8	**TOTAL General Services**	579,723	384,274	438,582	1,402,579		1,402,579	34,915	1,437,494			8
	B. Health Care and Programs											
9	Medical Director			17,500	17,500		17,500		17,500			9
10	Nursing and Medical Records	2,242,805	86,681	13,232	2,342,718		2,342,718	52,166	2,394,884			10
10a	Therapy	91,414		115	91,529		91,529		91,529			10a
11	Activities	96,383	14,417	424	111,224		111,224		111,224			11
12	Social Services	222,069	779	37	222,885		222,885	22,625	245,510			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							11,385	11,385			15
16	**TOTAL Health Care and Programs**	2,652,671	101,877	31,308	2,785,856		2,785,856	86,176	2,872,032			16
	C. General Administration											
17	Administrative	110,896			110,896		110,896	92,272	203,168			17
18	Directors Fees											18
19	Professional Services			416,620	416,620	(13,439)	403,181	(279,005)	124,176			19
20	Dues, Fees, Subscriptions & Promotions			27,576	27,576		27,576	(8,830)	18,746			20
21	Clerical & General Office Expenses	79,563	29,517	453,920	563,000		563,000	(226,296)	336,704			21
22	Employee Benefits & Payroll Taxes			660,692	660,692		660,692	(42,737)	617,955			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,850	2,850		2,850	2,554	5,404			24
25	Other Admin. Staff Transportation			1,685	1,685		1,685	1,067	2,752			25
26	Insurance-Prop.Liab.Malpractice			236,550	236,550		236,550	2,081	238,631			26
27	Other (specify):*							44,561	44,561			27
28	**TOTAL General Administration**	190,459	29,517	1,799,893	2,019,869	(13,439)	2,006,430	(414,333)	1,592,097			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,422,853	515,668	2,269,783	6,208,304	(13,439)	6,194,865	(293,242)	5,901,622			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 Nrsg & Rehab Ctr #0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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			59,815	59,815		59,815	158,404	218,219			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,678	73,678		73,678	243,090	316,768			32
33	Real Estate Taxes			236,650	236,650	13,439	250,089	3,317	253,406			33
34	Rent-Facility & Grounds			216,000	216,000		216,000	(216,000)				34
35	Rent-Equipment & Vehicles			12,700	12,700		12,700	1,009	13,709			35
36	Other (specify):*											36
37	**TOTAL Ownership**			598,843	598,843	13,439	612,282	189,820	802,102			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		315,355	743,080	1,058,435		1,058,435	(15,244)	1,043,191			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			321,162	321,162		321,162		321,162			42
43	Other (specify):*			1,742	1,742		1,742	(1,742)				43
44	**TOTAL Special Cost Centers**		315,355	1,065,984	1,381,339		1,381,339	(16,986)	1,364,353			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,422,853	831,023	3,934,610	8,188,486		8,188,486	(120,409)	8,068,077			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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	47,414	30		9
10	Interest and Other Investment Income	(7,522)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(55)	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	(590)	21		18
19	Entertainment				19
20	Contributions	(1,250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(357,425)	21		24
25	Fund Raising, Advertising and Promotional	(5,216)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,500)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(26,949)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (359,094)		$	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)	238,685		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 238,685		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (120,409)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Avenue Care Nrsg & Rehab Ctr

ID# 0050732

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (2,642)	21	1
2	Rental Income - Parking	(3,200)	06	2
3	Marketing	(1,742)	43	3
4	Jury Duty	(34)	21	4
5	Patient Clothing	(116)	10	5
6	Cook County Sales Tax	(587)	21	6
7	Theft Loss	(80)	21	7
8	Collection Expense	(3,173)	21	8
9	Non-allowable Dues	(500)	20	9
10	Non-allowable Legal	(12,957)	19	10
11	Additional R&M	3,300	06	11
12	COPE Dues	(5,217)	20	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**	(26,949)		49

Avenue Care Nrsg & Rehab Ctr

ID# 0050732

Report Period Beginning: 01/01/13

Ending: 12/31/13

	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	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary			301		7,702	(1,654)						6,349	1
2	Food Purchase	(55)		531									476	2
3	Housekeeping			532		109							641	3
4	Laundry													4
5	Heat and Other Utilities			702		145							847	5
6	Maintenance	100		4,583	8,738	53							13,474	6
7	Other (specify):*				11,957	1,171							13,128	7
8	**TOTAL General Services**	45		6,649	20,695	9,180	(1,654)						34,915	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(116)				52,282							52,166	10
10a	Therapy													10a
11	Activities													11
12	Social Services					22,625							22,625	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					11,385							11,385	15
16	**TOTAL Health Care and Programs**	(116)				86,292							86,176	16
	C. General Administration													
17	Administrative			3,514	19,400	69,358							92,272	17
18	Directors Fees													18
19	Professional Services	(12,957)		(176,423)		(89,625)							(279,005)	19
20	Fees, Subscriptions & Promotions	(12,183)		3,138		215							(8,830)	20
21	Clerical & General Office Expenses	(372,032)		14,833	122,127	8,776							(226,296)	21
22	Employee Benefits & Payroll Taxes				(42,737)								(42,737)	22
23	Inservice Training & Education													23
24	Travel and Seminar			402		2,152							2,554	24
25	Other Admin. Staff Transportation			1,067									1,067	25
26	Insurance-Prop.Liab.Malpractice			1,437		644							2,081	26
27	Other (specify):*				33,024	11,537							44,561	27
28	**TOTAL General Administration**	(397,172)		(152,032)	131,814	3,057							(414,333)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(397,244)		(145,383)	152,509	98,529	(1,654)						(293,242)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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	47,414	103,002	6,459		1,529							158,404	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,522)	216,000	1,768		32,844							243,090	32
33	Real Estate Taxes			2,751		566							3,317	33
34	Rent-Facility & Grounds		(216,000)										(216,000)	34
35	Rent-Equipment & Vehicles			1,009									1,009	35
36	Other (specify):*													36
37	**TOTAL Ownership**	39,892	103,002	11,987		34,939							189,820	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(356)	(599)	(14,273)	(17)			(15,244)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(1,742)											(1,742)	43
44	**TOTAL Special Cost Centers**	(1,742)					(356)	(599)	(14,273)	(17)			(16,986)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(359,094)	103,002	(133,396)	152,509	133,468	(2,009)	(599)	(14,273)	(17)			(120,409)	45

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 216,000	Avenue Associates, LLC	100.00%	$	$ (216,000)	1
2	V	30	Depreciation		Avenue Associates, LLC	100.00%	103,002	103,002	2
3	V	32	Interest Expense		Avenue Associates, LLC	100.00%	216,000	216,000	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 216,000			$ 319,002	$ * 103,002	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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%	$ 301	$ 301	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	531	531	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	532	532	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	702	702	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	4,583	4,583	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,514	3,514	20
21	V	19	Professional Fees	185,340	Extended Care Consulting, LLC	100.00%	8,917	(176,423)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,138	3,138	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	14,833	14,833	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	402	402	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,067	1,067	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,437	1,437	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	6,459	6,459	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	1,768	1,768	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,751	2,751	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,009	1,009	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			$ 185,340			$ 51,944	$ * (133,396)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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%	8,738	$ 8,738	15
16	V	06	Maintenance (Direct)	125,162	Extended Care Consulting, LLC	100.00%	125,162		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	896	896	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	11,061	11,061	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	19,400	19,400	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	122,127	122,127	22
23	V	21	Office and Clerical (Direct)	17,296	Extended Care Consulting, LLC	100.00%	17,296		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	26,434	26,434	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	6,590	6,590	25
26	V	22	Employee Benefits	42,737	Extended Care Consulting, LLC	100.00%		(42,737)	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			$ 185,195			$ 337,704	$ * 152,509	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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%	$ 109	$ 109	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	145	145	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	53	53	17
18	V	19	Professional Fees	91,284	Extended Care Clinical, LLC	100.00%	1,659	(89,625)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	215	215	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,227	2,227	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	2,152	2,152	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	644	644	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,529	1,529	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	32,844	32,844	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	566	566	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	7,702	7,702	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,171	1,171	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	52,282	52,282	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	22,625	22,625	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	11,385	11,385	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	69,358	69,358	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	6,549	6,549	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	11,537	11,537	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 91,284			$ 224,752	$ * 133,468	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 5,907	Care Centers Health Systems, Inc.	100.00%	$ 4,253	$ (1,654)	15
16	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			16
17	V	39	Ancillary Expense	1,270	Care Centers Health Systems, Inc.	100.00%	914	(356)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,177			$ 5,167	$ * (2,009)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	39	Ventilator Equipment	2,890	Vent Lease LLC	100.00%	2,291	$ (599)	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			$ 2,890			$ 2,291	$ * (599)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 737,681	Tri Care Rehab	100.00%	$ 723,408	$ (14,273)	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			$ 737,681			$ 723,408	$ * (14,273)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Equipment Rental	1,012	Reliable Medical of the Midwest, LLC	100.00%	1,003	$ (9)	15
16	V	39	Ancillary Expense	866	Reliable Medical of the Midwest, LLC	100.00%	859	(8)	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			$ 1,878			$ 1,861	$ * (17)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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%	$ 71,889	$ 71,889	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	71,889	CCS Employee Benefits Group	100.00%		(71,889)	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			$ 71,889			$ 71,889	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 GRANDCHILDREN TRUST	10.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	AVENUE ASSOCIATES, LLC	EVANSTON	BUILDING CO.	1
2	ERIC ROTHNER	90.00%	BOULEVARD CARE NURSING AND REHABILITATION CENTER,LL(	CHICAGO	EXTENDED CARE CONSULTIN(	EVANSTON	MANAGEMENT/BOOKKEEP	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 SUPPLEM	4
5			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6			DYER NURSING & REHAB	DYER, IN	ROTHNER VENTS LLC	EVANSTON	VENTALATOR RENTAL	6
7			GRASMERE PLACE, LLC	CHICAGO	TRICARE REHAB	HILLSIDE	THERAPY	7
8			HOMESTEAD NURSING & REAHB	LINCOLN, NE	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLY	8
9			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN	CARE CENTERS BUILDING LL(	EVANSTON	BLDG COMPANY	9
10			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				10
11			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				11
12			MCKINLEY HEALTH CARE CENTER	CANTON, OH				12
13			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				13
14			PARC AT JOLIET LLC	JOLIET				14
15			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				15
16			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				16
17			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				17
18			RAINBOW BEACH QOC, L.L.C.	CHICAGO				18
19			SEBOS NURSING & REHAB	HOLBART, IN				19
20			SHEFFIELD MANOR	DYER, IN				20
21			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				21
22			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				22
23			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				23
24			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				24
25			WHEATON CARE CENTER	WHEATON				25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	0.67	1.68%	Alloc. Salary	$ 1,170	22-7	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	3.04	5%	Alloc. Salary	10,624	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	$ 11,794		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	1,101,784	30	$ 7,195	$	46,094	$ 301	1
2	02	Food	Patient Days	1,101,784	30	12,684		46,094	531	2
3	03	Housekeeping	Patient Days	1,101,784	30	12,707		46,094	532	3
4	05	Utilities	Patient Days	1,101,784	30	16,778		46,094	702	4
5	06	Maintenance	Patient Days	1,101,784	30	109,559		46,094	4,583	5
6	17	Administrative	Patient Days	1,101,784	30	84,000		46,094	3,514	6
7	19	Professional Fees	Patient Days	1,101,784	30	213,139		46,094	8,917	7
8	20	Dues and Subscriptions	Patient Days	1,101,784	30	75,016		46,094	3,138	8
9	21	Office and Clerical	Patient Days	1,101,784	30	354,548		46,094	14,833	9
10	24	Seminar and Travel	Patient Days	1,101,784	30	9,615		46,094	402	10
11	25	Other Staff Admin. Trans.	Patient Days	1,101,784	30	25,510		46,094	1,067	11
12	26	Insurance	Patient Days	1,101,784	30	34,345		46,094	1,437	12
13	30	Depreciation	Patient Days	1,101,784	30	154,393		46,094	6,459	13
14	32	Interest	Patient Days	1,101,784	30	42,261		46,094	1,768	14
15	33	Real Estate Taxes	Patient Days	1,101,784	30	65,749		46,094	2,751	15
16	35	Rent - Equipment & Auto	Patient Days	1,101,784	30	24,117		46,094	1,009	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,241,615	$		$ 51,944	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	1,101,784	30	208,870	208,870	46,094	8,738	1
2	06	Maintenance (Direct)	Direct		30	331,520	331,520		125,162	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,101,784	30	21,409		46,094	896	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		30	37,937			11,061	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,101,784	30	463,710	463,710	46,094	19,400	7
8	21	Office and Clerical (Pooled)	Patient Days	1,101,784	30	2,919,199	2,919,199	46,094	122,127	8
9	21	Office and Clerical (Direct)	Direct		30	328,534	328,534		17,296	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,101,784	30	631,850		46,094	26,434	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		30	55,508			6,590	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					$ 4,998,538	$ 4,251,833		$ 337,704	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 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	610,520	17	$ 1,450	$	46,094	$ 109	1
2	05	Utilities	Patient Days	610,520	17	1,914		46,094	145	2
3	06	Maintenance	Patient Days	610,520	17	698		46,094	53	3
4	19	Professional Fees	Patient Days	610,520	17	21,974		46,094	1,659	4
5	20	Dues and Subscriptions	Patient Days	610,520	17	2,847		46,094	215	5
6	21	Office & Clerical	Patient Days	610,520	17	29,496		46,094	2,227	6
7	24	Travel and Seminar	Patient Days	610,520	17	28,507		46,094	2,152	7
8	26	Insurance	Patient Days	610,520	17	8,533		46,094	644	8
9	30	Depreciation	Patient Days	610,520	17	20,257		46,094	1,529	9
10	32	Interest	Patient Days	610,520	17	435,028		46,094	32,844	10
11	33	Real Estate Taxes	Patient Days	610,520	17	7,502		46,094	566	11
12	01	Dietary Salary	Patient Days	610,520	17	102,014	102,014	46,094	7,702	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	610,520	17	15,504		46,094	1,171	13
14	10	Nursing Salary	Patient Days	610,520	17	692,482	692,482	46,094	52,282	14
15	12	Social Service Salary	Patient Days	610,520	17	299,672	299,672	46,094	22,625	15
16	15	Emp. Ben. - Healthcare	Patient Days	610,520	17	150,791		46,094	11,385	16
17	17	Administration Salary	Patient Days	610,520	17	918,652	918,652	46,094	69,358	17
18	21	Office Salary	Patient Days	610,520	17	86,739	86,739	46,094	6,549	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	610,520	17	152,803		46,094	11,537	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,976,862	$ 2,099,559		$ 224,752	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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			$	$		$ 4,253	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						914	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					$	$		$ 5,167	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 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						2,291	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					$	$		$ 2,291	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: 240 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			$	$		$ 723,408	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					$	$		$ 723,408	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Equipment Rental	Direct Allocation						1,003	1
2	39	Ancillary Expense	Direct Allocation						859	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,861	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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			$	$		$ 71,889	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					$	$		$ 71,889	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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**		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	Pacific Mutual		X	Mortgage		12/95	$ 4,657,452	$ 2,934,190			$ 216,000	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Bank/HFG		X	LOC				3,354,333			73,678	6
7	Alloc. Ext. Care Clinical	X									32,844	7
8	See Supplemental Schedule										1,768	8
9	TOTAL Facility Related						$ 4,657,452	$ 6,288,522			$ 324,290	9
	B. Non-Facility Related*											
10	Interest Income		X								(7,522)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,522)	14
15	TOTALS (line 9+line14)						$ 4,657,452	$ 6,288,522			$ 316,768	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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Consulting	X					$	$			$ 1,768	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										1,768	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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 183,228	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.)		$ 200,327	2
3. Under or (over) accrual (line 2 minus line 1).		$ 17,099	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 206,860	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.)**		$ 13,439	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 $ 16,902 For 2009 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.		$ 237,398	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	174,622	8
	2009	167,921	9
	2010	175,232	10
	2011	174,503	11
	2012	197,010	12

2013 Accural = $197,010 X 1.05 = $206,860

Allocated from Extended Care Clinical $566

Allocated from Extended Care Consulting $2,751

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avenue Care Nrsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050732

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(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	$ 197,009.66	$ 197,009.66
2.	See Attached	Alloc. From 2201 Main LLC	$ 133,178.74	$ 2,615.19
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 330,188.40	$ 199,624.85

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Avenue Care Nrsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050732

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	51,736	1995	$ 100,000	1
2	Alloc. From Ext. Care Clinical / Consulting			16,102	2
3	TOTALS	51,736		$ 116,102	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 103,002	39	$ 103,746	$ 744	$ 1,958,347	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1988	5,400		20	90	90	5,400	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	28,873	13
14	Various			1993	17,484		20	431	431	10,861	14
15	Various			1994	25,290		20	882	882	17,267	15
16	Various			1995	48,214		20	1,144	1,144	24,526	16
17	Various			1996	14,555		20	373	373	6,489	17
18	Various			1997	81,665		20	2,094	2,094	34,536	18
19	Various			1998	77,656		20	2,256	2,256	62,815	19
20	Various			1999	57,028		20	1,462	1,462	21,259	20
21	Various			2000	13,093		20	476	476	6,259	21
22	Various			2001	75,231		20	3,225	3,225	41,406	22
23	Various			2002	3,877		20	141	141	1,643	23
24	Various			2003	28,341		20	1,099	1,099	11,611	24
25	Various			2004	16,990		20	618	618	5,651	25
26	Various			2005	15,280		20	1,727	1,727	11,691	26
27	Various			2006	76,699		20	3,704	3,704	28,716	27
28	Various			2007	228,261		20	5,264	5,264	50,536	28
29	Various			2008	41,058		20	795	795	3,123	29
30	Various			2009	55,583		20	2,637	2,637	15,334	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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)		65,364	4,441		4,441		44,238	68
69	Financial Statement Depreciation			59,815			(59,815)		69
70	TOTAL (lines 4 thru 69)		$ 5,054,233	$ 167,258		$ 137,892	$ (29,366)	$ 2,411,429	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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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		$ 5,054,233	$ 167,258		$ 137,892	$ (29,366)	$ 2,411,429	1
2	Elevator	2010	4,800		20	240	240	960	2
3	Water Cooler Dispensor	2010	4,222		20	422	422	3,694	3
4	Sprinklers	2010	3,640		20	182	182	667	4
5	Windows Treatments	2010	11,507		20	575	575	1,966	5
6	Ac	2010	4,289		20	357	357	1,191	6
7	Annunciator	2011	3,184		20	637	637	1,857	7
8	Smoke Room Fan	2011	2,500		20	500	500	1,375	8
9	Elevator Valve & Hydraulic Oil	2011	9,775		20	489	489	1,059	9
10	Plumbing - 9 Bath Tubs & 3 Showers	2011	29,090		20	1,455	1,455	3,151	10
11	Painting - Labor	2011	11,031		20	552	552	1,241	11
12	Painting - Labor	2011	7,712		20	386	386	835	12
13	155 Overhead Lights	2012	24,703		20	4,941	4,941	8,646	13
14	Wire Installation	2012	3,590		20	180	180	299	14
15	Light Fixtures	2012	5,250		20	1,050	1,050	1,663	15
16	Replace Two Doors	2012	4,891		20	245	245	306	16
17	80 Sconces	2012	6,725		20	1,345	1,345	1,681	17
18	Dishwasher Room Remodel-Remove And Replace Doors, Wall & F	2012	10,150		20	508	508	719	18
19	Phone System Project	2012	3,100		20	620	620	672	19
20	Replace Concrete Stop	2013	2,800		20	117	117	117	20
21	5 Fire Dampers	2013	8,500		20	354	354	354	21
22	Water Heater	2013	5,482		20	914	914	914	22
23	2Nd Fl Corridor - Baseboard & Shoe	2013	11,827		20	444	444	444	23
24	Nurses Station - Annuciator & Wiring	2013	4,100		20	154	154	154	24
25	Boiler System Piping	2013	3,800		20	143	143	143	25
26	Install Dry Sidewall Sprinkler Heads	2013	3,900		20	130	130	130	26
27	Dishwasher Room Remodel-Remove And Replace Doors, Wall & F	2013	10,150		20	338	338	338	27
28	58 Wood Blinds 2"	2013	10,631		20	1,240	1,240	1,240	28
29	57 Cornices	2013	15,987		20	1,599	1,599	1,599	29
30	Handrails	2013	5,254		20	438	438	438	30
31	Cubicle Curtains	2013	17,292		20	1,441	1,441	1,441	31
32	Installed Nurse Call System With 28 Bed Pullcords And 27 Bath Pu	2013	10,687		20	712	712	712	32
33	Handrails (3Rd Floor)	2013	11,825		20	788	788	788	33
34	TOTAL (lines 1 thru 33)		$ 5,326,628	$ 167,258		$ 161,385	$ (5,873)	$ 2,452,224	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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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		$ 5,326,628	$ 167,258		$ 161,385	$ (5,873)	$ 2,452,224	1
2	Installed New Sewer Lines For 1St, 2Nd, And 3Rd Utility Rooms	2013	7,500		20	94	94	94	2
3	2Nd & 3Rd Floor Corridor Flooring	2013	90,500		20	3,017	3,017	3,017	3
4	Primed And Installed Awnings At Facility	2013	5,995		20	200	200	200	4
5	Installed Corner Guards And Handrails	2013	5,829		20	97	97	97	5
6	Installed New G.A.L. Door Operator	2013	36,813		20	118	118	118	6
7	Elevator Door	2013	20,991		20	1,050	1,050	1,050	7
8	Wardrobe Cabinet Doors & Drawers, 1St Fl Corridor Flooring, El	2013	238,747		20	11,937	11,937	11,937	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)		$ 5,733,003	$ 167,258		$ 177,897	$ 10,639	$ 2,468,736	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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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		$ 5,733,003	$ 167,258		$ 177,897	$ 10,639	$ 2,468,736	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)		$ 5,733,003	$ 167,258		$ 177,897	$ 10,639	$ 2,468,736	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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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		$ 5,733,003	$ 167,258		$ 177,897	$ 10,639	$ 2,468,736	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)		$ 5,733,003	$ 167,258		$ 177,897	$ 10,639	$ 2,468,736	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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Clinical, 2201 Main LLC	2002	3,789	97	20	97		1,097	3
4	Allocated from Extended Care Consulting, 2201 Main LLC	2002	18,400	472	20	472		5,327	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Extended Care Clinical, 2201 Main LLC	2002	3,130	286	20	286		2,863	9
10	Allocated from Extended Care Clinical, 2201 Main LLC	2003	3,689	337	20	337		3,374	10
11	Allocated from Extended Care Clinical, 2201 Main LLC	2005	183	19	20	19		144	11
12	Allocated from Extended Care Clinical, 2201 Main LLC	2009	33	2	20	2		8	12
13									13
14	Allocated from Extended Care Consulting	2007	192	10	20	10		67	14
15	Allocated from Extended Care Consulting	2009	115	6	20	6		29	15
16	Allocated from Extended Care Consulting	2010	1,129	56	20	56		226	16
17	Allocated from Extended Care Consulting	2011	406	20	20	20		61	17
18	Allocated from Extended Care Consulting	2012	134	7	20	7		13	18
19									19
20	Allocated from Extended Care Consulting, 2201 Main LLC	2002	15,200	1,389	20	1,389		13,904	20
21	Allocated from Extended Care Consulting, 2201 Main LLC	2003	17,913	1,637	20	1,637		16,386	21
22	Allocated from Extended Care Consulting, 2201 Main LLC	2005	890	95	20	95		699	22
23	Allocated from Extended Care Consulting, 2201 Main LLC	2009	161	8	20	8		40	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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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
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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 (12H & 12I lines 1 thru 33)		$ 65,364	$ 4,441		$ 4,441	$	$ 44,238	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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 271,551	$ 433	$ 31,049	$ 30,616	10	$ 221,919	71
72	Current Year Purchases	43,772	83	6,242	6,159	10	6,242	72
73	Fully Depreciated Assets	474,505	2,256	2,256		10	474,505	73
74								74
75	TOTALS	$ 789,828	$ 2,772	$ 39,547	$ 36,775		$ 702,666	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Alloc. Ext. Care Clinical	2012	$ 3,879	$ 776	$ 776	$	5	$ 1,147	76
77		Alloc. Ext. Care Consulting	2011	6,484				5	6,484	77
78										78
79										79
80	TOTALS			$ 10,363	$ 776	$ 776	$		$ 7,631	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)	$ 6,649,296	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 170,806	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 218,220	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 47,414	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,179,034	85	

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] 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.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 13,709 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 272,174	$		$ 272,174	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			96,631			96,631	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			370,177			370,177	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				276,428		276,428	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					4,098	38,927		43,025	13
14	TOTAL			$		$ 743,080	$ 315,355		$ 1,058,435	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

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/13 (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	$ 30,431	$ 34,595	1
2	Cash-Patient Deposits	14,368	14,368	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,542,444	1,542,444	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,469	80,469	6
7	Other Prepaid Expenses	53,864	53,864	7
8	Accounts Receivable (owners or related parties)	3,500		8
9	Other(specify): See Attached Schedule	263,193	389,193	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,988,269	$ 2,114,933	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		3,624,349	14
15	Leasehold Improvements, at Historical Cost	180,732	335,732	15
16	Equipment, at Historical Cost	462,644	462,644	16
17	Accumulated Depreciation (book methods)	(87,226)	(3,300,148)	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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 556,150	$ 1,222,577	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,544,419	$ 3,337,510	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,734,550	$ 1,734,549	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,418	36,418	28
29	Short-Term Notes Payable	3,354,333	3,354,333	29
30	Accrued Salaries Payable	188,037	188,037	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,397	7,397	31
32	Accrued Real Estate Taxes(Sch.IX-B)	206,860	206,860	32
33	Accrued Interest Payable		126,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	355,160	832,177	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,882,755	$ 6,485,771	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,934,190	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,934,190	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,882,755	$ 9,419,961	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,338,336)	$ (6,082,451)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,544,419	$ 3,337,510	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (80,576)	1
2	Restatements (describe):		2
3	**Write off "Due From Oak Park"**	(164,966)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (245,542)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	167,206	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	(3,260,000)	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)**	$ (3,092,794)	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)**	$ (3,338,336)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 8,296,316	1
2	Discounts and Allowances for all Levels	(3,389,960)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,906,356	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,157,017	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,157,017	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	(70)	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,200	16
17	Sale of Drugs	248,586	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,991	19
20	Radiology and X-Ray		20
21	Other Medical Services	8,512	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 265,219	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,522	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,522	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	19,578	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,578	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,355,692	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,402,579	31
32	Health Care	2,785,856	32
33	General Administration	2,019,869	33
	B. Capital Expense		
34	Ownership	598,843	34
	C. Ancillary Expense		
35	Special Cost Centers	1,060,177	35
36	Provider Participation Fee	321,162	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,188,486	40
41	**Income before Income Taxes (line 30 minus line 40)****	167,206	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 167,206	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,383,097	44
45	Private Pay - Net Inpatient Revenue	134,475	45
46	Medicare - Net Inpatient Revenue	210,737	46
47	Other-(specify) Hospice	90,787	47
48	Other-(specify) Insurance	87,260	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,906,356	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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	2,004	2,165	$ 95,095	$ 43.92	1
2	Assistant Director of Nursing	1,784	2,352	83,582	35.54	2
3	Registered Nurses	10,953	13,284	391,601	29.48	3
4	Licensed Practical Nurses	31,037	33,995	842,066	24.77	4
5	CNAs & Orderlies	71,337	79,001	800,020	10.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,940	5,617	91,414	16.27	8
9	Activity Director	1,806	2,073	24,091	11.62	9
10	Activity Assistants	7,488	8,092	72,292	8.93	10
11	Social Service Workers	9,606	10,592	222,070	20.97	11
12	Dietician					12
13	Food Service Supervisor	1,964	2,162	40,543	18.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,268	5,708	52,617	9.22	15
16	Dishwashers	11,662	12,798	115,540	9.03	16
17	Maintenance Workers	11,791	12,746	146,814	11.52	17
18	Housekeepers	16,043	17,431	157,577	9.04	18
19	Laundry	5,522	6,425	66,632	10.37	19
20	Administrator	2,028	2,205	110,896	50.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,901	4,540	79,563	17.52	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	1,926	2,097	30,441	14.52	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	201,060	223,283	$ 3,422,854 *	$ 15.33	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	201	$ 10,116	01-03	35
36	Medical Director	Monthly	17,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,232	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Visit	115	10a-03	43
44	Activity Consultant	8	424	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	Admissions ECL	Visit	37	12-03	48
49	TOTAL (lines 35 - 48)	209	$ 41,424		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 Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joe Brew	Administrator	0	$ 110,896
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 110,896

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
Paycor	Payroll Processing	19,927
American Data	Electronic Charting	4,571
Nebo	Claims Consulting	124
Medifax-EDI	Transcription Service	617
Ability Network	Computer Services	161
National Datacare Corporation	Resident Fund Processing	3,381
FR&R	Accounting	27,773
Legal	See Attached	61,757
HFG	Line of Credit	14,337
See Supplemental Schedule		7,348
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 416,621

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,732
Unemployment Compensation Insurance	113,035
FICA Taxes	258,603
Employee Health Insurance	127,719
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Chicago City Tax	256
Employee Physicals	216
Pension Expense	11,490
Other Employee Welfare	2,079
Holiday Expense	1,825
TOTAL (agree to Schedule V, line 22, col.8)	$ 617,955

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	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	4,490
(Indicate # of checks performed 266)	
Patient Background Checks	
Licenses and Permits	945
Dues and Subscriptions	7,968
Allocated from Ext. Care Clinical	215
Allocated from Ext. Care Consulting	3,138
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,746

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,850
Allocated from Ext. Care Clinical	2,152
Allocated from Ext. Care Consulting	402
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,404

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Avenue Care Nrsg & Rehab Ctr # 0050732 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 $15,810**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **301** 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. $ **321,162**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **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 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.