

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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 License ID Number: <u>0033340</u></p> <p>Facility Name: <u>AVENUE CARE CENTER</u></p> <p>Address: <u>4505 SOUTH DREXEL</u> <u>CHICAGO</u> <u>60653</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(847) 329-1555</u> Fax # <u>(847) 329-9555</u></p> <p>HFS ID Number: <u>36-3558590</u></p> <p>Date of Initial License for Current Owners: <u>02/01/88</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<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>01/01/2008</u> to <u>12/31/2008</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"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>SHERWIN I. RAY</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>PRESIDENT</u></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> <tr> <td colspan="2"> <p>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> </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>SHERWIN I. RAY</u> (Date) _____		(Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	<p>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>	
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Facility Name & ID Number AVENUE CARE CENTER

0033340 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

III. STATISTICAL DATA

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

	1	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	155	Skilled (SNF)	155	56,730	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,730	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			3,411	3,411	8
9	SNF/PED					9
10	ICF	46,073	1,037		47,110	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,073	1,037	3,411	50,521	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.06%

D. How many bed-hold days during this year were paid by the Department? 1,123 (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

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 02/01/88

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/01/88 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 21 and days of care provided 3,411

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	191,231	22,116	12,033	225,380		225,380		225,380		1
2	Food Purchase		205,153		205,153	(20,093)	185,060	(333)	184,727		2
3	Housekeeping	137,881	29,489		167,370		167,370		167,370		3
4	Laundry	61,576	12,041		73,617		73,617		73,617		4
5	Heat and Other Utilities			164,923	164,923		164,923	100	165,023		5
6	Maintenance	72,208	18,585	47,016	137,809		137,809	20,051	157,860		6
7	Other (specify):*			23,614	23,614		23,614	42	23,656		7
8	TOTAL General Services	462,896	287,384	247,586	997,866	(20,093)	977,773	19,860	997,633		8
	B. Health Care and Programs										
9	Medical Director			8,000	8,000		8,000		8,000		9
10	Nursing and Medical Records	1,766,623	71,300	3,046	1,840,969		1,840,969	38,273	1,879,242		10
10a	Therapy	102,365	10,947	12,364	125,676		125,676	6,297	131,973		10a
11	Activities	92,468	13,705	2,365	108,538		108,538		108,538		11
12	Social Services	48,294			48,294		48,294		48,294		12
13	CNA Training										13
14	Program Transportation			60	60		60		60		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,009,750	95,952	25,835	2,131,537		2,131,537	44,570	2,176,107		16
	C. General Administration										
17	Administrative	172,455		150,000	322,455		322,455	(26,387)	296,068		17
18	Directors Fees										18
19	Professional Services			164,077	164,077		164,077	(74,622)	89,455		19
20	Dues, Fees, Subscriptions & Promotions			23,363	23,363		23,363	(7,655)	15,708		20
21	Clerical & General Office Expenses	68,846	16,663	126,561	212,070		212,070	20,779	232,849		21
22	Employee Benefits & Payroll Taxes			454,168	454,168	20,093	474,261		474,261		22
23	Inservice Training & Education							2,251	2,251		23
24	Travel and Seminar			1,943	1,943		1,943	83	2,026		24
25	Other Admin. Staff Transportation			1,227	1,227		1,227	13,407	14,634		25
26	Insurance-Prop.Liab.Malpractice			257,857	257,857		257,857	2,586	260,443		26
27	Other (specify):*							58,395	58,395		27
28	TOTAL General Administration	241,301	16,663	1,179,196	1,437,160	20,093	1,457,253	(11,163)	1,446,090		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,713,947	399,999	1,452,617	4,566,563		4,566,563	53,267	4,619,830		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	8,656
	REPAIRS & MAINTENANCE	3,377
		0
		12,033
3	HOUSEKEEPING	
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	86,269
	ELECTRICITY	55,702
	WATER	21,797
	CABLE TV - LOBBY	1,155
		0
		164,923
6	MAINTENANCE	
	GROUNDS MAINTENANCE	7,387
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	20,820
	ELEVATOR MAINTENANCE & REPAIR	6,906
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	6,795
	FIRE SERVICE	5,108
		0
		0
		0
		0
		47,016
7	OTHER	
	SCAVENGER	23,614
	SECURITY SERVICE	0
		0
		0
		23,614
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	8,000
		8,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,104
	PHARMACY CONSULTANT XVIII B 39-2	1,440
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	502
	COSTS REBILLED - SALARIES	0
		0
		3,046
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	149
	SPEECH THERAPY SERVICES	375
	OCCUPATIONAL THERAPY SERVICES	162
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	5,400
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	5,400
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	THERAPY CONTRACT SERVICE	878
		12,364
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,365
		0
		2,365
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	60
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	150,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	15,133
	ADMINISTRATIVE CONSULTANTS XIX C	93,000
	PROFESSIONAL FEES XIX C	55,944
		0
		164,077
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	10,211
	EMPLOYEE WANT ADS XIX F	5,122
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	930
	LICENSES & PERMITS XIX F	5,371
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,729
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		23,363
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	
	EQUIPMENT REPAIR & MAINTENANCE	15,602
	OUTSIDE CLERICAL SERVICES	55,800
	PENALTIES / OVERDRAFT CHARGES VI 18	32,671
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	96
	TELEPHONE	20,610
	MESSENGER SERVICE	1,782
		0
		126,561

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	202,993
	UNEMPLOYMENT COMPENSATION XIX D	75,188
	WORKERS COMPENSATION INSURANC XIX D	60,678
	HOSPITALIZATION INSURANCE XIX D	83,968
	EMPLOYEE BENEFITS - OTHER XIX D	122
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	27,623
	CHICAGO HEAD TAX XIX D	3,596
		0
		454,168
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,943
	TRAVEL XIX G	
		1,943
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,227
		1,227
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	257,857
		257,857
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,452,617

**AVENUE CARE CENTER
SCHEDULES
12/31/2008**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	205,153
LESS SALES TAX	<u>(333)</u>
NET FOOD	204,820

TOTAL PATIENT CENSUS	50,521
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	151,563

ADD # EMPLOYEE MEALS/DAY	45
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	16,470

PATIENT MEALS	151,563
ADD EMPLOYEE MEALS	<u>16,470</u>
TOTAL MEALS/YEAR	168,033

NET FOOD	204,820
DIVIDE TOTAL MEALS/YEAR	<u>168,033</u>

COST PER MEAL	1.22
TIME EMPLOYEE MEALS	<u>16,470</u>
EMPLOYEE MEAL RECLASSIFICATION	20,093

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Facility Name & ID Number AVENUE CARE CENTER

#0033340

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			68,846	68,846		68,846	112,941	181,787			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,640	18,640		18,640	507,381	526,021			32
33	Real Estate Taxes			171,003	171,003		171,003	8,447	179,450			33
34	Rent-Facility & Grounds			469,754	469,754		469,754	(469,754)				34
35	Rent-Equipment & Vehicles			58,199	58,199		58,199	9,340	67,539			35
36	Other (specify):* OFFICE RENT			22,200	22,200		22,200	(22,200)				36
37	TOTAL Ownership			808,642	808,642		808,642	146,155	954,797			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		109,390	213,110	322,500		322,500		322,500			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,096	85,096		85,096		85,096			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		109,390	298,206	407,596		407,596		407,596			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,713,947	509,389	2,559,465	5,782,801		5,782,801	199,422	5,982,223			45

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

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,931)	30		9
10	Interest and Other Investment Income	(34,651)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(333)	2		13
14	Non-Care Related Interest	(12,825)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(32,671)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(10,211)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,729)	20		28
29	Other-Attach Schedule	2,966			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (95,385)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	294,807		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 294,807		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 199,422		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 Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

AVENUE CARE CENTER

ID# 0033340

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 2,966	6 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	2,966	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AVENUE CARE CENTER

0033340

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(333)	0	0	0	0	0	0	0	0	0	0	(333)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	100	0	0	0	0	0	0	0	0	0	100	5
6	Maintenance	2,966	17,085	0	0	0	0	0	0	0	0	0	20,051	6
7	Other (specify):*	0	42	0	0	0	0	0	0	0	0	0	42	7
8	TOTAL General Services	2,633	17,227	0	0	0	0	0	0	0	0	0	19,860	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	38,273	0	0	0	0	0	0	0	0	0	38,273	10
10a	Therapy	0	0	6,297	0	0	0	0	0	0	0	0	6,297	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	38,273	6,297	0	44,570	16							
	C. General Administration													
17	Administrative	0	(150,000)	123,613	0	0	0	0	0	0	0	0	(26,387)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(93,000)	18,378	0	0	0	0	0	0	0	0	(74,622)	19
20	Fees, Subscriptions & Promotions	(11,940)	0	4,285	0	0	0	0	0	0	0	0	(7,655)	20
21	Clerical & General Office Expenses	(32,671)	(55,800)	109,250	0	0	0	0	0	0	0	0	20,779	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	2,251	0	0	0	0	0	0	0	0	2,251	23
24	Travel and Seminar	0	0	83	0	0	0	0	0	0	0	0	83	24
25	Other Admin. Staff Transportation	0	0	13,407	0	0	0	0	0	0	0	0	13,407	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,586	0	0	0	0	0	0	0	0	2,586	26
27	Other (specify):*	0	0	58,395	0	0	0	0	0	0	0	0	58,395	27
28	TOTAL General Administration	(44,611)	(298,800)	332,248	0	(11,163)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(41,978)	(243,300)	338,545	0	53,267	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AVENUE CARE CENTER

0033340

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(5,931)	0	10,034	108,838	0	0	0	0	0	0	0	112,941	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(47,476)	0	49,333	505,524	0	0	0	0	0	0	0	507,381	32
33	Real Estate Taxes	0	0	8,447	0	0	0	0	0	0	0	0	8,447	33
34	Rent-Facility & Grounds	0	0	0	(469,754)	0	0	0	0	0	0	0	(469,754)	34
35	Rent-Equipment & Vehicles	0	0	9,340	0	0	0	0	0	0	0	0	9,340	35
36	Other (specify):*	0	(22,200)	0	0	0	0	0	0	0	0	0	(22,200)	36
37	TOTAL Ownership	(53,407)	(22,200)	77,154	144,608	0	146,155	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	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(95,385)	(265,500)	415,699	144,608	0	199,422	45						

Facility Name & ID Number AVENUE CARE CENTER

0033340

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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
				CAREPLUS MGT.	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHAB	SKOKIE	THERAPY
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		AVENUE ASSOC.		
				LLC	SKOKIE	REAL ESTATE

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)	
1	V	17 MANAGEMENT FEES	\$ 150,000	CAREPLUS MANAGEMENT, INC.		\$	\$ (150,000)	1
2	V	19 ADMIN. CONSULT. FEES	93,000	" " "			(93,000)	2
3	V	21 CLERICAL FEES	55,800	" " "			(55,800)	3
4	V	36 OFFICE RENT	22,200	" " "			(22,200)	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V	5 UTILITIES		" " "		100	100	9
10	V	6 MAINT AND REPAIR		" " "		10,005	10,005	10
11	V	6 MAINTENANCE SALARIES		" " "		7,080	7,080	11
12	V	7 SECURITY		" " "		42	42	12
13	V	10 NURSING SALARIES		" " "		38,273	38,273	13
14	Total		\$ 321,000			\$ 55,500	\$ * (265,500)	14

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

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	\$	CAREPLUS MANAGEMENT, INC.		\$ 6,279	\$ 6,279
16	V	10A REHAB SUPPLIES		" " "		18	18
17	V	17 ADMIN. SALARIES		" " "		123,613	123,613
18	V	19 PROFESSIONAL FEES		" " "		18,378	18,378
19	V	20 ADVERTISING		" " "		4,285	4,285
20	V	21 TOTAL OFFICE		" " "		24,341	24,341
21	V	21 CLERICAL SALARIES		" " "		84,909	84,909
22	V	23 SEMINARS		" " "		2,251	2,251
23	V	24 TRAVEL		" " "		83	83
24	V	25 TRANSPORTATION		" " "		13,407	13,407
25	V	26 INSURANCE		" " "		2,586	2,586
26	V	27 EMPLOYEE BENEFITS		" " "		58,395	58,395
27	V	30 DEPRECIATION (SL)		" " "		10,034	10,034
28	V	32 INTEREST		" " "		46,081	46,081
29	V	32 INTEREST-TAG 18 PPTY-MTG		" " "		2,956	2,956
30	V	32 INTEREST-CP REHAB-EQ LOAN		" " "		296	296
31	V	33 REAL ESTATE TAX-TAG 18 PPTY		" " "		8,447	8,447
32	V	35 EQUIPMENT RENT		" " "		9,340	9,340
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 415,699	\$ * 415,699

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

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	30 SL DEPRECIATION	\$	CAREPLUS REHABILITATIVE SERVICES		\$ 5,092	\$ 5,092	15
16	V	32 INTEREST		" " "		801	801	16
17	V			" " "				17
18	V			" " "				18
19	V			" " "				19
20	V							20
21	V							21
22	V							22
23	V	34 RENT	469,754	AVENUE ASSOCIATES, LLC			(469,754)	23
24	V	30 SL DEPRECIATION		" " "		103,746	103,746	24
25	V	32 INTEREST		" " "		504,723	504,723	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		\$ 469,754			\$ 614,362	\$ * 144,608	39

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

Facility Name & ID Number

AVENUE CARE CENTER

#

0033340

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	CAREPLUS MGMT ALLOCATIONS								\$		1
2	SHERWIN I. RAY	PRESIDENT	ADMINISTRAT.		SEE	8.1	13.51	SALARY	26,348	17-7	2
3			FINANCE		ATTACHED						3
4					SCHEDULE						4
5	ROSLYN INDICH	CONTOLLER-A/P	CLERICAL			8.1	13.51	SALARY	8,213	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 34,561		13

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

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

Facility Name & ID Number AVENUE CARE CENTER

0033340

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

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 CAREPLUS MANAGEMENT, INC.
 Street Address 8320 SKOKIE BLVD.
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847) 329-1555
 Fax Number (847) 329-9555

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	5	UTILITIES	CENSUS DAYS	373,906	10	\$ 739	\$ 50,521	\$ 100	1
2	6	MAINT AND REPAIR	CENSUS DAYS	373,906	10	74,048	50,521	10,005	2
3	6	MAINTENANCE SALARIES	CENSUS DAYS	373,906	10	52,396	50,521	7,080	3
4	7	SECURITY	CENSUS DAYS	373,906	10	308	50,521	42	4
5	10	NURSING SALARIES	CENSUS DAYS	373,906	10	283,260	50,521	38,273	5
6	10A	THERAPY SALARIES	CENSUS DAYS	373,906	10	46,472	50,521	6,279	6
7	10A	REHAB SUPPLIES	CENSUS DAYS	373,906	10	132	50,521	18	7
8	17	ADMIN. SALARIES	CENSUS DAYS	373,906	10	914,862	50,521	123,613	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	373,906	10	136,016	50,521	18,378	9
10	20	ADVERTISING	CENSUS DAYS	373,906	10	31,710	50,521	4,285	10
11	21	TOTAL OFFICE	CENSUS DAYS	373,906	10	180,149	50,521	24,341	11
12	21	CLERICAL SALARIES	CENSUS DAYS	373,906	10	628,409	50,521	84,909	12
13	23	SEMINARS	CENSUS DAYS	373,906	10	16,659	50,521	2,251	13
14	24	TRAVEL	CENSUS DAYS	373,906	10	612	50,521	83	14
15	25	TRANSPORTATION	CENSUS DAYS	373,906	10	99,225	50,521	13,407	15
16	26	INSURANCE	CENSUS DAYS	373,906	10	19,140	50,521	2,586	16
17	27	EMPLOYEE BENEFITS	CENSUS DAYS	373,906	10	432,184	50,521	58,395	17
18	30	DEPRECIATION (SL)	CENSUS DAYS	373,906	10	74,261	50,521	10,034	18
19	32	INTEREST	CENSUS DAYS	373,906	10	341,048	50,521	46,081	19
20	32	INTEREST-TAG 18 PPTY-MTG	CENSUS DAYS	373,906	10	21,878	50,521	2,956	20
21	32	INTEREST-CP REHAB-EQ LOAN	CENSUS DAYS	373,906	10	2,189	50,521	296	21
22	33	REAL ESTATE TAX-TAG 18 PPTY	CENSUS DAYS	373,906	10	62,515	50,521	8,447	22
23	35		CENSUS DAYS	373,906	10	69,127	50,521	9,340	23
24									24
25	TOTALS					\$ 3,487,339	\$ 1,925,400	\$ 471,199	25

Facility Name & ID Number AVENUE CARE CENTER

0033340

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					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	RELATED PARTY: AVENUE ASSOCIATES LLC						\$	\$			\$	1					
2	PACIFIC MUTUAL		X	MORTGAGE		12/95	4,657,452	3,581,584	01/08	0.0888	504,723	2					
3												3					
4												4					
5												5					
	Working Capital																
6	A.I. IMPERIAL CREDIT		X	INSURANCE FINANCE							5,815	6					
7	CAREPLUS MGMT. ALLOCATION										49,333	7					
8	CAREPLUS REHAB ALLOCATION: EQUIPMENT LOANS										801	8					
9	TOTAL Facility Related						\$ 4,657,452	\$ 3,581,584			\$ 560,672	9					
	B. Non-Facility Related*																
10	IRS, IDR, ETC		X	LATE FEES							12,825	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ 12,825	14					
15	TOTALS (line 9+line14)						\$ 4,657,452	\$ 3,581,584			\$ 573,497	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

* 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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.

\$ **176,500** 1

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$ **172,887** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **(3,613)** 3

4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **174,616** 4

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$ 5

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$ 6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ **171,003** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	172,425	8
	2004	176,255	9
	2005	178,049	10
	2006	174,753	11
	2007	172,887	12

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2007	\$ 13
14	PLUS APPEAL COST FROM LINE 5	\$ 14
15	LESS REFUND FROM LINE 6	\$ 15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ 16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~101% OF PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2007 TAX BILL

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AVENUE CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0033340

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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>20-02-312-001-0000</u>	<u>NURSING HOME</u>	\$ <u>172,887.14</u>	\$ <u>172,887.14</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>172,887.14</u>	\$ <u>172,887.14</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? YES X 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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 AVENUE CARE CENTER

0033340

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (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 grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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:

(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	<u>NURSING HOME</u>	<u>51,736</u>	<u>1995</u>	<u>\$ 100,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	51,736		\$ 100,000	3

Facility Name & ID Number AVENUE CARE CENTER

0033340

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	155	1995	1971	\$ 4,046,250	\$ 103,746	39	\$ 103,746	\$	\$ 1,439,617	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	SPRINKLER SYSTEM		1988	5,400	171	25	216	45	4,446	9
10	LEASEHOLD IMPROVEMENTS		1989	1,035	33	20	52	19	988	10
11	LEASEHOLD IMPROVEMENTS		1990	5,400	171	20	270	99	5,017	11
12	LEASEHOLD IMPROVEMENTS		1991	14,414	458	20	721	263	12,618	12
13	LEASEHOLD IMPROVEMENTS		1992	42,003	1,288	31.5	1,288		22,433	13
14	LEASEHOLD IMPROVEMENTS		1993	16,403	431	31.5	431		7,625	14
15	LEASEHOLD IMPROVEMENTS		1993	1,081	37	15	37		1,081	15
16	LEASEHOLD IMPROVEMENTS		1994	15,686	402	39	402		5,897	16
17	LEASEHOLD IMPROVEMENTS		1994	9,604		20	480	480	6,960	17
18	ELEVATOR REPAIR & DOOR		1995	44,614	1,144	39	1,144		15,206	18
19	PAVING		1995	3,600	240	15	240		3,240	19
20	ALARM SYSTEM		1996	1,820	47	39	47		597	20
21	PLUMBING		1996	2,737	70	39	70		884	21
22	WALK-IN COOLER		1996	9,998	256	39	256		3,143	22
23	DOORS AND ROOF REPAIR		1997	5,110	131	39	131		1,552	23
24	FENCE		1997	19,800	508	39	508		5,863	24
25	FLOORING/BUMPER GUARDRAILS/HANDRAILS		1997	30,579	784	39	784		8,933	25
26	BUILT-IN NURSES' STATION & WARDROBES		1997	26,176	671	39	671		7,718	26
27	SMOKE & FIRE DAMPERS		1998	7,100	182	39	182		1,857	27
28	ELEVATOR REPAIR AND LAUNDRY ROOM ELECTRICAL/CIRCU		1998	5,931	152	39	152		1,618	28
29	PARKING LOT PAVING AND LANDSCAPING		1998	53,109	3,139	15	3,541	402	37,318	29
30	FLOORING		1998	11,516	295	39	295		3,086	30
31	FIRE SAFETY UPGRADE/LIGHTING/EXHAUST/ROOF		1999	57,028	1,462	39	1,462		13,949	31
32	ONE SUMP PUMP ASSEMBLY		2000	4,200	153	27.5	153		1,243	32
33	RELOCATION OF A/C UNIT		2000	3,015	109	27.5	109		897	33
34	INSTALL PULL STATION & REWIRE BLDG		2000	5,878	214	27.5	214		1,739	34
35	CONCRETE STAIRS & RAMP REPLACEMENT		2001	20,000	727	27.5	727		5,483	35
36	REPLACEMENT CARPET-1ST FLOOR		2001	2,422		20	121		968	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number AVENUE CARE CENTER

0033340

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	
37	LANDSCAPE INSTALLATION	2001	\$ 2,910	\$ 172	15	\$ 194	\$ 22	\$ 1,716	37
38	REPAIR PASSENGER & SMALL SERVICE ELEVATORS	2001	11,654	424	27.5	424		3,092	38
39	DECK	2001	12,170	718	15	811	93	7,178	39
40	SECOND FLOOR RESIDENT ROOMS-CLOSETS	2001	26,075	948	27.5	948		6,834	40
41	REPLACE PUMP MOTOR ON THE PASSENGER ELEVATOR	2002	2,580	94	27.5	94		654	41
42	BATHROOMS - INSTALLATION OF NEW SHEET VINYL	2002	1,297	47	27.5	47		284	42
43	RESIDENT BATHROOMS-NEW FLOOR	2003	3,274	119	27.5	119		699	43
44	INSTALLATION OF FIRE SPRINKLERS	2003	3,454	126	27.5	126		740	44
45	INSTALL NEW FRAMES FOR SLIDING DOORS	2003	2,765	101	27.5	101		559	45
46	BASEMENT CORRIDOR - FLOORING	2003	7,286	265	27.5	265		1,424	46
47	REPLACEMENT OF SEWER PIPES	2003	13,436	488	27.5	488		2,694	47
48	RECOVERY EXISTING CANOPY	2004	2,500	91	27.5	91		436	48
49	REMODELING BATHROOMS	2004	14,490	527	27.5	527		2,125	49
50	PAINTING HALLWAY	2005	15,280	1,870	20	764	(1,106)	3,056	50
51	INSTALL NEW SIGNS	2006	4,100	273	15	273		819	51
52	NEW LANDSCAPING	2006	26,080	1,739	15	1,739		5,217	52
53	REPLACED HOT WATER HEATER	2006	5,185	189	27.5	189		465	53
54	INSTALL SMOKE DETECTORS & FIRE ALARM SYSTEM	2006	10,239	372	27.5	372		915	54
55	INSTALL NEW ROOF DRAINS	2006	2,850	104	27.5	104		255	55
56	INSTALL EMERGENCY LIGHTS	2006	3,552	129	27.5	129		317	56
57	INSTALL NEW SHRUB ZONE	2006	2,125	77	27.5	77		189	57
58	3RD FLOOR SHOWERS ROOMS	2006	22,568	821	27.5	821		2,019	58
59	INSTALL EXHAUST FAN FOR SMOKING ROOM	2007	3,012	110	27.5	110		170	59
60	REHAB OF BUILDING AND RESIDENT BATHROOMS	2007	360,377	13,105	27.5	13,105		21,296	60
61	CUSTOM WINDOW TREATMENTS & CUBICLE CURTAINS	2007	18,883	6,043	5	6,043		9,820	61
62	ELEVATOR MODERNIZATION	2007	12,800	465	27.5	465		794	62
63	INSTALL NEW STEAM WELL	2007	2,656	97	27.5	97		149	63
64	BASEMENT DINNING A/C UNIT	2007	2,899	105	27.5	105		162	64
65	INSTALLED NEW ELEVATOR TRAVELING CABLES	2008	3,320	106	27.5	106		106	65
66	INSTALLED NEW CIRCUITS AND OUTLETS	2008	3,500	37	27.5	37		37	66
67	REHAB OF BUILDING AND RESIDENT BATHROOMS	2008	51,225	1,009	27.5	1,009		1,009	67
68	PLUMBING	2008	22,975	452	27.5	452		452	68
69	PASSENGER ELEVATOR-CHANGED SEALS AND PACKING	2008	4,863	96	27.5	96		96	69
70	TOTAL (lines 4 thru 69)		\$ 5,154,289	\$ 148,340		\$ 148,778	\$ 317	\$ 1,697,754	70

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

Facility Name & ID Number AVENUE CARE CENTER

0033340

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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		\$ 5,154,289	\$ 148,340		\$ 148,778	\$ 438	\$ 1,697,754	1
2	REPLACED CAR SILLS IN FREGHT ELEVATOR	2008	6,400	10	27.5	10		10	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	RELATED PARTY ALLOCATION								21
22	CAREPLUS REHAB								22
23	NEW ROOF VENTILATOR	2003	909	23	39	23			23
24									24
25									25
26	CAREPLUS MGMT								26
27	BUILDING-TAG-18 PROPERTIES	2004	58,370	2,113	39	2,113			27
28	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES	2004	22,931	1,598	39	1,598			28
29	BULDING IMPROVEMENTS-CAREPLUS MGMT	2007		9	39	9			29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,242,899	\$ 152,093		\$ 152,531	\$ 438	\$ 1,697,764	34

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

Facility Name & ID Number AVENUE CARE CENTER

0033340

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 173,347	\$ 10,032	\$ 16,617	\$ 6,585	8-15	\$ 105,686	71
72	Current Year Purchases	23,683	14,210	1,256	(12,954)	8-10	1,256	72
73	Fully Depreciated Assets	145,216					145,216	73
74	RELATED PARTY SL DEPRECIATION		11,383	11,383				74
75	TOTALS	\$ 342,246	\$ 35,625	\$ 29,256	\$ (6,369)		\$ 252,158	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,685,145	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 187,718	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 181,787	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,931)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,949,922	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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: \$ 47,418 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2006 FORD E35C	\$ 898.45	\$ 10,781	17
18					18
19					19
20					20
21	TOTAL		\$ 898.45	\$ 10,781	21

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. _____ \$ _____

13. _____ \$ _____

14. _____ \$ _____

* 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>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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	39-3	hrs	\$		\$ 105,585	\$		\$ 105,585	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			595			595	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			106,930			106,930	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts			108,670			108,670	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>MEDICAL SUPPLIES</u>	39-2				720			720	13
14	TOTAL			\$		\$ 322,500	\$		\$ 322,500	14

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

Facility Name & ID Number AVENUE CARE CENTER

0033340

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 496	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,050,066		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	123,806		6
7	Other Prepaid Expenses	33,302		7
8	Accounts Receivable (owners or related parties)	2,503,008		8
9	Other(specify): <u>Real Estate Tax Escrow</u>	24,265		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,734,943	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,104,836		15
16	Equipment, at Historical Cost	351,850		16
17	Accumulated Depreciation (book methods)	(579,199)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>REPLACEMENT RESERVE</u>	187,358		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,064,845	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,799,788	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 798,563	\$	26
27	Officer's Accounts Payable	65,176		27
28	Accounts Payable-Patient Deposits	164,747		28
29	Short-Term Notes Payable	332,249		29
30	Accrued Salaries Payable	188,517		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,870		31
32	Accrued Real Estate Taxes(Sch.IX-B)	174,616		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,747,738	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,747,738	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 5,052,050	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,799,788	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,132,653	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENR	(3,858)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,128,795	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	923,255	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	()	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)	\$ 923,255	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,052,050	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,648,789	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,648,789	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	1,816	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,816	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	20,800	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 20,800	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	34,651	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 34,651	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,706,056	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	997,866	31
32	Health Care	2,131,537	32
33	General Administration	1,437,160	33
	B. Capital Expense		
34	Ownership	808,642	34
	C. Ancillary Expense		
35	Special Cost Centers	322,500	35
36	Provider Participation Fee	85,096	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,782,801	40
41	Income before Income Taxes (line 30 minus line 40)**	923,255	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 923,255	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

*** 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 AVENUE CARE CENTER

0033340

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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	2,009	2,287	\$ 85,857	\$ 37.54	1
2	Assistant Director of Nursing	1,645	1,873	70,300	37.53	2
3	Registered Nurses	5,716	6,006	153,558	25.57	3
4	Licensed Practical Nurses	25,037	26,198	595,418	22.73	4
5	CNAs & Orderlies	68,734	74,111	685,478	9.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,451	6,893	102,365	14.85	8
9	Activity Director	1,918	2,023	20,252	10.01	9
10	Activity Assistants	7,044	7,652	72,216	9.44	10
11	Social Service Workers	2,032	2,165	48,294	22.31	11
12	Dietician					12
13	Food Service Supervisor	2,069	2,142	36,437	17.01	13
14	Head Cook	5,051	5,482	52,030	9.49	14
15	Cook Helpers/Assistants	11,192	12,208	102,764	8.42	15
16	Dishwashers					16
17	Maintenance Workers	7,325	7,854	72,208	9.19	17
18	Housekeepers	14,999	15,969	137,881	8.63	18
19	Laundry	5,298	5,832	61,576	10.56	19
20	Administrator	2,178	2,288	110,728	48.40	20
21	Assistant Administrator	1,967	2,113	61,727	29.21	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,151	6,504	68,846	10.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,921	1,999	18,035	9.02	31
32	Other Health Care(specify)	7,991	8,381	157,977	18.85	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	186,728	199,980	\$ 2,713,947 *	\$ 13.57	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	M	\$ 8,656	1-3	35
36	Medical Director	O	8,000	9-3	36
37	Medical Records Consultant	N	1,104	10-3	37
38	Nurse Consultant	T	502	10-3	38
39	Pharmacist Consultant	H	1,440	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,365	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 32,867		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	N/A	\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008
1	PAINT/DECORATING	07/05	\$ 1,500	3 YRS	\$ 250	\$ 500	\$ 500	\$ 250	\$	\$	\$	\$								
2	PAINT/DECORATING	07/06	8,150	3 YRS		1,359	2,716	2,716	1,359											
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20	TOTALS		\$ 9,650		\$ 250	\$ 1,859	\$ 3,216	\$ 2,966	\$ 1,359	\$	\$	\$								

Facility Name & ID Number AVENUE CARE CENTER

0033340

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL ASSOCIATES OF HEALTH CARE \$930
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23 Line 10-2
- (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. _____
- (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. \$ 85,096
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 20,093 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 5%
- d. Have vehicle usage logs been maintained? NO
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees