

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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.

<p>I. IDPH Facility ID Number: <u>0046201</u></p> <p>Facility Name: <u>Lemont Nursing & Rehabilitation Center</u></p> <p>Address: <u>12450 Walker Road</u> <u>Lemont</u> <u>60539</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(630) 243-0400</u> Fax # <u>(630) 243-5063</u></p> <p>HFS ID Number: <u>38366376001</u></p> <p>Date of Initial License for Current Owners: <u>02/01/03</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact Name: <u>Mike Kaplan</u> Telephone Number: <u>(847) 905-4042</u> Please send copies of desk review and audit adjustments to address on this page</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2006</u> to <u>12/31/2006</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Type or Print Name) <u>Mike Kaplan</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Title) <u>Chief Financial Officer</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # _____</td> </tr> </table> <p align="center"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Mike Kaplan</u>	Paid Preparer	(Title) <u>Chief Financial Officer</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Mike Kaplan</u>							
Paid Preparer	(Title) <u>Chief Financial Officer</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # _____							

Facility Name & ID Number Lemont Nursing & Rehabilitation Center

0046201 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF	22,644	16,205	12,754	51,603	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,644	16,205	12,754	51,603	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.48%

D. How many bed-hold days during this year were paid by the Department? 35 (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 Non-allowable costs have been eliminated in Schedule V, Column 7.

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

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 Date 02/01/2003 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 158 and days of care provided 12,346

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year YES NO

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
1	A. General Services										
1	Dietary	316,779	27,181	12,931	356,891		356,891	4,784	361,675		1
2	Food Purchase		251,340		251,340		251,340	(16,908)	234,432		2
3	Housekeeping	164,292	45,375	17,716	227,383		227,383	(3,156)	224,227		3
4	Laundry	44,729	15,157		59,886		59,886		59,886		4
5	Heat and Other Utilities			145,594	145,594		145,594	2,184	147,778		5
6	Maintenance	113,508		93,207	206,715		206,715	9,093	215,808		6
7	Other (specify):*			655	655		655	41,858	42,513		7
8	TOTAL General Services	639,308	339,053	270,103	1,248,464	0	1,248,464	37,855	1,286,319		8
	B. Health Care and Programs										
9	Medical Director			39,000	39,000		39,000		39,000		9
10	Nursing and Medical Records	3,500,308	188,031	19,428	3,707,767		3,707,767	4,939	3,712,706		10
10a	Therapy		1,214	818,105	819,319		819,319	(83,384)	735,935		10a
11	Activities	133,497	35,162	2,450	171,109		171,109		171,109		11
12	Social Services	99,323		220	99,543		99,543	11,601	111,144		12
13	CNA Training				0		0		0		13
14	Program Transportation				0		0		0		14
15	Other (specify):*				0		0	992	992		15
16	TOTAL Health Care and Programs	3,733,128	224,407	879,203	4,836,738	0	4,836,738	(65,852)	4,770,886		16
	C. General Administration										
17	Administrative	105,577		543,403	648,980		648,980	(493,655)	155,325		17
18	Directors Fees				0		0		0		18
19	Professional Services			104,973	104,973		104,973	3,115	108,088		19
20	Dues, Fees, Subscriptions & Promotion			32,983	32,983		32,983	8,872	41,855		20
21	Clerical & General Office Expense:	214,870	31,928	48,458	295,256		295,256	138,760	434,016		21
22	Employee Benefits & Payroll Tax:			765,875	765,875		765,875	(4,030)	761,845		22
23	Inservice Training & Education			2,133	2,133		2,133		2,133		23
24	Travel and Seminar			140	140		140	4,006	4,146		24
25	Other Admin. Staff Transportation			2,249	2,249		2,249	107	2,356		25
26	Insurance-Prop.Liab.Malpractice			145,811	145,811		145,811	1,296	147,107		26
27	Other (specify):*				0		0	27,059	27,059		27
28	TOTAL General Administration	320,447	31,928	1,646,025	1,998,400	0	1,998,400	(314,470)	1,683,930		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,692,883	595,388	2,795,331	8,083,602	0	8,083,602	(342,467)	7,741,135		29

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

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

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Lemont Nursing & Rehabilitation Center

#0046201

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			29,685	29,685		29,685	291,990	321,675			30
31	Amortization of Pre-Op. & Org						0		0			31
32	Interest						0	287,538	287,538			32
33	Real Estate Taxes			232,396	232,396		232,396	1,857	234,253			33
34	Rent-Facility & Grounds			523,777	523,777		523,777	(515,393)	8,384			34
35	Rent-Equipment & Vehicle:			25,576	25,576		25,576	(18,687)	6,889			35
36	Other (specify): ³						0	36,151	36,151			36
37	TOTAL Ownership			811,434	811,434	0	811,434	83,456	894,890			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior				0		0		0			38
39	Ancillary Service Center:		530,453		530,453		530,453	176	530,629			39
40	Barber and Beauty Shops			3,364	3,364		3,364		3,364			40
41	Coffee and Gift Shop:				0		0		0			41
42	Provider Participation Fee			86,505	86,505		86,505		86,505			42
43	Other (specify): ³ Nonallowable Cost			251,412	251,412		251,412	(251,412)	0			43
44	TOTAL Special Cost Centers	0	530,453	341,281	871,734	0	871,734	(251,236)	620,498			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,692,883	1,125,841	3,948,046	9,766,770	0	9,766,770	(510,247)	9,256,523			45

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

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number **Lemont Nursing & Rehabilitation Center**

0046201

Report Period Beginning: **01/01/2006**

Ending: **12/31/2006**

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals	(1,308)	2		4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,134)	30		9
10	Interest and Other Investment Income	(262,304)	32		10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt	(192,205)	43		24
25	Fund Raising, Advertising and Promotions	(15,108)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Sch5A	(209,526)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (683,585)		\$ 0	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	2	
		Amount	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)	173,338		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 173,338		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (510,247)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport		x	\$		38
39						39
40	Gift and Coffee Shop		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Lemont Nursing & Rehabilitation Center

Provider #: 0046201

01/01/2006 to 12/31/2006

Schedule 5A

VI. Adjustment Detail

Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
To offset Other Income	(7,810)	21
To disallow Sales Tax	(3,214)	43
To disallow Collection Expense	(789)	43
To disallow Radiology Expense	(31,614)	43
To disallow Laboratory Expense	(6,546)	43
To disallow Bldg. Co. Replacement Tax		43
To disallow Management Fees	(147,783)	17
To disallow Chamber Dues	(1,050)	20
To disallow Theft Loss	(1,936)	43
To disallow out of period Legal Fees	(8,784)	19
Total	(209,526)	

Lemont Nursing & Rehabilitation Center

ID# 0046201

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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
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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lemont Nursing & Rehabilitation Center# 0046201

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	0	0	436	0	789	0	0	(8)	3,567	0	0	4,784	1
2	Food Purchase	(1,308)	0	0	0	(15,600)	0	0	0	0	0	0	(16,908)	2
3	Housekeeping	0	0	0	0	0	0	0	(3,156)	0	0	0	(3,156)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,991	0	104	0	0	0	89	0	0	2,184	5
6	Maintenance	0	0	8,182	0	166	0	731	(45)	59	0	0	9,093	6
7	Other (specify):*	0	0	746	(372)	0	0	0	0	610	0	0	984	7
8	TOTAL General Services	(1,308)	0	11,355	(372)	(14,541)	0	731	(3,209)	4,325	0	0	(3,019)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	(460)	0	0	(13,705)	19,104	0	0	4,939	10
10a	Therapy	0	0	0	0	0	0	0	0	2,370	(85,754)	0	(83,384)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	2,849	0	0	0	0	0	8,752	0	0	11,601	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	382	0	0	0	0	0	4,254	37,230	0	41,866	15
16	TOTAL Health Care and Programs	0	0	3,231	0	(460)	0	0	(13,705)	34,480	(48,524)	0	(24,978)	16
	C. General Administration													
17	Administrative	0	0	(341,350)	0	1,607	0	0	0	32,527	9,357	0	(297,859)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	11,149	0	47	0	0	0	(47,630)	320	0	(36,114)	19
20	Fees, Subscriptions & Promotions	0	250	5,351	0	73	0	0	0	36	4,212	0	9,922	20
21	Clerical & General Office Expenses	0	0	133,781	0	2,185	0	0	0	9,195	1,409	0	146,570	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	(3,592)	0	(438)	0	0	0	(4,030)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,378	0	0	0	0	0	0	589	0	3,967	24
25	Other Admin. Staff Transportation	0	0	0	0	107	0	0	0	39	0	0	146	25
26	Insurance-Prop.Liab.Malpractice	0	0	(480)	0	160	0	0	0	20	1,596	0	1,296	26
27	Other (specify):*	0	0	18,928	602	535	0	0	0	5,680	1,314	0	27,059	27
28	TOTAL General Administration	0	250	(169,243)	602	4,714	(3,592)	0	(438)	(133)	18,797	0	(149,043)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,308)	250	(154,657)	230	(10,287)	(3,592)	731	(17,352)	38,672	(29,727)	0	(177,040)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lemont Nursing & Rehabilitation Center # 0046201 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Capital Expense	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)
	D. Ownership												
30	Depreciation	(3,134)	275,639	9,609	0	36	0	9,575	0	265	0	0	291,990 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(262,304)	521,092	22,537	0	4	0	1,031	0	756	4,422	0	287,538 32
33	Real Estate Taxes	0	0	1,646	0	37	0	0	0	174	0	0	1,857 33
34	Rent-Facility & Grounds	0	(519,030)	3,637	0	0	0	0	0	0	0	0	(515,393) 34
35	Rent-Equipment & Vehicles	0	0	974	0	66	0	(20,790)	0	0	1,063	0	(18,687) 35
36	Other (specify):*	0	36,151	0	0	0	0	0	0	0	0	0	36,151 36
37	TOTAL Ownership	(265,438)	313,852	38,403	0	143	0	(10,184)	0	1,195	5,485	0	83,456 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	6,619	0	0	(6,443)	0	0	0	176 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(207,313)	0	0	0	0	0	0	0	0	0	0	(207,313) 43
44	TOTAL Special Cost Centers	(207,313)	0	0	0	6,619	0	0	(6,443)	0	0	0	(207,137) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(474,059)	314,102	(116,254)	230	(3,525)	(3,592)	(9,453)	(23,795)	39,867	(24,242)	0	(300,721) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached List		See Attached List		Lemont Property, LLC	Evanston, IL	Building Co.
				See Attached List		

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 Professional Services	\$	Lemont Property LLC	100.00%	\$		1
2	V	19 Professional Services		Lemont Property LLC	100.00%			2
3	V	20 License and Fees		Lemont Property LLC	100.00%	250	250	3
4	V	30 Depreciation		Lemont Property LLC	100.00%	275,639	275,639	4
5	V	36 Amortization		Lemont Property LLC	100.00%	36,151	36,151	5
6	V	32 Interest Expense		Lemont Property LLC	100.00%	537,667	537,667	6
7	V	32 Interest Income		Lemont Property LLC	100.00%	(16,575)	(16,575)	7
8	V	33 Real Estate Tax	231,550	Lemont Property LLC	100.00%	231,550		8
9	V	34 Rent	519,030	Lemont Property LLC	100.00%		(519,030)	9
10	V	43 Illinois Replacement Tax						10
11	V							11
12	V							12
13	V							13
14	Total		\$ 750,580			\$ 1,064,682	\$ * 314,102	14

* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number Lemont Nursing & Rehabilitation Center# 0046201Report Period Beginning: 01/01/2006Ending: 12/31/2006

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary - Other	\$	Care Centers, Inc.	100.00%	\$ 436	\$ 436
16	V	05 Utilities		Care Centers, Inc.	100.00%	1,991	1,991
17	V	06 Maintenance Salary		Care Centers, Inc.	100.00%	5,162	5,162
18	V	06 Maintenance - Other		Care Centers, Inc.	100.00%	3,020	3,020
19	V	07 Employee Benefits - General Serv.		Care Centers, Inc.	100.00%	746	746
20	V	12 Social Service -Salary		Care Centers, Inc.	100.00%	2,849	2,849
21	V	15 Employee Benefits - Healthcare		Care Centers, Inc.	100.00%	382	382
22	V	17 Administrative - Salary		Care Centers, Inc.	100.00%	4,313	4,313
23	V	17 Administrative - Other	347,607	Care Centers, Inc.	100.00%	1,944	(345,663)
24	V	19 Professional Fees	3,600	Care Centers, Inc.	100.00%	14,749	11,149
25	V	20 Dues and Subscriptions		Care Centers, Inc.	100.00%	5,351	5,351
26	V	21 Office & Clerical - Salary		Care Centers, Inc.	100.00%	122,600	122,600
27	V	21 Office & Clerical - Other		Care Centers, Inc.	100.00%	11,181	11,181
28	V	22 Employee Benefits		Care Centers, Inc.	100.00%		
29	V	23 Inservice & Education		Care Centers, Inc.	100.00%		
30	V	24 Travel and Seminar		Care Centers, Inc.	100.00%	3,378	3,378
31	V	25 Other Admin. Staff Transportation		Care Centers, Inc.	100.00%		
32	V	26 Insurance		Care Centers, Inc.	100.00%	(480)	(480)
33	V	27 Employee Benefits - Admin Serv.		Care Centers, Inc.	100.00%	18,928	18,928
34	V	30 Depreciation		Care Centers, Inc.	100.00%	9,609	9,609
35	V	32 Interest		Care Centers, Inc.	100.00%	22,537	22,537
36	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	1,646	1,646
37	V	34 Rent-Building		Care Centers, Inc.	100.00%	3,637	3,637
38	V	35 Rent-Equipment & Auto		Care Centers, Inc.	100.00%	974	974
39	Total		\$ 351,207			\$ 234,953	\$ * (116,254)

* Total must agree with the amount recorded on line 34 of Schedule V1

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06 Maintenance Salary	\$ 760	Care Centers, Inc.	100.00%	\$ 760		15
16	V	07 Employee Benefits - Gen Service	655	Care Centers, Inc.	100.00%	283	(372)	16
17	V	21 Office Salary	3,604	Care Centers, Inc.	100.00%	3,604		17
18	V	27 Employee Benefits - Gen. Admin.		Care Centers, Inc.	100.00%	602	602	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		\$ 5,019			\$ 5,249	\$ *	230 39

* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number Lemont Nursing & Rehabilitation Center# 0046201Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary Other	\$ 139	Care Center Health System	100.00%	\$ 928	\$ 789
16	V	02 Food	16,653	Care Center Health System	100.00%	1,053	(15,600)
17	V	05 Utilities		Care Center Health System	100.00%	104	104
18	V	06 Maintenance		Care Center Health System	100.00%	166	166
19	V	10 Nursing Supplies	460	Care Center Health System	100.00%		(460)
20	V	17 Administrative- Salary		Care Center Health System	100.00%	1,364	1,364
21	V	17 Administrative- Other		Care Center Health System	100.00%	243	243
22	V	19 Professional Fees		Care Center Health System	100.00%	47	47
23	V	20 Dues & Subscriptions		Care Center Health System	100.00%	73	73
24	V	21 Office & Clerical Salary		Care Center Health System	100.00%	2,032	2,032
25	V	21 Office & Clerical Other		Care Center Health System	100.00%	153	153
26	V	23 Inservice & Education		Care Center Health System	100.00%		
27	V	24 Travel & Seminar		Care Center Health System	100.00%		
28	V	25 Other Admin. Staff Transportation		Care Center Health System	100.00%	107	107
29	V	26 Insurance		Care Center Health System	100.00%	160	160
30	V	27 Employee Benefits - Admin Serv.		Care Center Health System	100.00%	535	535
31	V	30 Depreciation		Care Center Health System	100.00%	36	36
32	V	32 Interest Expense		Care Center Health System	100.00%	4	4
33	V	33 Real Estate Taxes		Care Center Health System	100.00%	37	37
34	V	34 Rent-Building		Care Center Health System	100.00%		
35	V	35 Rent-Equipment & Auto		Care Center Health System	100.00%	66	66
36	V	39 Ancillary	3,370	Care Center Health System	100.00%	9,989	6,619
37	V						
38	V						
39	Total		\$ 20,622			\$ 17,097	\$ * (3,525)

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

Facility Name & ID Number Lemont Nursing & Rehabilitation Center

0046201

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	22 Employee Health Insurance	\$ 179,582	CCS Employee Benefit Group	100.00%	\$ 175,990	\$ (3,592)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 179,582			\$ 175,990	\$ * (3,592)

* Total must agree with the amount recorded on line 34 of Schedule V1

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 Maintenance	\$	Vent Lease LLC	100.00%	\$ 731	\$ 731
16	V	30 Depreciation		Vent Lease LLC	100.00%	9,575	9,575
17	V	32 Interest Expense		Vent Lease LLC	100.00%	1,031	1,031
18	V	35 Rent - Equipment	20,790	Vent Lease LLC	100.00%		(20,790)
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 20,790			\$ 11,337	\$ * (9,453)

* Total must agree with the amount recorded on line 34 of Schedule V1

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$ 101	Xcel Medical Supply, LLC		\$ 93	\$ (8)	15
16	V	02 Food		Xcel Medical Supply, LLC				16
17	V	03 Housekeeping	38,920	Xcel Medical Supply, LLC		35,764	(3,156)	17
18	V	04 Laundry		Xcel Medical Supply, LLC				18
19	V	06 Repairs & Maintenance	550	Xcel Medical Supply, LLC		505	(45)	19
20	V	10 Nursing	168,979	Xcel Medical Supply, LLC		155,274	(13,705)	20
21	V	10a Therapy		Xcel Medical Supply, LLC				21
22	V	11 Activities		Xcel Medical Supply, LLC				22
23	V	20 Dues, Fee, Subscriptions		Xcel Medical Supply, LLC				23
24	V	21 Clerical & General Office		Xcel Medical Supply, LLC				24
25	V	22 Employee Benefits	5,403	Xcel Medical Supply, LLC		4,965	(438)	25
26	V	39 Ancillary	79,434	Xcel Medical Supply, LLC		72,991	(6,443)	26
27	V	43 Other		Xcel Medical Supply, LLC				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		\$ 293,387			\$ 269,592	\$ * (23,795)	39

* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number Lemont Nursing & Rehabilitation Center# 0046201Report Period Beginning: 01/01/2006Ending: 12/31/2006

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary - Salary	\$	Care Center Clinical	100.00%	\$ 3,567	\$ 3,567
16	V	05 Utilities		Care Center Clinical	100.00%	89	89
17	V	06 Maintenance - Other		Care Center Clinical	100.00%	59	59
18	V	07 Employee Benefits - General Serv.		Care Center Clinical	100.00%	610	610
19	V	10 Nursing - Salary		Care Center Clinical	100.00%	19,104	19,104
20	V	10 Nursing - Other		Care Center Clinical	100.00%		
21	V	10a Therapy - Salary		Care Center Clinical	100.00%	2,370	2,370
22	V	12 Social Service - Salary		Care Center Clinical	100.00%	8,752	8,752
23	V	15 Employee Benefits - Healthcare		Care Center Clinical	100.00%	4,254	4,254
24	V	17 Administrative - Salary		Care Center Clinical	100.00%	32,527	32,527
25	V	19 Professional Fees	48,013	Care Center Clinical	100.00%	383	(47,630)
26	V	20 Dues and Subscriptions		Care Center Clinical	100.00%	36	36
27	V	21 Office & Clerical - Salary		Care Center Clinical	100.00%	9,168	9,168
28	V	21 Office & Clerical - Other		Care Center Clinical	100.00%	27	27
29	V	23 Inservice & Education		Care Center Clinical	100.00%		
30	V	24 Travel and Seminar		Care Center Clinical	100.00%		
31	V	25 Other Admin. Staff Transportation		Care Center Clinical	100.00%	39	39
32	V	26 Insurance		Care Center Clinical	100.00%	20	20
33	V	27 Employee Benefits - Admin Serv.		Care Center Clinical	100.00%	5,680	5,680
34	V	30 Depreciation		Care Center Clinical	100.00%	265	265
35	V	32 Interest		Care Center Clinical	100.00%	756	756
36	V	33 Real Estate Taxes		Care Center Clinical	100.00%	174	174
37	V	34 Rent-Building		Care Center Clinical	100.00%		
38	V	35 Rent-Equipment & Auto		Care Center Clinical	100.00%		
39	Total		\$ 48,013			\$ 87,880	\$ * 39,867

* Total must agree with the amount recorded on line 34 of Schedule V1

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10a Therapy Salaries PT	\$	Therapy Works Rehabilitation Services LLC	100.00%	\$ 79,716	\$ 79,716
16	V	10a Therapy Salaries OT		Therapy Works Rehabilitation Services LLC	100.00%	84,746	84,746
17	V	10a Therapy Salaries ST		Therapy Works Rehabilitation Services LLC	100.00%	32,681	32,681
18	V	10a Therapy Salaries Other		Therapy Works Rehabilitation Services LLC	100.00%	67,651	67,651
19	V	10a Therapy - Other		Therapy Works Rehabilitation Services LLC	100.00%	5	5
20	V	10a Therapy - Other PT	186,344	Therapy Works Rehabilitation Services LLC	100.00%	16,715	(169,629)
21	V	10a Therapy - Other OT	144,987	Therapy Works Rehabilitation Services LLC	100.00%		(144,987)
22	V	10a Therapy - Other ST	35,937	Therapy Works Rehabilitation Services LLC	100.00%		(35,937)
23	V	15 Employee Benefits - Health		Therapy Works Rehabilitation Services LLC	100.00%	37,230	37,230
24	V	17 Administrative- Salary		Therapy Works Rehabilitation Services LLC	100.00%	9,357	9,357
25	V	19 Professional Fees		Therapy Works Rehabilitation Services LLC	100.00%	320	320
26	V	20 Dues & Subscriptions		Therapy Works Rehabilitation Services LLC	100.00%	4,212	4,212
27	V	21 Office & Clerical -Salary		Therapy Works Rehabilitation Services LLC	100.00%		
28	V	21 Office & Clerical Other		Therapy Works Rehabilitation Services LLC	100.00%	1,409	1,409
29	V	24 Travel & Seminar		Therapy Works Rehabilitation Services LLC	100.00%	589	589
30	V	25 Other Admin. Staff Transport		Therapy Works Rehabilitation Services LLC	100.00%		
31	V	26 Insurance		Therapy Works Rehabilitation Services LLC	100.00%	1,596	1,596
32	V	27 Employee Ben. - Gen. Admin		Therapy Works Rehabilitation Services LLC	100.00%	1,314	1,314
33	V	30 Depreciation		Therapy Works Rehabilitation Services LLC	100.00%		
34	V	32 Interest		Therapy Works Rehabilitation Services LLC	100.00%	4,422	4,422
35	V	33 Real Estate Taxes		Therapy Works Rehabilitation Services LLC	100.00%		
36	V	34 Rent- Building		Therapy Works Rehabilitation Services LLC	100.00%		
37	V	35 Rent - Equipment & Auto		Therapy Works Rehabilitation Services LLC	100.00%	1,063	1,063
38	V						
39	Total		\$ 367,268			\$ 343,026	\$ * (24,242)

* Total must agree with the amount recorded on line 34 of Schedule V1

Lemont Nursing & Rehabilitation Center

Provider #: 0046201
01/01/2006 to **12/31/2006**

Schedule 6

Partner Name	Ownership %
Nathan & Shirley Rothner Trust	22.00%
Eric Rothner	1.00%
William Rothner Accum. Trust	11.00%
Daniel Rothner Accum. Trust	11.00%
Rachel Rothner Accum. Trust	11.00%
Mellissa Rothner Accum. Trust	11.00%
Adam Vales Accum. Trust	11.00%
Kathryn Vales Accum. Trust	11.00%
Kimberly Richman Accum. Trust	11.00%
	100.00%

Lemont Nursing & Rehabilitation Center
 Provider #:
 01/01/2006

0046201
 12/31/2006

Schedule 6A

CARE CENTERS, INC.
 SUMMARY OF NON-BUILDING RENTAL
 RELATED ENTITIES
 AS OF
 December 31, 2006

	CARE CENTERS, INC.	CARE CENTER CLINICAL	CARE CENTERS HEALTH SYSTEMS	CCS EMPLOYEE BENEFITS GROUP	XCEL MEDICAL SUPPLIES	CARE VENT LEASE LLC	THERAPY WORKS REHAB	HARBOR LIGHTS	
ILLINOIS HOMES									
Applewood Nursing & Rehabilitation Center	X	X	X	X	X	X	X		
Beecher Manor Nsg & Rehab	X	X	X	X	X	X	X		
Briar Place LTD.	X	X	X	X	X	X		X	
Center for the Hispanic Elderly	X	X	X	X	X	X			
Chateau Village Nursing & Rehabilitation Center	X	X	X	X	X	X	X		
Concord Extended Care	X	X	X	X	X			X	
Grasmere Place LLC	X	X		X	X				
International Village Nursing & Rehabilitation Center	X	X	X	X	X	X			
Lakewood Nursing & Rehabilitation Center	X	X	X	X	X	X	X		
Lemont Nursing & Rehabilitation Center	X	X	X	X	X	X	X		
Pavillion of Forest Park LLC	X	X	X	X	X	X		X	
Plum Grove Nursing & Rehabilitation Center	X	X		X	X				
Prairie Manor Health Care	X	X	X	X	X	X			
Rainbow Beach Nursing Center	X	X		X	X	X	X		
Ridgeland Nursing & Rehabilitation Center	X	X	X	X	X	X			
Sheridan Shores Nursing & Rehabilitation Center	X	X	X	X	X				
Snow Valley Nursing & Rehabilitation Center	X	X	X	X	X		X		
Somerset Place LLC	X	X		X	X	X			
South Shores Nursing & Rehabilitation Center	X	X	X	X	X	X			
Tri-State Nursing & Rehabilitation Center	X	X	X	X	X	X			
Washington Heights Nursing & Rehabilitation Center	X	X	X	X	X	X			
Westshire Nursing & Rehabilitation Center	X	X	X	X	X	X			
Wheaton Care Center, LTD	X	X	X	X	X	X		X	
INDIANA HOMES									
Clark Nursing & Rehabilitation Center	X	X	X	X	X	X		X	
Dyer Nursing & Rehabilitation Center	X	X	X	X	X	X	X	X	
East Lake Nursing & Rehabilitation Center	X	X	X	X	X	X		X	
Lake County Nursing & Rehabilitation Center	X	X	X	X	X	X		X	
Northlake Nursing & Rehabilitation Center	X	X	X	X	X	X		X	
Sebos, Nursing & Rehabilitation Center	X	X	X	X	X	X		X	
Sheffield Manor	X	X		X	X				
Valparaiso Care & Rehabilitation Center	X	X	X	X	X	X		X	
OHIO HOMES									
McKinley Health Care Center	X	X	X	X	X	X			

THIS INFORMATION IS PROVIDED ONLY FOR PURPOSES OF MEDICAID COST REPORTS COMPLIANCE.
 THE AFFILIATED PARTIES ARE NOT NECESSARY RELATED PARTIES OTHER THAN BY MEDICAID RULE.
 THESE RULES ARE NOT GUIDELINES FOR ANY OTHER PURPOSE.

Lemont Nursing & Rehabilitation Center

Provider #: 0046201

01/01/2006

12/31/2006

Schedule 6B

RELATED NURSING HOMES
December 31, 2006

GROUP NAME	FACILITY NAME	CITY
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CARE CENTERS, INC.

ILLINOIS HOMES

Applewood Nursing & Rehabilitation Center	MATTESON
Beecher Manor Nursing & Rehab	BEECHER
Briar Place LTD.	INDIAN HEAD
Center for the Hispanic Elderly	CHICAGO
Chateau Village Nursing & Rehabilitation Center	WILLOWBROOK
Concord Extended Care	OAK LAWN
Grasmere Place LLC	CHICAGO
International Village Nursing & Rehabilitation Center	CHICAGO
Lakewood Nursing & Rehabilitation Center	PLAINFIELD
Lemont Nursing & Rehabilitation Center	LEMONT
Pavillion of Forest Park LLC	FOREST PARK
Plum Grove Nursing & Rehabilitation Center	PALATINE
Prairie Manor Health Care	CHICAGO HEIGHTS
Rainbow Beach Nursing Center	CHICAGO
Ridgeland Nursing & Rehabilitation Center	PALOS HEIGHTS
Sheridan Shores Nursing & Rehabilitation Center	CHICAGO
Snow Valley Nursing & Rehabilitation Center	LISLE
Somerset Place LLC	CHICAGO
South Shores Nursing & Rehabilitation Center	CHICAGO
Tri-State Nursing & Rehabilitation Center	Lansing
Washington Heights Nursing & Rehabilitation Center	CHICAGO
Westshire Nursing & Rehabilitation Center	CICERO
Wheaton Care Center, LTD	WHEATON

INDIANA HOMES

Clark Nursing & Rehabilitation Center	Gary
Dyer Nursing & Rehabilitation Center	Dyer
East Lake Nursing & Rehabilitation Center	Elkhardt
Lake County Nursing & Rehabilitation Center	East Chicago
Northlake Nursing & Rehabilitation Center	Merriville
Sebos, Nursing & Rehabilitation Center	Holbart
Sheffield Manor	Dyer
Valparaiso Care & Rehabilitation Center	Valparaiso

OHIO HOMES

McKinley Health Care Center	Canton
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THIS INFORMATION IS PROVIDED ONLY FOR PURPOSES OF MEDICAID COST REPORTS COMPLIANCE.
THE AFFILIATED PARTIES ARE NOT NECESSARY RELATED PARTIES OTHER THAN BY MEDICAID RULE.
THESE RULES ARE NOT GUIDELINES FOR ANY OTHER PURPOSE.

Lemont Nursing & Rehabilitation Center

Provider #:

0046201

01/01/2006

12/31/2006

Schedule 6C

OTHER RELATED BUSINESS ENTITIES

AS OF

December 31, 2006

NAME		CITY	TYPE OF BUSINESS
CARE CENTERS, INC.		EVANSTON, IL	MANAGEMENT COMPANY
CARE CENTER CLINICAL		EVANSTON, IL	MANAGEMENT COMPANY
CARE CENTERS HEALTH SYSTEM		EVANSTON, IL	DIETARY & FOOD SUPPLEMENTS
HARBOR LIGHTS	*	GLEN ELLYN	HOSPICE
ROTHNER VENTS LLC		EVANSTON, IL	MEDICAL EQUIP RENTAL
XCEL MEDICAL SUPPLY		EVANSTON, IL	MEDICAL SUPPLIES
2201 MAIN, LLC		EVANSTON, IL	BUILDING COMPANY

* - Page 6 & 8 Are not required for this entity since there was no payment from the Nursing Homes to the Related Entity

SEE THE ATTACHED SUMMARY FOR THE APPLICABILITY OF EACH RELATED BUSINESS ENTITY TO THE RELATED NURSING HOME

THIS INFORMATION IS PROVIDED ONLY FOR PURPOSES OF MEDICAID COST REPORTS COMPLIANCE. THE AFFILIATED PARTIES ARE NOT NECESSARY RELATED PARTIES OTHER THAN BY MEDICAID RULE THESE RULES ARE NOT GUIDELINES FOR ANY OTHER PURPOSE.

Facility Name & ID Number Lemont Nursing & Rehabilitation Center # 0046201 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	1.0000%	See Attached	1.08	2.70%	CCI -Salary	\$ 1,769	17-7	1
2	Mark Steinberg	Relative	Administrative	0.0000%	See Attached	1.78	4.45%	CCI -Salary	4,328	17-7	2
3	Gale Rothner	Relative	Administrative	0.0000%	See Attached	1.13	2.83%	CCI -Salary	2,527	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 8,624		13

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

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

Facility Name & ID Number Lemont Nursing & Rehabilitation Center # 0046201 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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

Name of Related Organization Care Centers, Inc
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 6020
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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

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 - Other	Patient Days	32	\$ 13,468	\$ 51,603	51,603	\$ 436	1
2	05	Utilities	Patient Days	32	61,456	51,603	51,603	1,991	2
3	06	Maintenance Salary	Patient Days	32	159,318	159,318	51,603	5,162	3
4	06	Maintenance - Other	Patient Days	32	93,209	51,603	51,603	3,020	4
5	07	Employee Benefits - Gen Serv.	Patient Days	32	23,038	51,603	51,603	746	5
6	12	Social Service - Salary	Patient Days	32	87,938	87,938	51,603	2,849	6
7	15	Employee Benefits - Healthcare	Patient Days	32	11,794	51,603	51,603	382	7
8	17	Administrative - Salary	Patient Days	32	133,122	133,122	51,603	4,313	8
9	17	Administrative - Other	Patient Days	32	60,000	51,603	51,603	1,944	9
10	19	Professional Fees	Patient Days	32	455,203	51,603	51,603	14,749	10
11	20	Dues and Subscriptions	Patient Days	32	165,158	51,603	51,603	5,351	11
12	21	Office & Clerical - Salary	Patient Days	32	3,783,895	3,783,895	51,603	122,600	12
13	21	Office & Clerical - Other	Patient Days	32	345,085	51,603	51,603	11,181	13
14	22	Employee Benefits	Patient Days	32	51,603	51,603	51,603	0	14
15	23	Inservice & Education	Patient Days	32	51,603	51,603	51,603	0	15
16	24	Travel and Seminar	Patient Days	32	104,250	51,603	51,603	3,378	16
17	25	Other Admin. Staff Transport	Patient Days	32	51,603	51,603	51,603	0	17
18	26	Insurance	Patient Days	32	(14,814)	51,603	51,603	(480)	18
19	27	Employee Benefits - Admin Ser	Patient Days	32	584,195	51,603	51,603	18,928	19
20	30	Depreciation	Patient Days	32	296,584	51,603	51,603	9,609	20
21	32	Interest	Patient Days	32	695,586	51,603	51,603	22,537	21
22	33	Real Estate Taxes	Patient Days	32	50,799	51,603	51,603	1,646	22
23	34	Rent-Building	Patient Days	32	112,256	51,603	51,603	3,637	23
24	35	Rent-Equipment & Auto	Patient Days	32	30,066	51,603	51,603	974	24
25	TOTALS				\$ 7,251,606	\$ 4,164,273		\$ 234,953	25

Facility Name & ID Number Lemont Nursing & Rehabilitation Center # 0046201 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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

Name of Related Organization Care Centers, Inc
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 6020
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance Salary	Direct Cost	760	\$ 760	\$ 760	760	\$ 760	1
2	7	Emp. Ben. - Gen Services	Direct Cost	283	283		283	283	2
3	21	Office Salary	Direct Cost	3,604	3,604	3,604	3,604	3,604	3
4	27	Emp. Ben. - Gen Admin	Direct Cost	602	602		602	602	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,249	\$ 4,364		\$ 5,249	25

Facility Name & ID Number Lemont Nursing & Rehabilitation Center # 0046201 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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

Name of Related Organization Care Center Health System
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 6020
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary Other	2,455,454	27	\$ 91,698	\$	24,841	\$ 928	1
2	02	Food	2,455,454	27	104,128		24,841	1,053	2
3	05	Utilities	2,455,454	27	10,245		24,841	104	3
4	06	Maintenance	2,455,454	27	16,367		24,841	166	4
5	10	Nursing Supplies	2,455,454	27			24,841	0	5
6	17	Administrative- Salary	2,455,454	27	134,802	134,802	24,841	1,364	6
7	17	Administrative- Other	2,455,454	27	24,000		24,841	243	7
8	19	Professional Fees	2,455,454	27	4,618		24,841	47	8
9	20	Dues & Subscriptions	2,455,454	27	7,167		24,841	73	9
10	21	Office & Clerical Salary	2,455,454	27	200,852	200,852	24,841	2,032	10
11	21	Office & Clerical Other	2,455,454	27	15,126		24,841	153	11
12	23	Inservice & Education	2,455,454	27			24,841	0	12
13	24	Travel & Seminar	2,455,454	27			24,841	0	13
14	25	Other Admin. Staff Transport	2,455,454	27	10,605		24,841	107	14
15	26	Insurance	2,455,454	27	15,802		24,841	160	15
16	27	Employee Benefits - Admin Ser	2,455,454	27	52,885		24,841	535	16
17	30	Depreciation	2,455,454	27	3,557		24,841	36	17
18	32	Interest Expense	2,455,454	27	392		24,841	4	18
19	33	Real Estate Taxes	2,455,454	27	3,660		24,841	37	19
20	34	Rent-Building	2,455,454	27			24,841	0	20
21	35	Rent-Equipment & Auto	2,455,454	27	6,478		24,841	66	21
22	39	Ancillary	2,455,454	27	987,356		24,841	9,989	22
23									23
24									24
25	TOTALS				\$ 1,689,738	\$ 335,654		\$ 17,097	25

Facility Name & ID Number Lemont Nursing & Rehabilitation Center # 0046201 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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

Name of Related Organization CCS Employee Benefits Group, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 6020
 Phone Number (847) 905-4000
 Fax Number (847) 905-4040

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

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	<u>Employee Health Insuranc</u>	<u>Direct Allocation</u>						<u>175,990</u>	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				\$	\$		\$ <u>175,990</u>	25

Facility Name & ID Number Lemont Nursing & Rehabilitation Center # 0046201 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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

Name of Related Organization Vent Lease, LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 6020
 Phone Number (847) 905-4000
 Fax Number (847) 905-4040

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	868,537	29	\$ 30,521	\$ 20,790	731	\$ 731	1
2	30	Depreciation	868,537	29	400,000	20,790	20,790	9,575	2
3	32	Interest	868,537	29	43,063	20,790	20,790	1,031	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				\$ 473,584	\$		\$ 11,337	25

Facility Name & ID Number Lemont Nursing & Rehabilitation Center # 0046201 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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

Name of Related Organization Xcel Medical Supply, LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 6020
 Phone Number (847) 328-7600
 Fax Number (847) 328-7615

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1 Dietary	Direct allocation			\$	\$		93	1
2	2 Food	Direct allocation							2
3	3 Housekeeping	Direct allocation						35,764	3
4	4 Laundry	Direct allocation							4
5	6 Repair and Maintenance	Direct allocation						505	5
6	10 Nursing	Direct allocation						155,274	6
7	10a Therapy	Direct allocation							7
8	11 Activities	Direct allocation							8
9	20 Dues, Fee, Subscriptions	Direct allocation							9
10	21 Clerical & General Office	Direct allocation							10
11	22 Employee Benefits	Direct allocation						4,965	11
12	39 Ancillary	Direct allocation						72,991	12
13	43 Other	Direct allocation							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				\$	\$		269,592	25

Facility Name & ID Number Lemont Nursing & Rehabilitation Center # 0046201 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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

Name of Related Organization Care Center Clinical
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 6020
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary - Salary	Patient Days	32	\$ 110,093	\$ 110,093	51,603	\$ 3,567	1
2	05	Utilities	Patient Days	32	2,749		51,603	89	2
3	06	Maintenance - Other	Patient Days	32	1,817		51,603	59	3
4	07	Employee Benefits - Gen Serv	Patient Days	32	18,826		51,603	610	4
5	10	Nursing - Salary	Patient Days	32	589,608	289,608	51,603	19,104	5
6	10	Nursing - Other	Patient Days	32	1,592,658		51,603	0	6
7	10a	Therapy - Salary	Patient Days	32	73,158	73,158	51,603	2,370	7
8	12	Social Service - Salary	Patient Days	32	270,126	270,126	51,603	8,752	8
9	15	Employee Benefits - Healthcare	Patient Days	32	131,280		51,603	4,254	9
10	17	Administrative - Salary	Patient Days	32	1,003,912	1,003,912	51,603	32,527	10
11	19	Professional Fees	Patient Days	32	11,820		51,603	383	11
12	20	Dues and Subscriptions	Patient Days	32	1,118		51,603	36	12
13	21	Office & Clerical - Salary	Patient Days	32	282,969	282,969	51,603	9,168	13
14	21	Office & Clerical - Other	Patient Days	32	847		51,603	27	14
15	23	Inservice & Education	Patient Days	32	1,592,658		51,603	0	15
16	24	Travel and Seminar	Patient Days	32	1,201		51,603	39	16
17	25	Other Admin. Staff Transport	Patient Days	32	1,592,658		51,603	0	17
18	26	Insurance	Patient Days	32	623		51,603	20	18
19	27	Employee Benefits - Admin Ser	Patient Days	32	175,293		51,603	5,680	19
20	30	Depreciation	Patient Days	32	8,167		51,603	265	20
21	32	Interest	Patient Days	32	23,321		51,603	756	21
22	33	Real Estate Taxes	Patient Days	32	5,358		51,603	174	22
23	34	Rent-Building	Patient Days	32	1,592,658		51,603	0	23
24	35	Rent-Equipment & Auto	Patient Days	32	1,592,658			0	24
25	TOTALS				\$ 2,712,286	\$ 2,029,866		\$ 87,880	25

Facility Name & ID Number Lemont Nursing & Rehabilitation Center # 0046201 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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

Name of Related Organization Therapy Works Rehabilitation Services LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 6020
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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

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	10a	Therapy Salaries PT	1,681,285	9	\$ 379,954	\$ 379,954	352,743	\$ 79,716	1
2	10a	Therapy Salaries OT	1,681,285	9	403,928	403,928	352,743	84,746	2
3	10a	Therapy Salaries ST	1,681,285	9	155,766	155,766	352,743	32,681	3
4	10a	Therapy Salaries Other	1,681,285	9	322,445	322,445	352,743	67,651	4
5	10a	Therapy - Other	1,681,285	9	23		352,743	5	5
6	10a	Therapy - Other PT	1,681,285	9	79,669		352,743	16,715	6
7	10a	Therapy - Other OT	1,681,285	9			352,743	0	7
8	10a	Therapy - Other ST	1,681,285	9			352,743	0	8
9	15	Employee Benefits - Health	1,681,285	9	177,452		352,743	37,230	9
10	17	Administrative- Salary	1,681,285	9	44,598	44,598	352,743	9,357	10
11	19	Professional Fees	1,681,285	9	1,524		352,743	320	11
12	20	Dues & Subscriptions	1,681,285	9	20,074		352,743	4,212	12
13	21	Office & Clerical -Salary	1,681,285	9			352,743	0	13
14	21	Office & Clerical Other	1,681,285	9	6,717		352,743	1,409	14
15	24	Travel & Seminar	1,681,285	9	2,806		352,743	589	15
16	25	Other Admin. Staff Transport	1,681,285	9			352,743	0	16
17	26	Insurance	1,681,285	9	7,608		352,743	1,596	17
18	27	Employee Ben. - Gen. Admin	1,681,285	9	6,265		352,743	1,314	18
19	30	Depreciation	1,681,285	9			352,743	0	19
20	32	Interest	1,681,285	9	21,079		352,743	4,422	20
21	33	Real Estate Taxes	1,681,285	9			352,743	0	21
22	34	Rent- Building	1,681,285	9			352,743	0	22
23	35	Rent - Equipment & Auto	1,681,285	9	5,067		352,743	1,063	23
24									24
25	TOTALS				\$ 1,634,975	\$ 1,306,691		\$ 343,026	25

Facility Name & ID Number Lemont Nursing & Rehabilitation Center # 0046201 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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
		Related**					Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Business Partners (Net)		X	Mortgage			\$	\$ 6,167,456			\$ 519,670	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bulding Company		X								1,422	6
7												7
8	See Sch 9A										28,750	8
9	TOTAL Facility Related						\$ 0	\$ 6,167,456			\$ 549,842	9
	B. Non-Facility Related*											
10	Interest Income										(262,304)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ (262,304)	14
15	TOTALS (line 9+line14)						\$ 0	\$ 6,167,456			\$ 287,538	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.)

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

Facility Name & ID Number Lemont Nursing & Rehabilitation Center # 0046201 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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		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							
Working Capital																		
6	Allocated from Care Centers									22,537	6							
6a	Allocated from CCC									756	6a							
7	Allocated from Vent Lease									1,031	7							
8	Allocated from CCHS									4	8							
8	Allocated from Therapy Works									4,422	8a							
9	TOTAL Facility Related					\$ 0	\$ 0			\$ 28,750	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$ 0	\$ 0			\$ 0	14							
15	TOTALS (line 9+line14)					\$ 0	\$ 0			\$ 28,750	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. (See instructions.)

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lemont Nursing & Rehabilitation Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

CONTACT PERSON REGARDING THIS REPORT Mike Kaplan

TELEPHONE (847) 905-4042 FAX #: (547) 905-3030

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>22-27-300-048-0000</u>	<u>Long Term Care Property</u>	\$ <u>240,050.46</u>	\$ <u>240,050.46</u>
2. <u>See Attached Schedule</u>	<u>Long Term Care Property</u>	\$ <u>53,052.60</u>	\$ <u>1,857.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>293,103.06</u>	\$ <u>241,907.46</u>

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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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.

Facility Name & ID Number Lemont Nursing & Rehabilitation Center

0046201 Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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 (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? (a) Own the Equipment (b) Rent equipment from a Related Organization (c) Rent equipment from Completely Unrelated Organization

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, et al). 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 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: Organization Cost, Loan Closing Cost, Settlement Charge, HUD Appraisal
 (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	823,094	2003	\$ 823,094	1
2	2201 Main LLC			11,601	2
3	TOTALS	823,094		\$ 834,695	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	115	2003		\$ 4,683,421	\$	Various	\$ 197,159	\$ 197,159	\$ 1,091,840	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Land Improvements		2003	708,000		Various	55,546	55,546	231,722	9
10										10
11										11
12	Care Centers, Inc									12
13	2201 Main LLC Allocation Building		2002	14,173		20	364	364	1,560	13
14	2201 Main LLC Allocation Building Improvements		2002	11,708		20	488	488	2,634	14
15	2201 Main LLC Allocation Building Improvements		2003	13,797		20	263	263	2,415	15
16	2201 Main LLC Allocation Building Improvements		2005	686		20	30	30	51	16
17										17
18	Care Center Clinical									18
19	2201 Main LLC Allocation Building		2002	1,495		20	38	38	164	19
20	2201 Main LLC Allocation Building Improvements		2002	1,235		20	51	51	278	20
21	2201 Main LLC Allocation Building Improvements		2003	1,455		20	28	28	255	21
22	2201 Main LLC Allocation Building Improvements		2005	72		20	3	3	5	22
23										23
24	Care Center Health System									24
25	2201 Main LLC Allocation Building		2002	319		20	8	8	35	25
26	2201 Main LLC Allocation Building Improvements		2002	263		20	11	11	59	26
27	2201 Main LLC Allocation Building Improvements		2003	310		20	6	6	54	27
28	2201 Main LLC Allocation Building Improvements		2005	15		20	1	1	1	28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lemont Nursing & Rehabilitation Center

0046201

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,436,949	\$ 0		\$ 253,996	\$ 253,996	\$ 1,331,073	70

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

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number Lemont Nursing & Rehabilitation Center

0046201

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,436,949	\$ 0		\$ 253,996	\$ 253,996	\$ 1,331,073	1
2	Avary	2003	4,987	997	20	997		3,906	2
3	Cooler Repair	2003	522		20	26	26	102	3
4	Air Conditioner repair	2003	985	82	20	49	(33)	193	4
5	Sewer Rodding	2003	725		20	36	36	133	5
6	Sewer Maintenance	2003	640		20	32	32	117	6
7	Floor Tile Replacement	2003	508	51	20	25	(26)	93	7
8	Lunchroom Door repair	2003	852		20	43	43	153	8
9	Parking Lot Lights	2003	1,290	129	20	65	(64)	231	9
10	Keypad Alarm	2003	547	78	20	78		274	10
11	Hot Water Repair	2003	950	79	20	48	(31)	162	11
12	Walk in Cooler - Compressor Repair	2003	1,450	97	20	73	(24)	248	12
13	Light Pole repairs	2003	2,959		20	148	148	506	13
14	Light Pole repairs	2003	1,090		20	55	55	186	14
15	Generator Repair	2003	859	86	20	43	(43)	143	15
16	Check Hot Water System	2003	937	78	20	47	(31)	156	16
17	State Required Backflow Test	2003	930	93	20	47	(46)	155	17
18	Insurance Proceeds	2003	(1,050)		20	(53)	(53)	(175)	18
19	Door Keypads and Sounder Install	2003	2,226	318	20	318		1,060	19
20	Toilet Bowls with Accessories	2003	631	63	20	32	(31)	103	20
21	Water Heater Repair	2003	504	42	20	25	(17)	82	21
22	Electrical Work	2003	2,545	255	20	127	(128)	414	22
23	Electrical Vestibule Doors	2003	7,060	706	20	353	(353)	1,147	23
24	Flash to Field or Wall Flashings	2003	800	80	20	40	(40)	130	24
25	Keypads and Doesite Sounders	2003	6,679	891	20	334	(557)	1,085	25
26	Deposit on Above	2003	(2,226)		20	(111)	(111)	(362)	26
27	Speakman Valve Group	2003	710	71	20	35	(36)	112	27
28	Roton Hinge	2003	609	61	20	30	(31)	96	28
29	Rewire Feeds for Ceiling Lights	2003	630	63	20	32	(31)	100	29
30	Services on Fire Alarm Control Pane	2003	1,234	176	20	62	(114)	195	30
31	Install Softener System	2003	2,946	246	20	147	(99)	466	31
32	Adjust Rooms with Hot Water Problems	2003	930	77	20	46	(31)	147	32
33	Second Floor Dinning Room Heat Problems	2003	653	53	20	33	(20)	103	33
34	TOTAL (lines 1 thru 33)		\$ 5,482,061	\$ 4,872		\$ 257,258	\$ 252,386	\$ 1,342,534	34

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

Facility Name & ID Number Lemont Nursing & Rehabilitation Center

0046201

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 5,482,061	\$ 4,872		\$ 257,258	\$ 252,386	\$ 1,342,534		1
2	Replace Pipe	2003 633	127	20	32	(95)	100		2
3	Repair Four Mainnorthdry System	2003 625	125	20	31	(94)	99		3
4	Fire Alarm Repairs	2003 966	48	20	48		185		4
5	Fire Alarm Pipe	2003 820	41	20	41		154		5
6	Fire Alarm Control Pane	2003 508		20	25	25	93		6
7	Ceiling Tile	2004 1,702	340	20	340		993		7
8	Sprinkler Replacemen	2004 4,835	484	20	242	(242)	625		8
9	Ceiling Repair	2004 6,150	615	20	308	(307)	743		9
10	Water Heater	2004 4,347	362	20	362		1,087		10
11	HP Bronze Pump	2004 1,739	348	20	348		1,044		11
12	New Carpeting	2004 7,838	784	20	392	(392)	882		12
13	Painting	2004 6,500	650	20	325	(325)	704		13
14	Call Cords	2004 2,055	294	20	294		612		14
15	Repairs to Building Pipes	2005 7,375	738	20	369	(369)	707		15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 5,528,154	\$ 9,828		\$ 260,415	\$ 250,587	\$ 1,350,562		34

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

Facility Name & ID Number: Lemont Nursing & Rehabilitation Center # 0046201 Report Period Beginning: 01/01/2006 Ending: 12/31/2006
 XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	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	\$ 401,567	\$ 19,212	\$ 60,100	\$ 40,888	5-15 Yrs.	\$ 291,023	71
72	Current Year Purchases	12,486	734	781	47	5-15 Yrs.	781	72
73	Fully Depreciated Assets	12,065		0	0		12,065	73
74					0			74
75	TOTALS	\$ 426,118	\$ 19,946	\$ 60,881	\$ 40,935		\$ 303,869	75

D. Vehicle Depreciation (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				\$	\$	\$	0		\$	76
77	From Care Centers, Inc			23,299		283	283	5 Yrs	16,668	77
78	From Care Center Clinical			1,417		96	96	5 Yrs	96	78
79							0			79
80	TOTALS			\$ 24,716	\$ 0	\$ 379	\$ 379		\$ 16,764	80

E. Summary of Care-Related Asset

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,813,683	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 29,774	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 321,675	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 291,901	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,671,195	85

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

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

G. Construction-in-Progress

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

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

** This must agree with Schedule V line 30, column 1

Lemont Nursing & Rehabilitation Center
Moveable Equipment Schedule
1/1/06-12/31/06
0046201

Company Name	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Accumulated Straight Line Depreciation
Line 28: Prior Years					
Lemont Nursing & Rehab. Center LLC	108,518	19,212	19,398	186	49,818
Lemont Property LLC	199,083		22,934	22,934	164,681
2201 Main Street	4,427		516	516	1,992
Care Centers Inc.	89,539		7,677	7,677	74,532
Care Center Clinical					
Vent Lease			9,575	9,575	
Care Center Health System					
Total	401,567	19,212	60,100	40,888	291,023

Line 29: Current Year

Lemont Nursing & Rehab. Center LLC	12,171	734	734		734
Lemont Property LLC					
2201 Main Street					
Care Centers Inc.	315		47	47	47
Care Center Clinical					
Vent Lease					
Care Center Health System					
Total	12,486	734	781	47	781

Line 30: Fully Depreciated

Lemont Nursing & Rehab. Center LLC	12,065				12,065
Lemont Property LLC					
2201 Main Street					
Care Centers Inc.					
Care Center Clinical					
Vent Lease					
Care Center Health System					
Total	12,065				12,065

Total (Should tie to page 13)

Lemont Nursing & Rehab. Center LLC	132,754	19,946	20,132	186	62,617
Lemont Property LLC	199,083		22,934	22,934	164,681
2201 Main Street	4,427		516	516	1,992
Care Centers Inc.	89,854		7,724	7,724	74,579
Care Center Clinical					
Vent Lease			9,575	9,575	
Care Center Health System					
Total	426,118	19,946	60,881	40,935	303,869

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	Allocation from Care Centers, Inc				3,637			5
6	Storage Site				4,747			6
7	TOTAL				\$ 8,384			7

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. /2007 \$ _____
 13. /2008 \$ _____
 14. /2009 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34. N/A
 This amount was calculated by dividing the total amount to be amortized N/A
 by the length of the lease N/A.

9. Option to Buy: YES NO Terms: N/A *

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: \$ 6,823 Description: \$3,045 Copier, \$1,741 Dishwasher, \$974 Care Centers, \$1,063 Therapy Works
 (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	Allocated from CCHS			66	18
19					19
20					20
21	TOTAL		\$	\$ 66	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.

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)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$	\$	\$ 0
2 Books and Supplies				0
3 Classroom Wages (a)				0
4 Clinical Wages (b)				0
5 In-House Trainer Wage (c)				0
6 Transportation				0
7 Contractual Payment:				0
8 CNA Competency Tests				0
9 TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10 SUM OF line 9, col. 1 and 2 (e)	\$ 0			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit.
- (c) For in-house training programs only. Do not include fringe benefit.
- (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.

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	

- (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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10a,C2	hrs	\$		\$ 270,711	\$		\$ 270,711	1
2	Licensed Speech and Language Development Therapist	L10a, C 3	hrs			83,950			83,950	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C 3	hrs			376,149			376,149	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				444,642		444,642	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs			1,536			1,536	10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Sch 16A					2,370	77,217		79,587	13
14	TOTAL			\$		\$ 734,716	\$ 521,859		\$ 1,256,575	14

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

Lemont Nursing & Rehabilitation Center

Provider #: 0046201

01/01/2006 to 12/31/2006

Schedule 16A

XIV. Special Services

Line 13 Other (specify):

<u>Service</u>	<u>Line Reference</u>	<u>Outside Practioner Units</u>	<u>Cost</u>	<u>Supplies</u>
Therapy And Rehab. Supplies	L 10A C 2			1,219
Ventilation Equipment	L 10A C 3			
Low Pressure Mattress	L 39 C 2			25
Oxygen	L 39 C 2			9,740
Other Services Medicare	L 39 C 3			625
Ambulance Services	L 39 C 3			412
Food Pump	L 39 C 2			59
Medical Supplies Chargeable	L 39 C 2			64,660
Respiratory Therapist CCI	L 10A C 3		2,370	
Wheelchairs and Walker	L 39 C 2			477
Total			<u>2,370</u>	<u>77,217</u>

Facility Name & ID Number Lemont Nursing & Rehabilitation Center

0046201

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 300	\$ 300	1
2	Cash-Patient Deposits	37,822	37,822	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 175,000)	1,643,653	1,643,653	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,077	22,077	6
7	Other Prepaid Expenses	9,670	9,670	7
8	Accounts Receivable (owners or related parties)	275,389	275,389	8
9	Other(specify): See Sch 17A	3,596,234	3,596,234	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,585,145	\$ 5,585,145	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		834,695	13
14	Buildings, at Historical Cost		4,699,408	14
15	Leasehold Improvements, at Historical Cost	83,172	828,746	15
16	Equipment, at Historical Cost	131,512	450,834	16
17	Accumulated Depreciation (book methods)	(90,505)	(1,671,195)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Financing Fee (Net)		101,139	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 124,179	\$ 5,243,627	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,709,324	\$ 10,828,772	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 591,886	\$ 591,886	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,442	25,442	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	228,922	228,922	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	10,995	10,995	31
32	Accrued Real Estate Taxes(Sch.IX-B)	132,075	132,075	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	341,223	341,223	36
37	See Sch 17A	112,240	112,240	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,442,783	\$ 1,442,783	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,167,456	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)	\$ 0	\$ 6,167,456	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,442,783	\$ 7,610,239	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,266,541	\$ 3,218,533	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,709,324	\$ 10,828,772	48

*(See instructions.)

Lemont Nursing & Rehabilitation Center
0046201
12/31/2006

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.

A. Current Assets

Other Current Assets (specify):	After	
	Operating	Consolidation
Due From Employees	863	863
Note Payable LaSalle	3,595,371	3,595,371
Total Line 9 - Other Current Assets(specify):	<u>3,596,234</u>	<u>3,596,234</u>

B. Long Term Assets

Other Long Term Assets (specify):	After	
	Operating	Consolidation
Total Line 23 - Other Long Term Assets Assets(spec	<u>0</u>	<u>0</u>

C. Current Liabilities

Other Current Liabilities (specify):	After	
	Operating	Consolidation
Real Estate Escrow Deposit	12,364	12,364
Accrued Expenses	167,036	167,036
Due to Medicaid	116,329	116,329
Due to Third Party Insurance	34,528	34,528
Medicare Settlement	9,992	9,992
PRW - Union Dues	974	974
Total Line 36 - Other Current Liabilities(specify):	<u>341,223</u>	<u>341,223</u>

Other Current Liabilities (specify):

Other Long Term Assets (specify):	After	
	Operating	Consolidation
Due to Others	3,826	3,826
Due to Other Related Parties	(2,217)	(2,217)
Due to Prior Owners	110,631	110,631
Total Line 37 - Other Current Liabilities(specify):	<u>112,240</u>	<u>112,240</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,361,724	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,361,725	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,273,683	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	(368,867)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 904,816	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,266,541	24 *

Operating Entity Only

* This must agree with page 17, line 47.

Facility Name & ID Number Lemont Nursing & Rehabilitation Center

0046201

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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 expenses.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,547,887	1
2	Discounts and Allowances for all Level	(4,111,004)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,436,883	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,573,983	6
7	Oxygen	1,633	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,575,616	8
C. Other Operating Revenue			
9	Payments for Educator		9
10	Other Government Grants		10
11	CNA Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,103	13
14	Non-Patient Meals	1,308	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	453,726	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory	169,337	19
20	Radiology and X-Ray	31,200	20
21	Other Medical Services	95,062	21
22	Laundry	4,104	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 757,840	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**	262,304	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 262,304	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Sch 19A</u>	7,810	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,810	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,040,453	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,248,464	31
32	Health Care	4,836,738	32
33	General Administrator	1,998,400	33
B. Capital Expense			
34	Ownership	811,434	34
C. Ancillary Expense			
35	Special Cost Centers	785,229	35
36	Provider Participation Fee	86,505	36
D. Other Expenses (specify):			
37		0	37
38		0	38
39		0	39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,766,770	40
41	Income before Income Taxes (line 30 minus line 40)**	1,273,683	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,273,683	43

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

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

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

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

Facility Name & ID Number **Lemont Nursing & Rehabilitation Center**

0046201

Report Period Beginning: **01/01/2006**

Ending:

12/31/2006

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,922	2,146	\$ 73,788	\$ 34.38	1
2	Assistant Director of Nursing	2,024	2,204	66,780	30.30	2
3	Registered Nurses	30,138	33,159	1,012,230	30.53	3
4	Licensed Practical Nurses	24,480	26,856	662,635	24.67	4
5	CNAs & Orderlies	102,021	112,011	1,284,255	11.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,285	1,458	25,020	17.16	9
10	Activity Assistants	11,923	12,320	108,477	8.80	10
11	Social Service Worker	5,473	6,111	99,323	16.25	11
12	Dietician	1,113	1,240	17,103	13.79	12
13	Food Service Supervisor	1,981	2,175	38,573	17.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,062	6,751	88,629	13.13	15
16	Dishwashers	17,187	19,081	172,474	9.04	16
17	Maintenance Worker	6,100	6,515	113,508	17.42	17
18	Housekeepers	18,535	20,088	164,292	8.18	18
19	Laundry	5,411	5,906	44,729	7.57	19
20	Administrator	1,954	2,211	100,815	45.60	20
21	Assistant Administrator	171	214	4,762	22.25	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,731	13,899	214,870	15.46	24
25	Vocational Instructor					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	2,824	3,218	39,554	12.29	31
32	Other Health C: See Sch 20 A	17,178	19,596	361,066	18.43	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	270,513	297,159	\$ 4,692,883 *	\$ 15.79	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	300	\$ 12,931	L. 1 C. 3	35
36	Medical Director	Monthly	39,000	L. 9 C. 3	36
37	Medical Records Consultant	Monthly	324	L. 10 C. 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,370	L. 10 C. 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	50	2,450	L. 11 C. 3	44
45	Social Service Consultant	4	220	L. 12 C. 3	45
46	Other(specify) See Sch 20B	260	4,364		46
47	Therapy Program Consultant	39	1,536	L. 10a C. 3	47
48					48
49	TOTAL (lines 35 - 48)	653	\$ 63,195		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	232	\$ 13,200	L. 10 C. 3	50
51	Licensed Practical Nurses	79	3,534	L. 10 C. 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	311	\$ 16,734		53

Lemont Nursing & Rehabilitation Center
 0046201
 12/31/2006

Schedule 20A

XVIII. STAFFING AND SALARY COSTS

LINE 32 - Other (Health Care specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Rehab Nurse	1,625	1,965	\$ 56,041	28.52
Rehab Aides	8,012	9,216	\$ 110,572	12.00
Ward Clerk	1,573	1,764	\$ 19,433	11.02
Nursing Personnel Director	97	97	\$ 1,496	15.42
Care Plan Coord.	5,871	6,554	\$ 173,524	26.48
Total Line 32 - Other	17,178	19,596	\$ 361,066	\$ 18.43

XVIII. STAFFING AND SALARY COSTS

LINE 33 - Other (specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
				#DIV/0!
				#DIV/0!
				#DIV/0!
Total Line 33 - Other	0	0	\$ -	#DIV/0!

Lemont Nursing & Rehabilitation Center
0046201
12/31/2006

Schedule 20B

XVIII. Consultant Services
LINE 46

	# of Hrs. Actually Worked	Reporting Period Total Consultant Costs	Schedule V Line & Column
Bookkeeping - CCI	226	\$ 3,604	L 21 C 3
Maintenance - CCI	34	760	L 6 C 3
Total Line 46 - Other	260	\$ 4,364	

Facility Name & ID Number Lemont Nursing & Rehabilitation Center

0046201

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Franciso J Guajardo	Administrator	0	100,815	Workers' Compensation Insurance	\$ 126,471	IDPH License Fee	\$ 1,990		
Jason H Gold	Asst. Administrator	0	4,762	Unemployment Compensation Insurance	175,763	Advertising: Employee Recruitment	21,545		
				FICA Taxes	354,801	Health Care Worker Background Check			
				Employee Health Insurance	91,944	(Indicate # of checks performed 222)	4,947		
				Employee Meals		Patient Background Checks Monthly	748		
				Illinois Municipal Retirement Fund (IMRF)*		Various Dues & Sub, License	2,953		
				Employee Physicals	10,102	Allocated from Therapy Works	4,212		
				Other Misc. Employee Benefits	352	Allocated from Care Centers	5,351		
				Holiday Expense	2,412	Allocated From Care Center Health Sy	73		
						Allocated From Care Center Clinical	36		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 105,577	TOTAL (agree to Schedule V, line 22, col.8)	\$ 761,845	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 41,855		
(List each licensed administrator separately.)									
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Home Office Services Care Centers, Inc.			\$ 347,607				Out-of-State Travel	\$	
Home Office Services Care Centers Clinical			48,013						
Management Fees			147,783	N/A			In-State Travel		
These Expenses were Eliminated in Col 7									
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 543,403				Seminar Expense	140	
(Attach a copy of any management service agreement)							Allocation From Care Centers	3,378	
C. Professional Services							Allocation From Care Center Clinical	39	
Vendor/Payee	Type		Amount				Allocated From Therapy Works	589	
Neal, Gerber & Eisenberg LLP	Legal		\$ 37,823				Entertainment Expense	()	
Meyer Magence	Legal		2,238				(agree to Sch. V, line 24, col. 8)		
Winston & Strawn	Legal		4,413				TOTAL	\$ 4,146	
Stone, McGuire, & Siegel	Legal		3,203						
Foley & Lardner	Legal		1,080						
FR&R	Accounting		9,000						
Personnel Planners	Unemployment Consultant		1,590						
Talx UMC Services	Unemployment Consultant		173						
Care Center Inc.	Medicaid Application		3,600						
SMS	Part B Billing		12,813						
ADP, INC	Payroll Services		7,248						
See Sch 21A			21,792						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$			
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 104,973						

* Attach copy of IMRF notifications

**See instructions.

Lemont Nursing & Rehabilitation Center

Provider #: 0046201
01/01/2006 to 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Achieve Healthcare	Consultant on A/R Software	7,783
National Hotline Services	Compliance Services	150
Prospect Resource	Natural Gas Procurement	447
Legat Architect Inc.	Engineering Consultant	1,549
Life Safety Resources LLC	FSES Preparation	1,800
WJE Engineers Architects Materials Scientist	Inspection of Wood Trusses	6,473
Robert A Nowicki & Associates	Plat Survey of Legal Descriptions	735
IIT/Sourcetech	Computer Support	130
Ehealth Data Solutions	Billing Program System	2,725

Total 21,792

Total (agree to Schedule V, line 19, column 3) 104,973

Allocated from Management Company		
Allocated from Care Centers, Inc		14,749
Allocated from Care Center Clinical		383
Allocated from Care Center Health System		47
Allocated from Therapy Works. - Legal		320
Allocated from Bldg. Co. - Other Professional Fees		
To disallow Care Centers, Inc Medicaid Application Fee		(3,600)
To disallow Out of Period Legal Fees		(8,784)
Total (agree to Schedule V, line 19, column 8)		<u>108,088</u>

Facility Name & ID Number Lemont Nursing & Rehabilitation Center# 0046201Report Period Beginning: 01/01/2006Ending: 12/31/2006**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union No
- (2) Are there any dues to nursing home associations included on the cost report No
If YES, give association name and amount N/A
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7.57 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 101,455 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
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. 86,505
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 for an individual employee? No If YES, attach an explanation of the allocation
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services if 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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount \$ 1,308
- (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 program during this reporting period. \$
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- 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 \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain
- (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 \$2500, 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

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	316,779	27,181	12,931	356,891	0	356,891	4,784	361,675
2. Food Purchase	0	251,340	0	251,340	0	251,340	-16,908	234,432
3. Housekeeping	164,292	45,375	17,716	227,383	0	227,383	-3,156	224,227
4. Laundry	44,729	15,157	0	59,886	0	59,886	0	59,886
5. Heat and Other Utilities	0	0	145,594	145,594	0	145,594	2,184	147,778
6. Maintenance	113,508	0	93,207	206,715	0	206,715	9,093	215,808
7. Other (specify)*	0	0	655	655	0	655	41,858	42,513
8. Total General Services	639,308	339,053	270,103	1,248,464	0	1,248,464	37,855	1,286,319
9. Medical Director	0	0	39,000	39,000	0	39,000	0	39,000
10. Nursing & Medical Records	3,500,308	188,031	19,428	3,707,767	0	3,707,767	4,939	3,712,706
10a. Therapy	0	1,214	818,105	819,319	0	819,319	-83,384	735,935
11. Activities	133,497	35,162	2,450	171,109	0	171,109	0	171,109
12. Social Services	99,323	0	220	99,543	0	99,543	11,601	111,144
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	992	992
16. Total Health Care & Programs	3,733,128	224,407	879,203	4,836,738	0	4,836,738	-65,852	4,770,886
17. Administrative	105,577	0	543,403	648,980	0	648,980	-493,655	155,325
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	104,973	104,973	0	104,973	3,115	108,088
20. Fees, Subscriptions & Promotion	0	0	32,983	32,983	0	32,983	8,872	41,855
21. Clerical & General Office	214,870	31,928	48,458	295,256	0	295,256	138,760	434,016
22. Employee Benefits & Payroll	0	0	765,875	765,875	0	765,875	-4,030	761,845
23. Inservice Training & Education	0	0	2,133	2,133	0	2,133	0	2,133
24. Travel and Seminar	0	0	140	140	0	140	4,006	4,146
25. Other Admin. Staff Trans	0	0	2,249	2,249	0	2,249	107	2,356
26. Insurance-Prop.Liab.Malpractice	0	0	145,811	145,811	0	145,811	1,296	147,107
27. Other (specify)*	0	0	0	0	0	0	27,059	27,059
28. Total General Adminis	320,447	31,928	1,646,025	1,998,400	0	1,998,400	-314,470	1,683,930
29. Total General Administrative	4,692,883	595,388	2,795,331	8,083,602	0	8,083,602	-342,467	7,741,135
30. Depreciation	0	0	29,685	29,685	0	29,685	291,990	321,675
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	287,538	287,538
33. Real Estate	0	0	232,396	232,396	0	232,396	1,857	234,253
34. Rent - Facility & Grounds	0	0	523,777	523,777	0	523,777	-515,393	8,384
35. Rent - Equipment & Vehicles	0	0	25,576	25,576	0	25,576	-18,687	6,889
36. Other (specify):*	0	0	0	0	0	0	36,151	36,151
37. Total Ownership	0	0	811,434	811,434	0	811,434	83,456	894,890
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	530,453	0	530,453	0	530,453	176	530,629
40. Barber and Beauty Shop	0	0	3,364	3,364	0	3,364	0	3,364
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	86,505	86,505	0	86,505	0	86,505
43. Other (specify):*	0	0	251,412	251,412	0	251,412	-251,412	0
44. Total Special Cost Ce	0	530,453	341,281	871,734	0	871,734	-251,236	620,498
45. Grand Total	4,692,883	1,125,841	3,948,046	9,766,770	0	9,766,770	-510,247	9,256,523

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	300	300
2. Cash - Patient Deposits	37,822	37,822
3. Accounts & Notes Recievable	1,643,653	1,643,653
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	22,077	22,077
7. Other Prepaid Expenses	9,670	9,670
8. Accounts Receivable-Owner/Related Party	275,389	275,389
9. Other (specify):	3,596,234	3,596,234
10. Total current assets	5,585,145	5,585,145
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	834,695
14. Buildings, at Historical Cost	0	4,699,408
15. Leasehold Improvements, Historical Cost	83,172	828,746
16. Equipment, at Historical Cost	131,512	450,834
17. Accumulated Depreciation (book methods)	-90,505	-1,671,195
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	101,139
24. Total Long-Term Assets	124,179	5,243,627
25. Total Assets	5,709,324	10,828,772
CURRENT LIABILITIES		
26. Accounts Payable	591,886	591,886
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	25,442	25,442
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	228,922	228,922
31. Accrued Taxes Payable	10,995	10,995
32. Accrued Real Estate Taxes	132,075	132,075
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	341,223	341,223
37. Other Current Liabilities (specify):	112,240	112,240
38. Total Current Liabilities	1,442,783	1,442,783
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	6,167,456
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	0	6,167,456
46. Total Liabilities	1,442,783	7,610,239
47. Total Equity	4,266,541	3,218,533
48. Total Liabilities and Equity	5,709,324	10,828,772

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	10,547,887
2. Discounts and Allowances for all Levels	-4,111,004
Subtotal - Inpatient Care	6,436,883
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	3,573,983
7. Oxygen	1,633
Subtotal - Ancillary Revenue	3,575,616
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	3,103
14. Non-Patient Meals	1,308
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	453,726
18. Sale of Supplies to Non-Patients	0
19. Laboratory	169,337
20. Radiology and X-Ray	31,200
21. Other Medical Services	95,062
22. Laundry	4,104
Subtotal - Other Operating Revenue	757,840
24. Contributions	0
25. Interest and Other Investments Income	262,304
Subtotal - Non-Operating Revenue	262,304
27. Other Revenue (specify):	7,810
28. Other Revenue (specify):	0
Subtotal - Other Revenue	7,810
30. Total Revenue	11,040,453
31. General Services	1,238,160
32. Health Care	4,833,171
33. General Administration	1,741,315
34. Ownership	816,672
35. Special Cost Centers	623,555
35. Provider Participation Fee	86,505
37. Other	0
40. Total Expenses	9,339,378
41. Income Before Income Taxes	1,701,075
42. Income Taxes	0
43. Net Income or Loss for the Year	1,701,075