

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	<u>158</u>	Skilled (SNF)	<u>158</u>	<u>57,828</u>	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	<u>158</u>	TOTALS	<u>158</u>	<u>57,828</u>	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	<u>21,039</u>	<u>11,668</u>	<u>18,794</u>	<u>51,501</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,039</u>	<u>11,668</u>	<u>18,794</u>	<u>51,501</u>	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?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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 16,938

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	264,685	68,524	16,870	350,079		350,079	(3,353)	346,726		1
2	Food Purchase		265,473		265,473		265,473	(1,217)	264,256		2
3	Housekeeping	178,711	42,363	32	221,106		221,106	(3,032)	218,074		3
4	Laundry	57,975	21,101		79,076		79,076	(97)	78,979		4
5	Heat and Other Utilities			216,330	216,330		216,330	2,964	219,294		5
6	Maintenance	117,729		163,001	280,730		280,730	9,715	290,445		6
7	Other (specify):*							2,469	2,469		7
8	TOTAL General Services	619,100	397,461	396,233	1,412,794		1,412,794	7,448	1,420,242		8
	B. Health Care and Programs										
9	Medical Director			39,000	39,000		39,000		39,000		9
10	Nursing and Medical Records	3,194,175	177,228	199,258	3,570,661		3,570,661	18,131	3,588,792		10
10a	Therapy	210,271			210,271		210,271	2,333	212,604		10a
11	Activities	153,777	37,044	200	191,021		191,021		191,021		11
12	Social Services	206,680	774	2,025	209,479		209,479	13,538	223,017		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							7,707	7,707		15
16	TOTAL Health Care and Programs	3,764,903	215,046	240,483	4,220,432		4,220,432	41,709	4,262,141		16
	C. General Administration										
17	Administrative	99,797			99,797		99,797	86,650	186,447		17
18	Directors Fees										18
19	Professional Services			526,495	526,495		526,495	(421,558)	104,937		19
20	Dues, Fees, Subscriptions & Promotions			66,619	66,619		66,619	(11,779)	54,840		20
21	Clerical & General Office Expenses	121,758	40,461	297,744	459,963		459,963	(40,901)	419,062		21
22	Employee Benefits & Payroll Taxes			693,423	693,423		693,423	(9,361)	684,062		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,824	5,824		5,824	4,640	10,464		24
25	Other Admin. Staff Transportation			1,368	1,368		1,368	1,494	2,862		25
26	Insurance-Prop.Liab.Malpractice			157,290	157,290		157,290	5,052	162,342		26
27	Other (specify):*							33,113	33,113		27
28	TOTAL General Administration	221,555	40,461	1,748,763	2,010,779		2,010,779	(352,649)	1,658,130		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,605,558	652,968	2,385,479	7,644,005		7,644,005	(303,492)	7,340,513		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

#0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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			51,190	51,190	51,190	274,513	325,703				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						324,068	324,068				32
33	Real Estate Taxes			256,205	256,205	256,205	4,214	260,419				33
34	Rent-Facility & Grounds			519,030	519,030	519,030	(515,135)	3,895				34
35	Rent-Equipment & Vehicles			16,509	16,509	16,509	6,018	22,527				35
36	Other (specify):*											36
37	TOTAL Ownership			842,934	842,934	842,934	93,678	936,612				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		940,386	1,287,164	2,227,550	2,227,550	(269,260)	1,958,290				39
40	Barber and Beauty Shops			1,769	1,769	1,769	(1,769)					40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			86,742	86,742	86,742		86,742				42
43	Other (specify):*						134,176	134,176				43
44	TOTAL Special Cost Centers		940,386	1,375,675	2,316,061	2,316,061	(136,853)	2,179,208				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,605,558	1,593,354	4,604,088	10,803,000	10,803,000	(346,667)	10,456,333				45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	(1,068)	02		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	38,620	30		9
10	Interest and Other Investment Income	(257,343)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(591)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,376)	21		18
19	Entertainment				19
20	Contributions	(370)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(189,297)	21		24
25	Fund Raising, Advertising and Promotional	(16,748)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(137)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(93,250)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (523,560)		\$	30

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)	176,892		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 176,892		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (346,667)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Lemont Nursing & Rehab Center

ID# 0046201

Report Period Beginning: 01/01/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Other Income	\$ (2,294)	21 1
2	Patient Clothing	(154)	10 2
3	Barber and Beauty Shop	(1,769)	40 3
4	Prior Period Adjustment- Dues & Subscriptions	(2,000)	20 4
5	Theft Loss	(4,643)	21 5
6	Collection Expenses	(5,584)	21 6
7	Annual Report	(250)	20 7
8	Non-allowable Marketing Expenses	(648)	21 8
9	Capitalized R&M	(3,177)	06 9
10	Amortization- Building Company	(72,514)	36 10
11	Non-Allowable Legal	(217)	19 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	(93,250)	49

Lemont Nursing & Rehab Center

ID# 0046201

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

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

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/08

Ending:

12/31/08**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			433		3,185	(6,872)	(99)					(3,353)	1
2	Food Purchase	(1,659)		442									(1,217)	2
3	Housekeeping			429		47		(3,508)					(3,032)	3
4	Laundry							(97)					(97)	4
5	Heat and Other Utilities			2,614		109	241						2,964	5
6	Maintenance	(3,177)		3,302	6,375	14	41	(92)		3,252			9,715	6
7	Other (specify):*				2,057	412							2,469	7
8	TOTAL General Services	(4,836)		7,220	8,432	3,767	(6,590)	(3,797)		3,252			7,448	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(154)				27,303		(9,018)					18,131	10
10a	Therapy					2,333							2,333	10a
11	Activities													11
12	Social Services					13,538							13,538	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,707							7,707	15
16	TOTAL Health Care and Programs	(154)				50,881		(9,018)					41,709	16
	C. General Administration													
17	Administrative			2,079	7,748	39,559	3,452				33,812		86,650	17
18	Directors Fees													18
19	Professional Services	(217)		(350,120)		(87,060)	132				15,707		(421,558)	19
20	Fees, Subscriptions & Promotions	(18,998)		5,746		8	117				1,348		(11,779)	20
21	Clerical & General Office Expenses	(206,349)		25,075	120,604	13,437	4,094			(9,854)	12,092		(40,901)	21
22	Employee Benefits & Payroll Taxes				(6,639)	(2,122)		(600)					(9,361)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,468		169					3,003		4,640	24
25	Other Admin. Staff Transportation			1,249			226			19			1,494	25
26	Insurance-Prop.Liab.Malpractice			909		15	280			67	3,781		5,052	26
27	Other (specify):*				21,336	6,826	953				3,998		33,113	27
28	TOTAL General Administration	(225,564)		(313,594)	143,049	(29,168)	9,254	(600)		(9,768)	73,741		(352,649)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(230,554)		(306,374)	151,481	25,480	2,664	(13,414)		(6,516)	73,741		(303,492)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08 Ending:

12/31/08

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
30	Depreciation	38,620	203,036	11,775		809	256			17,786	2,231		274,513	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(257,343)	521,773	32,447		6,012	786			3,445	16,948		324,068	32
33	Real Estate Taxes			4,038		176							4,214	33
34	Rent-Facility & Grounds		(519,030)	3,068			827						(515,135)	34
35	Rent-Equipment & Vehicles			1,022			80				4,916		6,018	35
36	Other (specify):*	(72,514)	72,514											36
37	TOTAL Ownership	(291,237)	278,293	52,350		6,997	1,949			21,231	24,095		93,678	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(5,330)	(13,282)		(27,390)	(223,258)		(269,260)	39
40	Barber and Beauty Shops	(1,769)											(1,769)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*										134,176		134,176	43
44	TOTAL Special Cost Centers	(1,769)					(5,330)	(13,282)		(27,390)	(89,082)		(136,853)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(523,560)	278,293	(254,024)	151,481	32,477	(717)	(26,697)		(12,675)	8,754		(346,667)	45

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		See Attached			See Attached	
					lemont Property LLC	Building Company

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	34 Rent	\$ 519,030	Lemont Property, LLC	100.00%	\$	\$ (519,030)	1
2	V	33 Real Estate Tax	256,205	Lemont Property, LLC	100.00%	256,205		2
3	V	36 Amortization		Lemont Property, LLC	100.00%	72,514	72,514	3
4	V	30 Depreciation		Lemont Property, LLC	100.00%	203,036	203,036	4
5	V	32 Interest		Lemont Property, LLC	100.00%	521,773	521,773	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 775,235			\$ 1,053,528	\$ * 278,293	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center# 0046201Report Period Beginning: 01/01/08Ending: 12/31/08

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	\$	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	\$ 433	\$ 433	15
16	V	02 Food		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	442	442	16
17	V	03 Housekeeping		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	429	429	17
18	V	05 Utilities		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,614	2,614	18
19	V	06 Maintenance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,302	3,302	19
20	V	17 Administrative		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,079	2,079	20
21	V	19 Professional Fees	365,578	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	15,458	(350,120)	21
22	V	20 Dues and Subscriptions		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	5,746	5,746	22
23	V	21 Office and Clerical		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	25,075	25,075	23
24	V	24 Seminar and Travel		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,468	1,468	24
25	V	25 Other Staff Admin. Trans.		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,249	1,249	25
26	V	26 Insurance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	909	909	26
27	V	30 Depreciation		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	11,775	11,775	27
28	V	32 Interest		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	32,447	32,447	28
29	V	33 Real Estate Taxes		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	4,038	4,038	29
30	V	34 Rent - Building		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,068	3,068	30
31	V	35 Rent - Equipment & Auto		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,022	1,022	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 365,578			\$ 111,554	\$ * (254,024)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center# 0046201Report Period Beginning: 01/01/08Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	06	Maintenance (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	6,375	\$ 6,375	15
16	V	06	Maintenance (Direct)	406	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	406		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,011	2,011	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	46	46	18
19	V	17	Administrative (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	7,748	7,748	19
20	V	21	Office and Clerical (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	120,604	120,604	20
21	V	21	Office and Clerical (Direct)	19,926	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	19,926		21
22	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	19,164	19,164	22
23	V	27	Emp. Ben. - Gen. Admin. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,172	2,172	23
24	V	22	Employee Benefits	6,639	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%		(6,639)	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			\$ 26,971			\$ 178,452	\$ * 151,481	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center# 0046201Report Period Beginning: 01/01/08Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	03	Housekeeping	\$	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	\$ 47	\$ 47	15	
16	V	05	Utilities		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	109	109	16	
17	V	06	Maintenance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	14	14	17	
18	V	19	Professional Fees	88,299	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	1,239	(87,060)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	8	8	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	208	208	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	169	169	21	
22	V	26	Insurance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	15	15	22	
23	V	30	Depreciation		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	809	809	23	
24	V	32	Interest		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	6,012	6,012	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	176	176	25	
26	V	01	Dietary Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	3,185	3,185	26	
27	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	412	412	27	
28	V	10	Nursing Salary	21,448	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	48,751	27,303	28	
29	V	10a	Rehab Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	2,333	2,333	29	
30	V	12	Social Service Salary	2,025	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	15,563	13,538	30	
31	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	7,707	7,707	31	
32	V	17	Administration Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	39,559	39,559	32	
33	V	21	Office Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	13,229	13,229	33	
34	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	6,826	6,826	34	
35	V	22	Employee Benefits	2,122	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%		(2,122)	35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 113,894			\$ 146,371	\$ * 32,477	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center# 0046201Report Period Beginning: 01/01/08Ending: 12/31/08

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	\$	Care Centers Health Systems, Inc.	100.00%	\$ 2,137	\$ 2,137	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	241	241	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	41	41	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	132	132	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	117	117	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	525	525	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	226	226	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	280	280	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	256	256	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%	786	786	25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%			26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	827	827	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	80	80	28
29	V	01 Dietary	14,273	Care Centers Health Systems, Inc.	100.00%	5,264	(9,009)	29
30	V	02 Food		Care Centers Health Systems, Inc.	100.00%			30
31	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			31
32	V	10 Nursing		Care Centers Health Systems, Inc.	100.00%			32
33	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%			33
34	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			34
35	V	39 Ancillary	8,444	Care Centers Health Systems, Inc.	100.00%	3,114	(5,330)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	3,452	3,452	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	3,569	3,569	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	953	953	38
39	Total		\$ 22,717			\$ 22,000	\$ *	(717) 39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	1 Dietary	\$ 1,123	Xcel Supply, LLC	100.00%	\$ 1,023	\$ (99)	15
16	V	3 Housekeeping	39,609	Xcel Supply, LLC	100.00%	36,101	(3,508)	16
17	V	4 Laundry	1,094	Xcel Supply, LLC	100.00%	997	(97)	17
18	V	6 Repairs & Maintenance	1,039	Xcel Supply, LLC	100.00%	947	(92)	18
19	V	10 Nursing	101,808	Xcel Supply, LLC	100.00%	92,791	(9,018)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	6,769	Xcel Supply, LLC	100.00%	6,169	(600)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	149,952	Xcel Supply, LLC	100.00%	136,669	(13,282)	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		\$ 301,394			\$ 274,697	\$ * (26,697)	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center# 0046201Report Period Beginning: 01/01/08Ending: 12/31/08

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	\$	CCS Employee Benefits Group	100.00%	\$ 145,929	\$ 145,929	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	145,929	CCS Employee Benefits Group	100.00%		(145,929)	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			\$ 145,929			\$ 145,929	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Repairs	\$	Vent Lease, LLC.	100.00%	\$ 3,252	\$ 3,252	15
16	V	21 Office and Clerical		Vent Lease, LLC.	100.00%	366	366	16
17	V	25 Auto Expense / Travel		Vent Lease, LLC.	100.00%	19	19	17
18	V	26 Insurance		Vent Lease, LLC.	100.00%	67	67	18
19	V	30 Depreciation		Vent Lease, LLC.	100.00%	10,814	10,814	19
20	V	32 Interest		Vent Lease, LLC.	100.00%	1,824	1,824	20
21	V	30 Depreciation - Matrix		Vent Lease, LLC.	100.00%	6,972	6,972	21
22	V	32 Interest - Matrix		Vent Lease, LLC.	100.00%	1,621	1,621	22
23	V	21 Office and Clerical	10,220	Vent Lease, LLC.	100.00%		(10,220)	23
24	V	39 Ancillary	27,390	Vent Lease, LLC.	100.00%		(27,390)	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		\$ 37,610			\$ 24,935	\$ * (12,675)	39

* 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	17 Administration	\$	Therapy Works Rehabilitation Services, LLC	100.00%	\$ 3,582	\$ 3,582	15
16	V	19 Professional Fees		Therapy Works Rehabilitation Services, LLC	100.00%	15,707	15,707	16
17	V	20 Dues and Subscriptions		Therapy Works Rehabilitation Services, LLC	100.00%	1,348	1,348	17
18	V	21 Office & Clerical		Therapy Works Rehabilitation Services, LLC	100.00%	12,092	12,092	18
19	V	24 Travel and Seminar		Therapy Works Rehabilitation Services, LLC	100.00%	3,003	3,003	19
20	V	26 Insurance		Therapy Works Rehabilitation Services, LLC	100.00%	3,781	3,781	20
21	V	30 Depreciation		Therapy Works Rehabilitation Services, LLC	100.00%	2,231	2,231	21
22	V	32 Interest		Therapy Works Rehabilitation Services, LLC	100.00%	16,948	16,948	22
23	V	35 Rent - Equipment		Therapy Works Rehabilitation Services, LLC	100.00%	4,916	4,916	23
24	V	39 Ancillary		Therapy Works Rehabilitation Services, LLC	100.00%	103	103	24
25	V	39 Ancillary (Direct)		Therapy Works Rehabilitation Services, LLC	100.00%			25
26	V	17 Administrative Salaries		Therapy Works Rehabilitation Services, LLC	100.00%	30,230	30,230	26
27	V	27 Emp. Ben. - Gen. Admin.		Therapy Works Rehabilitation Services, LLC	100.00%	3,998	3,998	27
28	V	39 Ancillary Salaries	1,237,858	Therapy Works Rehabilitation Services, LLC	100.00%	1,014,497	(223,361)	28
29	V	43 Emp. Ben. - Other		Therapy Works Rehabilitation Services, LLC	100.00%	134,176	134,176	29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,237,858			\$ 1,246,612	\$ * 8,754	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning: 01/01/08

Ending: 12/31/08

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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	Shareholder	Administrative	1.00%	See Attached	1.05	3.15%		\$		1
2	Adam Vales	Relative	Clerical	N/A	See Attached	1.12	2.80%	Alloc. Salary	2,009	22-7	2
3	Kim Rudolph	Relative	Clerical	N/A	See Attached	0.46	2.76%	Alloc. Salary	408	22-7	3
4	Mark Steinberg	Relative	Administrative	N/A	See Attached	1.73	3.15%	Alloc. Salary	4,812	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 7,229		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers Inc/Extended Care Consulting LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	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	Patient Days	1,635,146	31	\$ 13,778	\$ 51,501	\$ 433	1
2	02	Food	Patient Days	1,635,146	31	13,971	51,501	442	2
3	03	Housekeeping	Patient Days	1,635,146	31	13,659	51,501	429	3
4	05	Utilities	Patient Days	1,635,146	31	83,022	51,501	2,614	4
5	06	Maintenance	Patient Days	1,635,146	31	104,857	51,501	3,302	5
6	17	Administrative	Patient Days	1,635,146	31	66,000	51,501	2,079	6
7	19	Professional Fees	Patient Days	1,635,146	31	491,332	51,501	15,458	7
8	20	Dues and Subscriptions	Patient Days	1,635,146	31	182,607	51,501	5,746	8
9	21	Office and Clerical	Patient Days	1,635,146	31	797,040	51,501	25,075	9
10	24	Seminar and Travel	Patient Days	1,635,146	31	46,589	51,501	1,468	10
11	25	Other Staff Admin. Trans.	Patient Days	1,635,146	31	39,698	51,501	1,249	11
12	26	Insurance	Patient Days	1,635,146	31	28,827	51,501	909	12
13	30	Depreciation	Patient Days	1,635,146	31	505,348	51,501	11,775	13
14	32	Interest	Patient Days	1,635,146	31	1,031,834	51,501	32,447	14
15	33	Real Estate Taxes	Patient Days	1,635,146	31	128,276	51,501	4,038	15
16	34	Rent - Building	Patient Days	1,635,146	31	97,438	51,501	3,068	16
17	35	Rent - Equipment & Auto	Patient Days	1,635,146	31	32,530	51,501	1,022	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,676,806	\$	\$ 111,554	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers Inc/Extended Care Consulting LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	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	06	Maintenance (Pooled)	Patient Days	1,635,146	31	202,448	202,448	51,501	6,375	1
2	06	Maintenance (Direct)	Direct		31	422,013	422,013		406	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,635,146	31	63,663		51,501	2,011	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	53,015			46	4
5	17	Administrative (Pooled)	Patient Days	1,635,146	31	246,132	246,132	51,501	7,748	5
6	21	Office and Clerical (Pooled)	Patient Days	1,635,146	31	3,830,025	3,830,025	51,501	120,604	6
7	21	Office and Clerical (Direct)	Direct		31	695,305	695,305		19,926	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,635,146	31	608,507		51,501	19,164	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	90,171			2,172	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,211,280	\$ 5,395,924		\$ 178,452	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Center Clinical/Extended Care Clinical
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	03	Housekeeping	Patient Days	1,635,146	31	\$ 1,505	\$ 51,501	\$ 47	1	
2	05	Utilities	Patient Days	1,635,146	31	3,449	51,501	109	2	
3	06	Maintenance	Patient Days	1,635,146	31	431	51,501	14	3	
4	19	Professional Fees	Patient Days	1,635,146	31	39,159	51,501	1,239	4	
5	20	Dues and Subscriptions	Patient Days	1,635,146	31	244	51,501	8	5	
6	21	Office & Clerical	Patient Days	1,635,146	31	6,594	51,501	208	6	
7	24	Travel and Seminar	Patient Days	1,635,146	31	5,327	51,501	169	7	
8	26	Insurance	Patient Days	1,635,146	31	465	51,501	15	8	
9	30	Depreciation	Patient Days	1,635,146	31	25,565	51,501	809	9	
10	32	Interest	Patient Days	1,635,146	31	191,164	51,501	6,012	10	
11	33	Real Estate Taxes	Patient Days	1,635,146	31	5,595	51,501	176	11	
12	01	Dietary Salary	Patient Days	1,635,146	31	101,177	101,177	51,501	3,185	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,635,146	31	13,096	51,501	412	13	
14	10	Nursing Salary	Patient Days	1,635,146	31	867,390	867,390	51,501	27,303	14
15	10a	Rehab Salary	Patient Days	1,635,146	31	74,072	74,072	51,501	2,333	15
16	12	Social Service Salary	Patient Days	1,635,146	31	430,372	430,372	51,501	13,538	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,635,146	31	177,415	51,501	5,585	17	
18	17	Administration Salary	Patient Days	1,635,146	31	1,257,059	1,257,059	51,501	39,559	18
19	21	Office Salary	Patient Days	1,635,146	31	420,417	420,417	51,501	13,229	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,635,146	31	216,825	51,501	6,826	20	
21	10	Nursing Salary	Direct Allocation			401,447	401,447		21,448	21
22	12	Social Service Salary	Direct Allocation			61,016	61,016		2,025	22
23	15	Emp. Ben. - Healthcare	Direct Allocation			51,816			2,122	23
24										24
25	TOTALS					\$ 4,351,600	\$ 3,612,950	\$ 146,371		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers Health Systems, Inc.
 Street Address 200 Howard
 City / State / Zip Code Des Plaines, Illinois 60018
 Phone Number (224) 612-5662
 Fax Number (224) 612-5862

1	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	Gross Billable Income	31	111,096		74,378	2,137	1
2	03	Housekeeping	Gross Billable Income	31			74,378		2
3	05	Heat and Other Utilities	Gross Billable Income	31	12,529		74,378	241	3
4	06	Maintenance	Gross Billable Income	31	2,136		74,378	41	4
5	19	Professional Fees	Gross Billable Income	31	6,873		74,378	132	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	31	6,095		74,378	117	6
7	21	Clerical and General Office	Gross Billable Income	31	27,280		74,378	525	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	31	11,773		74,378	226	8
9	26	Insurance	Gross Billable Income	31	14,568		74,378	280	9
10	30	Depreciation	Gross Billable Income	31	13,298		74,378	256	10
11	32	Interest	Gross Billable Income	31	40,850		74,378	786	11
12	33	Real Estate Taxes	Gross Billable Income	31			74,378		12
13	34	Rent - Building	Gross Billable Income	31	43,000		74,378	827	13
14	35	Rent - Equipment	Gross Billable Income	31	4,135		74,378	80	14
15	01	Dietary	Direct Billable Income	31	102,965		14,273	5,264	15
16	02	Food	Direct Billable Income	31	1,612				16
17	03	Housekeeping	Direct Billable Income	31					17
18	10	Nursing	Direct Billable Income	31					18
19	21	Clerical and General Office	Direct Billable Income	31					19
20	25	Other Admin. Staff Transport.	Direct Billable Income	31					20
21	39	Ancillary	Direct Billable Income	31	1,321,550		8,444	3,114	21
22	17	Administrative	Gross Billable Income	31	179,474	179,474	74,378	3,452	22
23	21	Clerical and General Office	Gross Billable Income	31	185,549	185,549	74,378	3,569	23
24	27	Employee Benefits	Gross Billable Income	31	49,573		74,378	953	24
25	TOTALS				\$ 2,134,357	\$ 365,023		\$ 22,000	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Xcel Supply, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

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	1	Dietary						\$ 1,023	1
2	3	Housekeeping						36,101	2
3	4	Laundry						997	3
4	6	Repairs & Maintenance						947	4
5	10	Nursing						92,791	5
6	11	Activities							6
7	12	Social Service							7
8	20	Dues, Fees And Subscriptions							8
9	21	Office And Clerical							9
10	22	Employee Benefits						6,169	10
11	24	Seminars & Education							11
12	39	Ancillary						136,669	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							\$ 274,697	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 145,929	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 145,929	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Vent Lease, LLC
 Street Address 2201 W. Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

1	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	06	Repairs	Direct Billing	669,310	26	\$ 79,460	\$ 27,390	\$ 3,252	1
2	21	Office and Clerical	Direct Billing	669,310	26	8,933	27,390	366	2
3	25	Auto Expense / Travel	Direct Billing	669,310	26	473	27,390	19	3
4	26	Insurance	Direct Billing	669,310	26	1,630	27,390	67	4
5	30	Depreciation	Direct Billing	669,310	26	264,263	27,390	10,814	5
6	32	Interest	Direct Billing	669,310	26	44,568	27,390	1,824	6
7	30	Depreciation - Matrix	Patient Days	1,635,146	31	221,356	51,501	6,972	7
8	32	Interest - Matrix	Patient Days	1,635,146	31	51,456	51,501	1,621	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					\$ 672,138	\$	\$ 24,935	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Therapy Works Rehabilitation Services, LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 922-0702
 Fax Number (847) 905-4040

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	17	Administration	Billable Income	(4,665,397)	14	\$ 13,500	\$ (1,237,858)	\$ 3,582	1	
2	19	Professional Fees	Billable Income	(4,665,397)	14	59,199	(1,237,858)	15,707	2	
3	20	Dues and Subscriptions	Billable Income	(4,665,397)	14	5,081	(1,237,858)	1,348	3	
4	21	Office & Clerical	Billable Income	(4,665,397)	14	45,575	(1,237,858)	12,092	4	
5	24	Travel and Seminar	Billable Income	(4,665,397)	14	11,318	(1,237,858)	3,003	5	
6	26	Insurance	Billable Income	(4,665,397)	14	14,252	(1,237,858)	3,781	6	
7	30	Depreciation	Billable Income	(4,665,397)	14	8,410	(1,237,858)	2,231	7	
8	32	Interest	Billable Income	(4,665,397)	14	63,875	(1,237,858)	16,948	8	
9	35	Rent - Equipment	Billable Income	(4,665,397)	14	18,528	(1,237,858)	4,916	9	
10	39	Ancillary	Billable Income	(4,665,397)	14	389	(1,237,858)	103	10	
11	39	Ancillary (Direct)	Direct			143,969			11	
12	17	Administrative Salaries	Billable Income	(4,665,397)	14	113,937	113,937	(1,237,858)	30,230	12
13	27	Emp. Ben. - Gen. Admin.	Billable Income	(4,665,397)	14	15,069	(1,237,858)	3,998	13	
14	39	Ancillary Salaries	Billable Income	(4,665,397)	14	3,823,568	3,823,568	(1,237,858)	1,014,497	14
15	43	Emp. Ben. - Other	Billable Income	(4,665,397)	14	505,700	(1,237,858)	134,176	15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 4,842,370	\$ 3,937,504	\$ 1,246,612	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	National City		X	Note Payable			\$	7,967,552			\$	521,773	1
2	Business Partners (Net)		X	Mortgage				262,087					2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6													6
7													7
8	See Supplemental Schedule											59,638	8
9	TOTAL Facility Related						\$	8,229,639			\$	581,411	9
	B. Non-Facility Related*												
10	Interest Income											(257,343)	10
11													11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	(257,343)	14
15	TOTALS (line 9+line14)						\$	8,229,639			\$	324,068	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8	Alloc from CCI/Ext Care Const. Inc	X					\$	\$			\$	32,447	8
9	Alloc from CCC/Ext Care Clinical	X										6,012	9
10	Alloc from Care Centers Health Syst	X										786	10
11	Allov from Vent Lease		X									3,445	11
12	Alloc from Therapy Works		X									16,948	12
13													13
14	TOTAL Working Capital											59,638	14
	B. Non-Facility Related*												
15							\$	\$			\$		15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

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

** 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:** 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 Lemont Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>22-27-300-077-0000</u>	<u>Long Term Care Property</u>	\$ <u>228,961.86</u>	\$ <u>228,961.86</u>
2. <u>22-27-300-077-0000</u>	<u>Long Term Care Property</u>	\$ <u>13,821.06</u>	\$ <u>13,821.06</u>
3. <u>See Attached</u>	<u>2201 Main, LLC</u>	\$ <u>122,122.75</u>	\$ <u>1,721.31</u>
4. <u>See Attached</u>	<u>Care Centers Building, LLC</u>	\$ <u>43,667.89</u>	\$ <u>916.74</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>408,573.56</u>	\$ <u>245,420.97</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 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.

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 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 the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

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

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lemont Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>_____</u>	\$ <u>_____</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 NO

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

C. Tax Bills

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201 Report Period Beginning:

01/01/08 Ending:

12/31/08

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>823,094</u>	<u>2003</u>	<u>\$ 823,094</u>	<u>1</u>
2	<u>Allocated From CCI/ECC</u>			<u>12,789</u>	<u>2</u>
3	TOTALS	823,094		\$ 835,883	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9	Various			2003	48,664		20	2,525	2,525	18,055	9
10	Various			2004	35,166		20	2,611	2,611	11,909	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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	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		5,391,421	203,036		252,705	49,669	1,828,972	67
68		71,310	3,767		3,767		24,583	68
69			51,189			(51,189)		69
70		\$ 5,546,561	\$ 257,992		\$ 261,608	\$ 3,616	\$ 1,883,519	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 5,546,561	\$ 257,992		\$ 261,608	\$ 3,616	\$ 1,883,519	1
2	Replace Pipes	2005	7,375		20	369	369	1,444	2
3	Replaced Heat Exchangers	2007	16,500		20	1,100	1,100	2,200	3
4	Painting (Transfer Expense From Home Office)	2007	4,792		20	799	799	4,792	4
5	Painting (Transfer Expense From Home Office)	2007	5,091		20	2,546	2,546	5,091	5
6	Painting (Transfer Expense From Home Office)	2007	19,331		20	11,276	11,276	19,331	6
7	Roof Repair	2007	2,500		20	125	125	177	7
8	Air Unit, Supply Duct & Registers	2007	4,475		20	224	224	298	8
9	Dorr Wreck Repair	2007	7,200		20	360	360	420	9
10	Repair A/C	2008	4,475		20	224	224	224	10
11	Install New Smoke Dampers	2008	14,039		20	643	643	643	11
12	Programming For Additions & Alterations - Architect	2008	9,341		20	272	272	272	12
13	Replace Heating/Ac Unit	2008	5,250		20	131	131	131	13
14	Dining Room Remodeling	2008	3,600		20	60	60	60	14
15	Replace Heat Exchangers	2008	6,500		20	81	81	81	15
16	Additions & Alterations - Architect	2008	3,520		20	29	29	29	16
17	Sprinkler Repairs	2008	6,104		20	25	25	25	17
18	Sprinkler Repairs	2008	3,311		20	14	14	14	18
19	Replace Fire Pump	2008	3,177		20	159	159	159	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)		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	
1	Totals from Page 12C, Carried Forward		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	
1	Totals from Page 12D, Carried Forward		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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 12E, Carried Forward		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	
1	Totals from Page 12F, Carried Forward		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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 12G, Carried Forward		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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 12H, Carried Forward		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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 12I, Carried Forward		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	
1	Totals from Page 12J, Carried Forward		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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 12K, Carried Forward		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	
1	Totals from Page 12L, Carried Forward		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	
1	Totals from Page 12M, Carried Forward		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	
1	Totals from Page 12N, Carried Forward		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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 12O, Carried Forward		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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 12P, Carried Forward		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,673,142	\$ 257,992		\$ 280,045	\$ 22,053	\$ 1,918,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	115		2003	1995	\$ 4,683,421	\$	Various	\$ 197,159	\$ 197,159	\$ 1,486,158	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Land Improvements		2003		708,000		Various	55,546		342,814	9
10											10
11											11
12	Building Company Book Depreciation					203,036			(203,036)		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	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)	\$	\$		\$	\$	\$	70	
			5,391,421		203,036		252,705	(5,877)	1,828,972

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	
	FOR OHF USE ONLY	Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
	Bed* [*]	Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation	
4	Allocated from EC/CC Clinical, Inc.	2002	2002	\$ 1,588	\$ 41	39	\$ 41	\$	\$ 256	4
5	Allocated from CCI/ECC - CCI Building		1996	23,540	604	39	604		7,268	5
6	Allocated from CCI/Extended Care Consulting, LLC	2002	2002	14,202	364	39	364		2,291	6
7										7
8										8
	Improvement Type**									
9	Allocated from CCI/Extended Care Consulting, LLC		2002	11,732	1,072	20	1,072		5,371	9
10	Allocated from CCI/Extended Care Consulting, LLC		2003	13,826	1,264	20	1,264		6,330	10
11	Allocated from CCI/Extended Care Consulting, LLC		2005	687	73	20	73		175	11
12	Allocated from CCI/Extended Care Consulting, LLC		2007	143	7	20	7		17	12
13										13
14	Allocated from CCI/ECC- CCI Building		1996	397	-	20	-		397	14
15	Allocated from CCI/ECC- CCI Building		1997	2,260	73	20	73		1,149	15
16										16
17	Allocated from CC/EC Clinical, Inc.		2002	1,312	120	20	120		601	17
18	Allocated from CC/EC Clinical, Inc.		2003	1,546	141	20	141		708	18
19	Allocated from CC/EC Clinical, Inc.		2005	77	8	20	8		20	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	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)	\$	71,310	\$	3,767	\$	3,767	\$	24,583	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	\$ 230,441	\$ 26,880	\$ 31,133	\$ 4,253	10	\$ 195,980	71
72	Current Year Purchases	14,184	31	877	846	10	877	72
73	Fully Depreciated Assets	211,148		11,468	11,468	10	211,148	73
74								74
75	TOTALS	\$ 455,773	\$ 26,911	\$ 43,478	\$ 16,567		\$ 408,005	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		Allocated from CCC/EC Clinical	2008	\$ 2,275	\$ 455	\$ 455		5	\$ 885	76
77		Allocated from CCI/ECC	2008	26,973	1,676	1,676		5	23,190	77
78		Allocated from CC Health Sys	2008	243	49	49		5	57	78
79										79
80	TOTALS			\$ 29,491	\$ 2,180	\$ 2,180			\$ 24,132	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 6,994,289	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 287,083	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 325,703	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 38,620	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,351,047	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	<u>Alloc from CCI/Ext Care Cons., Inc</u>				<u>3,068</u>			5
6	<u>Alloc from Care Centers Health Systems</u>				<u>827</u>			6
7	TOTAL				\$ 3,895			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.	<u> </u> /2009	\$ <u> </u>
13.	<u> </u> /2010	\$ <u> </u>
14.	<u> </u> /2011	\$ <u> </u>

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: \$ 22,528 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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. 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>
--	--	---

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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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 - 03	hrs	\$		\$ 510,302	\$		\$ 510,302	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			95,271			95,271	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			633,039			633,039	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				728,423		728,423	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					48,552	211,963		260,515	13
14	TOTAL			\$		\$ 1,287,164	\$ 940,386		\$ 2,227,550	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center# 0046201Report Period Beginning: 01/01/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 300	\$ 118,733	1
2	Cash-Patient Deposits	38,696	38,696	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,244,429	1,244,429	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,311	26,311	6
7	Other Prepaid Expenses	6,191	6,191	7
8	Accounts Receivable (owners or related parties)	1,930,195	3,828,219	8
9	Other(specify): <u>See Attached Schedule</u>	5,550,766	5,496,766	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,796,888	\$ 10,759,345	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		823,094	13
14	Buildings, at Historical Cost		5,590,504	14
15	Leasehold Improvements, at Historical Cost	167,549	167,549	15
16	Equipment, at Historical Cost	186,061	186,061	16
17	Accumulated Depreciation (book methods)	(188,883)	(2,150,558)	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>See Attached Schedule</u>		60,200	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 164,727	\$ 4,676,850	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,961,615	\$ 15,436,195	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,052,032	\$ 1,052,032	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,823	27,823	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	182,872	182,872	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,713	13,713	31
32	Accrued Real Estate Taxes(Sch.IX-B)	490,753	490,753	32
33	Accrued Interest Payable		18,869	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	110,631	115,113	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,877,824	\$ 1,901,175	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		7,967,552	39
40	Mortgage Payable		262,087	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,229,639	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,877,824	\$ 10,130,814	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,083,791	\$ 5,305,381	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,961,615	\$ 15,436,195	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,581,174	1
2	Restatements (describe):		2
3	Profit Sharing Contribution	(7,664)	3
4	Rounding	(4)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,573,506	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	2,222,304	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	(712,019)	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)	\$ 1,510,285	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)	\$ 7,083,791	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	\$ 12,613,371	1
2	Discounts and Allowances for all Levels	(5,490,946)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,122,425	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,526,242	6
7	Oxygen	9,401	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,535,643	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	2,082	13
14	Non-Patient Meals	1,068	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	723,448	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	172,026	19
20	Radiology and X-Ray	48,595	20
21	Other Medical Services	154,354	21
22	Laundry	4,548	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,106,121	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	257,343	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 257,343	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	3,772	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,772	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,025,304	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,412,794	31
32	Health Care	4,220,432	32
33	General Administration	2,010,779	33
B. Capital Expense			
34	Ownership	842,934	34
C. Ancillary Expense			
35	Special Cost Centers	2,229,319	35
36	Provider Participation Fee	86,742	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,803,000	40
41	Income before Income Taxes (line 30 minus line 40)**	2,222,304	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,222,304	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lemont Nursing & Rehab Center

0046201

Report Period Beginning: 01/01/08

Ending:

12/31/08

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	1,736	1,984	\$ 79,491	\$ 40.07	1
2	Assistant Director of Nursing	1,460	1,718	61,937	36.05	2
3	Registered Nurses	24,265	27,056	877,192	32.42	3
4	Licensed Practical Nurses	30,446	33,847	862,643	25.49	4
5	CNAs & Orderlies	92,421	100,761	1,240,814	12.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,042	12,096	210,271	17.38	8
9	Activity Director	1,843	1,957	31,904	16.30	9
10	Activity Assistants	12,463	12,993	121,873	9.38	10
11	Social Service Workers	10,984	12,025	206,680	17.19	11
12	Dietician	109	216	3,041	14.08	12
13	Food Service Supervisor	1,874	2,150	51,440	23.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,338	6,852	95,829	13.99	15
16	Dishwashers	12,755	13,563	114,375	8.43	16
17	Maintenance Workers	5,926	6,205	117,729	18.97	17
18	Housekeepers	18,631	20,114	178,711	8.88	18
19	Laundry	6,327	6,877	57,975	8.43	19
20	Administrator	2,019	2,103	85,329	40.57	20
21	Assistant Administrator	544	584	14,468	24.77	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,734	8,474	121,758	14.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,973	3,401	43,958	12.93	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,556	1,694	28,140	16.61	33
34	TOTAL (lines 1 - 33)	253,446	276,670	\$ 4,605,558 *	\$ 16.65	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	Monthly	\$ 16,870	01-03	35
36	Medical Director	Monthly	39,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,370	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	4	200	11-03	44
45	Social Service Consultant	41			45
46	Other(specify)				46
47	<u>See Attached</u>		2,025	12-03	47
48	<u>See Attached</u>		21,447	10-03	48
49	TOTAL (lines 35 - 48)	45	\$ 81,912		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	790	\$ 42,578	10-03	50
51	Licensed Practical Nurses	2,964	108,888	10-03	51
52	Certified Nurse Assistants/Aides	1,163	23,975	10-03	52
53	TOTAL (lines 50 - 52)	4,917	\$ 175,441		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

Report Period Beginning: 01/01/08 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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 action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 97,100 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 86,742
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. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,068
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A 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. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT