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: 0046201

Facility Name: Lemont Nrsg & Rehab Center

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2003

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/13 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 Lemont Nrsg & Rehab Center # 0046201 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 _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	158	Skilled (SNF)	158	57,670	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	158	TOTALS	158	57,670	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	23,372	11,190	18,943	53,505	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,372	11,190	18,943	53,505	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.78%

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 02/01/2003

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 158 and days of care provided 18,293

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: 12/31/2013 Fiscal Year: 12/31/2013

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	332,701	99,757	21,082	453,540		453,540	3,377	456,917			1
2	Food Purchase		362,313		362,313		362,313	(144)	362,169			2
3	Housekeeping	207,240	55,153		262,393		262,393	744	263,137			3
4	Laundry	55,776	32,797		88,573		88,573		88,573			4
5	Heat and Other Utilities			178,859	178,859		178,859	(5,216)	173,643			5
6	Maintenance	121,257		255,755	377,012		377,012	23,351	400,363			6
7	Other (specify):*							4,417	4,417			7
8	**TOTAL General Services**	716,974	550,020	455,696	1,722,690		1,722,690	26,529	1,749,219			8
	B. Health Care and Programs											
9	Medical Director			51,000	51,000		51,000		51,000			9
10	Nursing and Medical Records	3,545,184	187,317	31,612	3,764,113		3,764,113	60,688	3,824,801			10
10a	Therapy	238,625		93	238,718		238,718		238,718			10a
11	Activities	193,738	42,993		236,731		236,731		236,731			11
12	Social Services	227,023	815		227,838		227,838	26,263	254,101			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							13,215	13,215			15
16	**TOTAL Health Care and Programs**	4,204,570	231,125	82,705	4,518,400		4,518,400	100,166	4,618,566			16
	C. General Administration											
17	Administrative	178,673			178,673		178,673	107,107	285,780			17
18	Directors Fees											18
19	Professional Services			827,365	827,365	(117)	827,248	(696,670)	130,578			19
20	Dues, Fees, Subscriptions & Promotions			65,712	65,712		65,712	(30,215)	35,497			20
21	Clerical & General Office Expenses	153,537	39,902	268,635	462,074		462,074	(20,556)	441,518			21
22	Employee Benefits & Payroll Taxes			894,324	894,324		894,324	(2,515)	891,809			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,143	5,143		5,143	2,965	8,108			24
25	Other Admin. Staff Transportation			2,953	2,953		2,953	1,239	4,192			25
26	Insurance-Prop.Liab.Malpractice			325,979	325,979		325,979	2,416	328,395			26
27	Other (specify):*							44,075	44,075			27
28	**TOTAL General Administration**	332,210	39,902	2,390,111	2,762,223	(117)	2,762,106	(592,154)	2,169,952			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,253,754	821,047	2,928,512	9,003,313	(117)	9,003,196	(465,459)	8,537,737			29

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

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

Facility Name & ID Number Lemont Nrsg & Rehab Center #0046201 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			120,850	120,850		120,850	233,976	354,826			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,808	1,808		1,808	716,646	718,454			32
33	Real Estate Taxes			358,260	358,260	117	358,377	3,850	362,227			33
34	Rent-Facility & Grounds			1,850,000	1,850,000		1,850,000	(1,850,000)				34
35	Rent-Equipment & Vehicles			8,206	8,206		8,206	1,171	9,377			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,339,124	2,339,124	117	2,339,241	(894,357)	1,444,884			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,295,370	1,993,059	3,288,429		3,288,429	(44,527)	3,243,902			39
40	Barber and Beauty Shops			219	219		219	(219)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			299,232	299,232		299,232		299,232			42
43	Other (specify):*			662	662		662	(662)	0			43
44	**TOTAL Special Cost Centers**		1,295,370	2,293,172	3,588,542		3,588,542	(45,408)	3,543,134			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,253,754	2,116,417	7,560,808	14,930,979		14,930,979	(1,405,223)	13,525,756			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	(14)	02		4
5	Telephone, TV & Radio in Resident Rooms	(6,199)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	86,437	30		9
10	Interest and Other Investment Income	(62,893)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(746)	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	(1,757)	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	(164,095)	21		24
25	Fund Raising, Advertising and Promotional	(26,435)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(60,847)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (237,798)		$	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)	(1,167,425)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,167,425)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,405,223)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lemont Nrsg & Rehab Center

ID# 0046201

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber and Beauty Shop	$ (219)	40	1
2	Cook County Sales Tax	(1,856)	21	2
3	Theft Loss	(3,445)	21	3
4	Collections Expense	(5,826)	21	4
5	COPE	(5,318)	20	5
6	Prior Period Refunds	(12,745)	21	6
7	Chamber of Commerce Dues	(575)	20	7
8	Website Design Fee	(12)	43	8
9	Design Services	(650)	43	9
10	Non-Allowable Legal	(6,322)	19	10
11	Annual Reports	(530)	20	11
12	Building Company - Bank Charges	(49)	21	12
13	Building Company - Filing Fees	(250)	20	13
14	Building Company -Amortization	(30,877)	36	14
15	Capitalized R&M	(10,633)	06	15
16	Additional R&M	18,460	06	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**	(60,847)		49

Lemont Nrsg & Rehab Center

ID# 0046201

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 Lemont Nrsg & Rehab Center # 0046201 **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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			349		8,940	(5,912)						3,377	1
2	Food Purchase	(760)		616									(144)	2
3	Housekeeping			617		127							744	3
4	Laundry													4
5	Heat and Other Utilities	(6,199)		815		168							(5,216)	5
6	Maintenance	7,827		5,320	10,143	61							23,351	6
7	Other (specify):*				3,058	1,359							4,417	7
8	**TOTAL General Services**	868		7,717	13,201	10,655	(5,912)						26,529	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records					60,688							60,688	10
10a	Therapy													10a
11	Activities													11
12	Social Services					26,263							26,263	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					13,215							13,215	15
16	**TOTAL Health Care and Programs**					100,166							100,166	16
	C. General Administration													
17	Administrative			4,079	22,519	80,509							107,107	17
18	Directors Fees													18
19	Professional Services	(6,322)		(460,410)		(229,938)							(696,670)	19
20	Fees, Subscriptions & Promotions	(34,358)	250	3,643		250							(30,215)	20
21	Clerical & General Office Expenses	(189,773)	49	17,218	141,763	10,187							(20,556)	21
22	Employee Benefits & Payroll Taxes				(2,515)								(2,515)	22
23	Inservice Training & Education													23
24	Travel and Seminar			467		2,498							2,965	24
25	Other Admin. Staff Transportation			1,239									1,239	25
26	Insurance-Prop.Liab.Malpractice			1,668		748							2,416	26
27	Other (specify):*				30,684	13,391							44,075	27
28	**TOTAL General Administration**	(230,453)	299	(432,096)	192,451	(122,355)							(592,154)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(229,584)	299	(424,379)	205,652	(11,534)	(5,912)						(465,459)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 **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	86,437	138,266	7,498		1,775							233,976	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(62,893)	739,362	2,052		38,125							716,646	32
33	Real Estate Taxes			3,193		657							3,850	33
34	Rent-Facility & Grounds		(1,850,000)										(1,850,000)	34
35	Rent-Equipment & Vehicles			1,171									1,171	35
36	Other (specify):*	(30,877)	30,877											36
37	**TOTAL Ownership**	(7,333)	(941,495)	13,914		40,557							(894,357)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(1,944)	(3,812)	(38,075)	(696)			(44,527)	39
40	Barber and Beauty Shops	(219)											(219)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(662)											(662)	43
44	**TOTAL Special Cost Centers**	(881)					(1,944)	(3,812)	(38,075)	(696)			(45,408)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(237,798)	(941,196)	(410,465)	205,652	29,023	(7,856)	(3,812)	(38,075)	(696)			(1,405,223)	45

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	Rent	$ 1,850,000	Lemont Property, LLC		$	$ (1,850,000)	1
2	V	33	Rent - RE Taxes	358,260	Lemont Property, LLC			(358,260)	2
3	V	32	Interest	136,065	Lemont Property, LLC		875,427	739,362	3
4	V	21	Bank Service Charge		Lemont Property, LLC		49	49	4
5	V	20	Filing Fees		Lemont Property, LLC		250	250	5
6	V	30	Depreciation		Lemont Property, LLC		138,266	138,266	6
7	V	36	Amortization		Lemont Property, LLC		30,877	30,877	7
8	V	33	Real Estate Tax		Lemont Property, LLC		358,260	358,260	8
9	V				Lemont Property, LLC				9
10	V				Lemont Property, LLC				10
11	V				Lemont Property, LLC				11
12	V				Lemont Property, LLC				12
13	V								13
14	Total			$ 2,344,325			$ 1,403,129	$ * (941,196)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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%	$ 349	$ 349	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	616	616	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	617	617	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	815	815	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	5,320	5,320	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	4,079	4,079	20
21	V	19	Professional Fees	470,760	Extended Care Consulting, LLC	100.00%	10,350	(460,410)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,643	3,643	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	17,218	17,218	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	467	467	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,239	1,239	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,668	1,668	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	7,498	7,498	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	2,052	2,052	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,193	3,193	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,171	1,171	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			$ 470,760			$ 60,295	$ * (410,465)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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%	10,143	$ 10,143	15
16	V	06	Maintenance (Direct)	8,383	Extended Care Consulting, LLC	100.00%	8,383		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,040	1,040	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	2,018	2,018	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	22,519	22,519	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	141,763	141,763	22
23	V	21	Office and Clerical (Direct)		Extended Care Consulting, LLC	100.00%			23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	30,684	30,684	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%			25
26	V	22	Employee Benefits	2,515	Extended Care Consulting, LLC	100.00%		(2,515)	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			$ 10,898			$ 216,550	$ * 205,652	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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%	$ 127	$ 127	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	168	168	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	61	61	17
18	V	19	Professional Fees	231,864	Extended Care Clinical, LLC	100.00%	1,926	(229,938)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	250	250	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,585	2,585	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	2,498	2,498	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	748	748	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,775	1,775	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	38,125	38,125	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	657	657	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	8,940	8,940	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,359	1,359	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	60,688	60,688	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	26,263	26,263	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	13,215	13,215	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	80,509	80,509	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	7,602	7,602	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	13,391	13,391	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 231,864			$ 260,887	$ * 29,023	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	$ 21,117	Care Centers Health Systems, Inc.	100.00%	$ 15,204	$ (5,912)	15
16	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			16
17	V	39	Ancillary Expense	6,944	Care Centers Health Systems, Inc.	100.00%	4,999	(1,944)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 28,060			$ 20,204	$ * (7,856)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	Ventilator Equipment	18,380	Vent Lease LLC	100.00%	14,568	$ (3,812)	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			$ 18,380			$ 14,568	$ * (3,812)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	$ 1,967,901	Tri Care Rehab	100.00%	$ 1,929,826	$ (38,075)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,967,901			$ 1,929,826	$ * (38,075)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	Ancillary Expense	78,173	Reliable Medical of the Midwest, LLC	100.00%	77,477	$ (696)	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			$ 78,173			$ 77,477	$ * (696)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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%	$ 253,905	$ 253,905	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	253,905	CCS Employee Benefits Group	100.00%		(253,905)	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			$ 253,905			$ 253,905	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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 Lemont Nrsg & Rehab Center # 0046201 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	ROTHNER HEALTH VENTURES G II, LLC	100.0000%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	LEMONT PROPERTY, LLC		BLDG COMPANY	1
2			BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	EXTENDED CARE CONSULTIN	EVANSTON	MANAGEMENT/BOOKKEEP	2
3			BOULEVARD CARE NURSING AND REHABILITATION CENTER,LL	CHICAGO	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4			BRIAR PLACE LTD	INDIAN HEAD PARK	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPLEM	4
5			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	ROTHNER VENTS LLC	EVANSTON	VENTALATOR RENTAL	6
7			DYER NURSING & REHAB	DYER, IN	TRICARE REHAB	HILLSIDE	THERAPY	7
8			GRASMERE PLACE, LLC	CHICAGO	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLY	8
9			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN	CARE CENTER BULDING LLC	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 Lemont Nrsg & Rehab Center # 0046201 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 Lemont Nrsg & Rehab Center # 0046201 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	Mark Steinberg	Relative	Administrative	N/A	See Attached	3.53	6.26%	Alloc Sal/Fee	$ 12,332	17-07	1
2	Adam Vales	Relative	Clerical	N/A	See Attached	2.37	5.93%	Alloc Salary	4,134	22-07	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	$ 16,466		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 Lemont Nrsg & Rehab Center # 0046201 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 Lemont Nrsg & Rehab Center # 0046201 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	$	53,505	$ 349	1
2	02	Food	Patient Days	1,101,784	30	12,684		53,505	616	2
3	03	Housekeeping	Patient Days	1,101,784	30	12,707		53,505	617	3
4	05	Utilities	Patient Days	1,101,784	30	16,778		53,505	815	4
5	06	Maintenance	Patient Days	1,101,784	30	109,559		53,505	5,320	5
6	17	Administrative	Patient Days	1,101,784	30	84,000		53,505	4,079	6
7	19	Professional Fees	Patient Days	1,101,784	30	213,139		53,505	10,350	7
8	20	Dues and Subscriptions	Patient Days	1,101,784	30	75,016		53,505	3,643	8
9	21	Office and Clerical	Patient Days	1,101,784	30	354,548		53,505	17,218	9
10	24	Seminar and Travel	Patient Days	1,101,784	30	9,615		53,505	467	10
11	25	Other Staff Admin. Trans.	Patient Days	1,101,784	30	25,510		53,505	1,239	11
12	26	Insurance	Patient Days	1,101,784	30	34,345		53,505	1,668	12
13	30	Depreciation	Patient Days	1,101,784	30	154,393		53,505	7,498	13
14	32	Interest	Patient Days	1,101,784	30	42,261		53,505	2,052	14
15	33	Real Estate Taxes	Patient Days	1,101,784	30	65,749		53,505	3,193	15
16	35	Rent - Equipment & Auto	Patient Days	1,101,784	30	24,117		53,505	1,171	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,241,615	$		$ 60,295	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	53,505	10,143	1
2	06	Maintenance (Direct)	Direct		30	331,520	331,520		8,383	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,101,784	30	21,409		53,505	1,040	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		30	37,937			2,018	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,101,784	30	463,710	463,710	53,505	22,519	7
8	21	Office and Clerical (Pooled)	Patient Days	1,101,784	30	2,919,199	2,919,199	53,505	141,763	8
9	21	Office and Clerical (Direct)	Direct		30	328,534	328,534			9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,101,784	30	631,850		53,505	30,684	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		30	55,508				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		$ 216,550	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	$	53,505	$ 127	1
2	05	Utilities	Patient Days	610,520	17	1,914		53,505	168	2
3	06	Maintenance	Patient Days	610,520	17	698		53,505	61	3
4	19	Professional Fees	Patient Days	610,520	17	21,974		53,505	1,926	4
5	20	Dues and Subscriptions	Patient Days	610,520	17	2,847		53,505	250	5
6	21	Office & Clerical	Patient Days	610,520	17	29,496		53,505	2,585	6
7	24	Travel and Seminar	Patient Days	610,520	17	28,507		53,505	2,498	7
8	26	Insurance	Patient Days	610,520	17	8,533		53,505	748	8
9	30	Depreciation	Patient Days	610,520	17	20,257		53,505	1,775	9
10	32	Interest	Patient Days	610,520	17	435,028		53,505	38,125	10
11	33	Real Estate Taxes	Patient Days	610,520	17	7,502		53,505	657	11
12	01	Dietary Salary	Patient Days	610,520	17	102,014	102,014	53,505	8,940	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	610,520	17	15,504		53,505	1,359	13
14	10	Nursing Salary	Patient Days	610,520	17	692,482	692,482	53,505	60,688	14
15	12	Social Service Salary	Patient Days	610,520	17	299,672	299,672	53,505	26,263	15
16	15	Emp. Ben. - Healthcare	Patient Days	610,520	17	150,791		53,505	13,215	16
17	17	Administration Salary	Patient Days	610,520	17	918,652	918,652	53,505	80,509	17
18	21	Office Salary	Patient Days	610,520	17	86,739	86,739	53,505	7,602	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	610,520	17	152,803		53,505	13,391	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,976,862	$ 2,099,559		$ 260,887	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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			$	$		$ 15,204	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						4,999	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					$	$		$ 20,204	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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						14,568	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					$	$		$ 14,568	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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			$	$		$ 1,929,826	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,929,826	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	Ancillary Expense	Direct Allocation						77,477	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					$	$		$ 77,477	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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			$	$		$ 253,905	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					$	$		$ 253,905	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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 Lemont Nrsg & Rehab Center # 0046201 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Cole Taylor		X				$	$ 14,145,000			$ 875,428	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Alloc from Extended Care Consult		X								2,052	6
7	Alloc from Extended Care Clinical		X								38,125	7
8	See Supplemental Schedule										1,808	8
9	TOTAL Facility Related						$	$ 14,145,000			$ 917,413	9
	B. Non-Facility Related*											
10	Interest Income		X								(62,893)	10
11	Interest Income - Bldg Co.		X								(136,065)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (198,958)	14
15	TOTALS (line 9+line14)						$	$ 14,145,000			$ 718,455	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	DAIQA		X	Line of Credit			$	$			$ 1,808	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										1,808	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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.**	$ 342,965	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.)		$ 345,911	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,946	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 359,164	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.)**		$ 117	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 362,227	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	314,643	8
	2009	341,908	9
	2010	352,925	10
	2011	326,633	11
	2012	342,061	12

2013 Accrual: $342,061 x 1.05 = $359,164

Allocated from Extended Care Consulting: $3,193

Allocated from Extended Care Clinical: $657

	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 Lemont Nrsg & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 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.	22-27-300-076-0000	Long Term Care Property	$ 334,092.58	$ 334,092.58
2.	22-27-300-077-0000	Long Term Care Property	$ 7,968.66	$ 7,968.66
3.	See Attached	Alloc from 2201 Main/Care Center	$ 133,178.74	$ 3,035.66
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 475,239.98	$ 345,096.90

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 Lemont Nrsg & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$

4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 Report Period Beginning: 01/01/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2003	$ 823,094	1
2	Allocated from 2201 Main/Care Centers Building LLC			18,691	2
3	TOTALS			$ 841,785	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	158		2003	1995	$ 5,391,423	$ 138,266	Various	$ 252,705	$ 114,439	$ 3,098,043	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	48,664		20	2,045	2,045	28,929	9
10	Various			2004	35,166		20	1,628	1,628	20,935	10
11	Various			2005	7,375		20	369	369	3,288	11
12	Various			2007	30,675		20	1,809	1,809	12,139	12
13	Various			2008	46,456		20	2,323	2,323	12,859	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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
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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)		75,873	5,156		5,156		51,356	68
69	Financial Statement Depreciation			120,850			(120,850)		69
70	TOTAL (lines 4 thru 69)		$ 5,635,632	$ 264,272		$ 266,035	$ 1,763	$ 3,227,550	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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		$ 5,635,632	$ 264,272		$ 266,035	$ 1,763	$ 3,227,550	1
2	Exhaust Fan	2010	2,350		20	118	118	421	2
3	Exhaust Fan	2010	2,350		20	118	118	421	3
4	Fire System	2010	2,573		20	129	129	418	4
5	Improvements	2010	36,450		20	1,823	1,823	5,771	5
6	Rooftop A/C Unit	2010	16,850		20	843	843	2,598	6
7	Fire System	2010	7,628		20	381	381	1,176	7
8	Security Cameras	2010	5,302		20	530	530	1,635	8
9	Fire System	2010	18,990		20	950	950	2,928	9
10	Fire System	2010	19,225		20	961	961	2,964	10
11	Fire System	2010	8,998		20	450	450	1,387	11
12	Sprinkler System Repair	2011	2,745		20	137	137	412	12
13	Dry System Repair	2011	5,710		20	286	286	833	13
14	Flooring & Trim Renovation	2011	35,000		20	1,750	1,750	4,229	14
15	Blinds	2011	9,834		20	1,967	1,967	5,081	15
16	Flooring & Trim Renovation	2011	35,000		20	1,750	1,750	4,083	16
17	Flooring & Trim Renovations	2011	25,000		20	1,250	1,250	2,917	17
18	Flooring & Trim Renovations	2011	35,000		20	1,750	1,750	3,938	18
19	Flooring & Trim Renovations	2011	80,000		20	4,000	4,000	9,000	19
20	Fuel Injection Pump	2011	5,895		20	295	295	614	20
21	Pipe Repair - Fire Alarm System	2011	3,372		20	169	169	450	21
22	Fire Sprinkler System Repair	2011	6,285		20	314	314	838	22
23	Painting	2011	5,547		20	277	277	693	23
24	Painting	2011	6,688		20	334	334	808	24
25	Painting	2011	12,721		20	636	636	1,484	25
26	Painting	2011	4,439		20	222	222	499	26
27	Painting	2011	3,660		20	183	183	397	27
28	Painting	2011	3,262		20	163	163	340	28
29	Flooring & Trim	2012	24,700		20	4,940	4,940	8,645	29
30	Landmark Construction - Wood Trim In Hallways, Flooring	2012	25,000		20	5,000	5,000	10,000	30
31	Flooring & Trim Renovation	2012	15,540		20	3,108	3,108	6,216	31
32	Hvac	2012	8,725		20	436	436	509	32
33	Architectual Fees	2012	20,000		20	1,000	1,000	1,667	33
34	TOTAL (lines 1 thru 33)		$ 6,130,471	$ 264,272		$ 302,303	$ 38,031	$ 3,310,920	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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		$ 6,130,471	$ 264,272		$ 302,303	$ 38,031	$ 3,310,920	1
2	Replace 2 Metal Doors	2012	6,185		20	309	309	361	2
3	Painting	2012	2,523		20	126	126	252	3
4	Painting	2012	3,208		20	160	160	307	4
5	Sprinkler System Repair	2012	5,470		20	274	274	433	5
6	New Conduit & Wire For Lighting In North Corridor, Nurse Static	2012	3,900		20	195	195	293	6
7	Installed Wiring, Fire Cable & Transformer	2012	4,558		20	228	228	399	7
8	New Piping In Attic And First Floor	2012	7,534		20	377	377	691	8
9	Corridors On All Floors - Painting	2012	35,637		20	1,782	1,782	1,930	9
10	Flood Repair	2012	7,000		20	350	350	613	10
11	Room 160 - Removed Concrete, Installed Vinyl Tiles	2013	3,400		20	170	170	170	11
12	Nurse Call System	2013	12,239		20	272	272	272	12
13	Patched Asphalt, Installed Concrete Slabs	2013	5,140		20	144	144	144	13
14	Physical Therapy Rm -Carpentry, Framing, Drywall, Electrical, Pa	2013	13,350		20	556	556	556	14
15	1St & 2Nd Floor Elevators - Piping Skylights And Sprinklers	2013	6,440		20	268	268	268	15
16	Dining Rm, Pt Closets - Flooring, Trim And Paint, Wallcover, Dry	2013	57,717		20	2,164	2,164	2,164	16
17	Toilet And Sewer Line Repairs; Slab Jacking	2013	3,350		20	98	98	98	17
18	Fire Damper Repairs	2013	2,575		20	300	300	300	18
19	Installed Backflow Preventer For Sprinkler System	2013	7,950		20	133	133	133	19
20	Front Site Lighting And Repair	2013	16,500		20	825	825	825	20
21	Sprinklers - Repaired Butterfly Valves From Sprinklers	2013	2,778		20	139	139	139	21
22	Sprinklers - Replaced Dry Valve, Installed New Trim, Accelerator,	2013	5,023		20	251	251	251	22
23	Generator Repair - E-Stop Button And Wiring	2013	2,832		20	142	142	142	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)		$ 6,345,779	$ 264,272		$ 311,566	$ 47,294	$ 3,321,661	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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		$ 6,345,779	$ 264,272		$ 311,566	$ 47,294	$ 3,321,661	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,345,779	$ 264,272		$ 311,566	$ 47,294	$ 3,321,661	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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		$ 6,345,779	$ 264,272		$ 311,566	$ 47,294	$ 3,321,661	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,345,779	$ 264,272		$ 311,566	$ 47,294	$ 3,321,661	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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
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29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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
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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 Lemont Nrsg & Rehab Center # 0046201 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 2201 Main LLC/Care Centers Building LLC	2002	21,359	548	20	548		6,184	3
4	Allocated from Extended Care Clinical LLC	2002	4,398	113	20	113		1,273	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Extended Care Consulting LLC	2007	223	11	20	11		78	9
10	Allocated from Extended Care Consulting LLC	2009	134	7	20	7		34	10
11	Allocated from Extended Care Consulting LLC	2010	1,310	66	20	66		262	11
12	Allocated from Extended Care Consulting LLC	2011	472	24	20	24		71	12
13	Allocated from Extended Care Consulting LLC	2012	155	8	20	8		16	13
14									14
15	Allocated from 2201 Main LLC/Care Centers Building LLC	2002	17,644	1,612	20	1,612		16,140	15
16	Allocated from 2201 Main LLC/Care Centers Building LLC	2003	20,793	1,900	20	1,900		19,021	16
17	Allocated from 2201 Main LLC/Care Centers Building LLC	2005	1,033	110	20	110		812	17
18	Allocated from 2201 Main LLC/Care Centers Building LLC	2009	186	9	20	9		47	18
19									19
20	Allocated from Extended Care Clinical LLC	2002	3,633	332	20	332		3,324	20
21	Allocated from Extended Care Clinical LLC	2003	4,282	391	20	391		3,917	21
22	Allocated from Extended Care Clinical LLC	2005	213	23	20	23		167	22
23	Allocated from Extended Care Clinical LLC	2009	38	2	20	2		10	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 75,873	$ 5,156		$ 5,156	$	$ 51,356	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	$ 181,186	$ 502	$ 31,854	$ 31,352	10	$ 109,868	71
72	Current Year Purchases	62,442	96	7,888	7,792	10	7,888	72
73	Fully Depreciated Assets	519,172	2,620	2,620		10	519,172	73
74								74
75	TOTALS	$ 762,800	$ 3,218	$ 42,362	$ 39,144		$ 636,928	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Extended Care C	2013	$ 7,526	$	$	$	5	$ 7,526	76
77		Allocated from Extended Care Cl	2013	4,503	901	900	(1)	5	1,331	77
78										78
79										79
80	TOTALS			$ 12,029	$ 901	$ 900	$ (1)		$ 8,857	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,962,393	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 268,391	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 354,828	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 86,437	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,967,446	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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 ☐ 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 ☐ NO

16. Rental Amount for movable equipment: $ 9,377 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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 Lemont Nrsg & Rehab Center # 0046201 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	$		$ 806,796	$		$ 806,796	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			121,829			121,829	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			1,040,811			1,040,811	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				854,730		854,730	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					23,623	440,640		464,263	13
14	TOTAL			$		$ 1,993,059	$ 1,295,370		$ 3,288,429	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 Lemont Nrsg & Rehab Center # 0046201 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	$ 276,534	$ 524,204	1
2	Cash-Patient Deposits	39,067	39,067	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,389,690	1,389,690	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	243,824	243,824	6
7	Other Prepaid Expenses	3,265	37,560	7
8	Accounts Receivable (owners or related parties)	68,240	8,138,283	8
9	Other(specify): See Attached Schedule	11,533,618	11,731,181	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 13,554,238	$ 22,103,809	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		823,094	13
14	Buildings, at Historical Cost		5,590,504	14
15	Leasehold Improvements, at Historical Cost	790,784	790,784	15
16	Equipment, at Historical Cost	410,100	410,100	16
17	Accumulated Depreciation (book methods)	(546,433)	(3,199,234)	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):		100,350	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 654,451	$ 4,515,598	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,208,689	$ 26,619,407	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,754,961	$ 1,754,962	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,221	33,221	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	328,602	328,602	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,058	21,058	31
32	Accrued Real Estate Taxes(Sch.IX-B)	359,164	359,164	32
33	Accrued Interest Payable		73,083	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36			54,292	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,497,006	$ 2,624,382	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		14,145,000	39
40	Mortgage Payable			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)**	$	$ 14,145,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,497,006	$ 16,769,382	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,711,683	$ 9,850,025	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,208,689	$ 26,619,407	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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**	$ 10,781,097	1
2	Restatements (describe):		2
3	**Prior Year Depreciation**	(5,336)	3
4	**Prior Year R&M**	(7,000)	4
5	**Rounding**	7	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,768,768	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,778,720	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	(834,805)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)	(1,000)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 942,915	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)**	$ 11,711,683	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 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	$ 16,562,015	1
2	Discounts and Allowances for all Levels	(10,018,802)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,543,213	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,895,937	6
7	Oxygen	300	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 8,896,237	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,918	13
14	Non-Patient Meals	14	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	870,014	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	161,521	19
20	Radiology and X-Ray	35,771	20
21	Other Medical Services	118,905	21
22	Laundry	6,468	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,194,611	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	62,893	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 62,893	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	12,745	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,745	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,709,699	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,722,690	31
32	Health Care	4,518,400	32
33	General Administration	2,762,223	33
	B. Capital Expense		
34	Ownership	2,339,124	34
	C. Ancillary Expense		
35	Special Cost Centers	3,289,310	35
36	Provider Participation Fee	299,232	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,930,979	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,778,720	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,778,720	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,568,884	44
45	Private Pay - Net Inpatient Revenue	2,361,307	45
46	Medicare - Net Inpatient Revenue	219,235	46
47	Other-(specify) Hospice	355,489	47
48	Other-(specify) Insurance	38,298	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,543,213	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 Lemont Nrsg & Rehab Center # 0046201 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	1,971	2,028	$ 101,747	$ 50.17	1
2	Assistant Director of Nursing	1,257	1,397	55,452	39.69	2
3	Registered Nurses	27,188	29,626	1,024,875	34.59	3
4	Licensed Practical Nurses	32,661	34,849	977,715	28.06	4
5	CNAs & Orderlies	98,069	104,071	1,305,520	12.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,707	12,680	238,625	18.82	8
9	Activity Director	1,628	1,880	40,284	21.43	9
10	Activity Assistants	15,579	16,460	153,454	9.32	10
11	Social Service Workers	9,557	10,415	227,023	21.80	11
12	Dietician					12
13	Food Service Supervisor	3,888	4,147	96,642	23.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,060	6,812	101,866	14.95	15
16	Dishwashers	13,482	14,273	134,193	9.40	16
17	Maintenance Workers	5,825	6,324	121,257	19.17	17
18	Housekeepers	20,012	21,641	207,240	9.58	18
19	Laundry	4,757	5,230	55,776	10.66	19
20	Administrator	1,919	2,101	125,064	59.53	20
21	Assistant Administrator	1,808	2,020	53,609	26.54	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,057	8,669	153,537	17.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,935	3,239	51,551	15.92	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,677	1,723	28,324	16.44	33
34	TOTAL (lines 1 - 33)	270,037	289,585	$ 5,253,754 *	$ 18.14	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	450	$ 21,082	01-03	35
36	Medical Director	Monthly	51,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,106	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	93	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	451	$ 82,281		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	12	$ 719	10-03	50
51	Licensed Practical Nurses	270	12,122	10-03	51
52	Certified Nurse Assistants/Aides	349	8,665	10-03	52
53	TOTAL (lines 50 - 52)	631	$ 21,506		53

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

** See instructions.

Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Wendy Janulis	Administrator	0.00%	$ 125,064
Jamie Krieps	Assistant Admin	0.00%	53,609
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 178,673

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Rothblatt, and Ruttenberg	Accounting	$ 25,783
Personal Planners	Unemployment Consultant	3,240
Paycor Payroll Services	Payroll Processing	26,735
E-Health Data Solutions	MDS Software Fee	3,180
AIS Assessment & Intelligence	Customer Satisfaction Survey	1,260
Ability Network	Medicare Billing	161
National Datacare Corporation	Resident Fund Processing	1,441
Online MSDS	MSDS Management	585
Pinnacle Consulting	Customer Satisf. Survey	3,073
Limitless Technology	Cost Reduction Services	938
Legat Architects	Architectural Services	12,939
See Supplemental Schedule		748,031
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 827,366

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 121,595
Unemployment Compensation Insurance	204,681
FICA Taxes	392,396
Employee Health Insurance	157,481
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	13,374
Holiday Expense	2,283
TOTAL (agree to Schedule V, line 22, col.8)	$ 891,809

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	3,063
Health Care Worker Background Check	7,385
(Indicate # of checks performed 678)	
Patient Background Checks	
Dues and Subscriptions	16,976
Licenses and Fees	2,190
Alloc. from Extended Care Consulting	3,643
Alloc. from Extended Care Clinical	250
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,497

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,143
Alloc. from Extended Care Consulting	467
Alloc. from Extended Care Clinical	2,498
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,108

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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Facility Name & ID Number Lemont Nrsg & Rehab Center # 0046201 Report Period Beginning: 01/01/13 Ending: 12/31/13

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on Long Term Care $16,116**

(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. $ **69,840** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **299,232**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **14**

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

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

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

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