



Facility Name & ID Number Lemont Nursing & Rehab Center

# 0046201 Report Period Beginning: 01/01/09 Ending: 12/31/09

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>57,670</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>57,670</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>20,005</u>	<u>11,667</u>	<u>19,300</u>	<u>50,972</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>20,005</u>	<u>11,667</u>	<u>19,300</u>	<u>50,972</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.39%

D. How many bed-hold days during this year were paid by the Department? 1 (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 18,650

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: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/09 Ending: 12/31/09

**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
	<b>A. General Services</b>										
1	Dietary	278,927	73,498	20,715	373,140		373,140	(4,981)	368,159		1
2	Food Purchase		282,154		282,154		282,154	(88)	282,066		2
3	Housekeeping	187,912	42,249		230,161		230,161	(3,272)	226,889		3
4	Laundry	61,359	29,462		90,821		90,821	(1,016)	89,805		4
5	Heat and Other Utilities			198,002	198,002		198,002	2,429	200,431		5
6	Maintenance	119,143		111,438	230,581		230,581	38,810	269,391		6
7	Other (specify):*							2,065	2,065		7
8	<b>TOTAL General Services</b>	647,341	427,363	330,155	1,404,859		1,404,859	33,947	1,438,806		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			39,000	39,000		39,000		39,000		9
10	Nursing and Medical Records	3,431,134	226,099	107,889	3,765,122		3,765,122	(12,660)	3,752,462		10
10a	Therapy	187,929			187,929		187,929	22,144	210,073		10a
11	Activities	186,506	39,019		225,525		225,525		225,525		11
12	Social Services	191,628	90	4,431	196,149		196,149	9,164	205,313		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							8,786	8,786		15
16	<b>TOTAL Health Care and Programs</b>	3,997,197	265,208	151,320	4,413,725		4,413,725	27,434	4,441,159		16
	<b>C. General Administration</b>										
17	Administrative	143,785			143,785		143,785	54,449	198,234		17
18	Directors Fees										18
19	Professional Services			564,411	564,411		564,411	(449,358)	115,053		19
20	Dues, Fees, Subscriptions & Promotions			51,468	51,468		51,468	(10,631)	40,837		20
21	Clerical & General Office Expenses	145,810	38,877	334,089	518,776		518,776	(101,237)	417,539		21
22	Employee Benefits & Payroll Taxes			722,653	722,653		722,653	(9,858)	712,795		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,950	8,950		8,950	1,068	10,018		24
25	Other Admin. Staff Transportation			1,987	1,987		1,987	523	2,510		25
26	Insurance-Prop.Liab.Malpractice			181,527	181,527		181,527	(496)	181,031		26
27	Other (specify):*							32,960	32,960		27
28	<b>TOTAL General Administration</b>	289,595	38,877	1,865,085	2,193,557		2,193,557	(482,581)	1,710,976		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,934,133	731,448	2,346,560	8,012,141		8,012,141	(421,200)	7,590,941		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: 01/01/09 Ending: 12/31/09

## 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	
	<b>D. Ownership</b>											
30	Depreciation			38,150	38,150		38,150	250,929	289,079			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			242	242		242	390,058	390,300			32
33	Real Estate Taxes			428,958	428,958		428,958	(272,406)	156,553			33
34	Rent-Facility & Grounds			519,030	519,030		519,030	(513,983)	5,047			34
35	Rent-Equipment & Vehicles			14,318	14,318		14,318	2,544	16,862			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,000,698	1,000,698		1,000,698	(142,858)	857,841			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,040,058	1,504,624	2,544,682		2,544,682	(241,318)	2,303,364			39
40	Barber and Beauty Shops			1,481	1,481		1,481	(1,481)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			86,505	86,505		86,505		86,505			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		1,040,058	1,592,610	2,632,668		2,632,668	(242,799)	2,389,869			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,934,133	1,771,506	4,939,868	11,645,507		11,645,507	(806,857)	10,838,650			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

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(144)	01		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	88,640	30		9
10	Interest and Other Investment Income	(243,169)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(646)	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	(8,320)	21		18
19	Entertainment				19
20	Contributions	(250)	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	(103,692)	21		24
25	Fund Raising, Advertising and Promotional	(12,549)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(500)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(429,307)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (709,937)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(96,920)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (96,920)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (806,857)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Lemont Nursing & Rehab Center

ID# 0046201

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Other Income	\$ (17)	21	1
2	Patient Clothing	(1,126)	10	2
3	Barber and Beauty Shop	(1,481)	40	3
4	Prior Period Adjustment- Medical Supplies & Tests	(32,003)	10	4
5	Prior Period Adjustment- Insurance Policy	(1,866)	26	5
6	Theft Loss	(4,840)	21	6
7	Collection Expenses	(452)	21	7
8	Annual Report	(250)	20	8
9	Additional R&M	24,395	06	9
10	Non-Allowable Legal	(2,453)	19	10
11	Prior Period R/E Taxes	(274,694)	33	11
12	Non-Allowable Expenses	(134,278)	21	12
13	Non-Allowable Interest	(242)	32	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	<b>Total</b>	(429,307)		49

Lemont Nursing & Rehab Center

ID# 0046201

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(144)		251		4,353					(9,441)		(4,981)	1
2	Food Purchase	(646)		558									(88)	2
3	Housekeeping			521		57	(3,850)						(3,272)	3
4	Laundry						(1,016)						(1,016)	4
5	Heat and Other Utilities			2,135		137					157		2,429	5
6	Maintenance	24,395		3,314	8,119	18			2,844		120		38,810	6
7	Other (specify):*				1,434	631							2,065	7
8	<b>TOTAL General Services</b>	<b>23,605</b>		<b>6,779</b>	<b>9,553</b>	<b>5,196</b>	<b>(4,866)</b>		<b>2,844</b>		<b>(9,164)</b>		<b>33,947</b>	8
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(33,129)				29,630	(9,161)						(12,660)	10
10a	Therapy					1,704				20,440			22,144	10a
11	Activities													11
12	Social Services					9,164							9,164	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					8,786							8,786	15
16	<b>TOTAL Health Care and Programs</b>	<b>(33,129)</b>				<b>49,284</b>	<b>(9,161)</b>			<b>20,440</b>			<b>27,434</b>	16
	<b>C. General Administration</b>													
17	Administrative			2,445	8,864	38,649					4,491		54,449	17
18	Directors Fees													18
19	Professional Services	(2,453)		(356,878)		(90,350)			156		167		(449,358)	19
20	Fees, Subscriptions & Promotions	(12,799)		2,092		8					68		(10,631)	20
21	Clerical & General Office Expenses	(252,349)		17,125	133,322	8,667			(13,437)		5,435		(101,237)	21
22	Employee Benefits & Payroll Taxes				(2,982)	(6,631)	(245)						(9,858)	22
23	Inservice Training & Education													23
24	Travel and Seminar			65		1,003							1,068	24
25	Other Admin. Staff Transportation			382					13		128		523	25
26	Insurance-Prop.Liab.Malpractice	(1,866)		840		50			161		319		(496)	26
27	Other (specify):*				24,285	6,715					1,960		32,960	27
28	<b>TOTAL General Administration</b>	<b>(269,467)</b>		<b>(333,929)</b>	<b>163,489</b>	<b>(41,889)</b>	<b>(245)</b>		<b>(13,107)</b>		<b>12,568</b>		<b>(482,581)</b>	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(278,992)</b>		<b>(327,150)</b>	<b>173,042</b>	<b>12,591</b>	<b>(14,272)</b>		<b>(10,263)</b>	<b>20,440</b>	<b>3,404</b>		<b>(421,200)</b>	29

## STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
<b>30</b>	<b>D. Ownership</b>													
	Depreciation	88,640	138,198	4,280		948			18,535		328		250,929	30
<b>31</b>	Amortization of Pre-Op. & Org.													31
<b>32</b>	Interest	(243,411)	555,843	62,916		11,451			3,259				390,058	32
<b>33</b>	Real Estate Taxes	(274,694)		2,064		224							(272,406)	33
<b>34</b>	Rent-Facility & Grounds		(519,030)	3,580							1,467		(513,983)	34
<b>35</b>	Rent-Equipment & Vehicles			2,528							16		2,544	35
<b>36</b>	Other (specify):*													36
<b>37</b>	<b>TOTAL Ownership</b>	<b>(429,465)</b>	<b>175,011</b>	<b>75,368</b>		<b>12,623</b>			<b>21,794</b>		<b>1,811</b>		<b>(142,858)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
<b>38</b>	Medically Necessary Transportation													38
<b>39</b>	Ancillary Service Centers						(17,594)		(28,905)	(187,126)	(7,693)		(241,318)	39
<b>40</b>	Barber and Beauty Shops	(1,481)											(1,481)	40
<b>41</b>	Coffee and Gift Shops													41
<b>42</b>	Provider Participation Fee													42
<b>43</b>	Other (specify):*													43
<b>44</b>	<b>TOTAL Special Cost Centers</b>	<b>(1,481)</b>					<b>(17,594)</b>		<b>(28,905)</b>	<b>(187,126)</b>	<b>(7,693)</b>		<b>(242,799)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
<b>45</b>	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(709,937)</b>	<b>175,011</b>	<b>(251,782)</b>	<b>173,042</b>	<b>25,214</b>	<b>(31,867)</b>		<b>(17,374)</b>	<b>(166,686)</b>	<b>(2,478)</b>		<b>(806,857)</b>	<b>45</b>

**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 Rental Income	\$ 519,030	Lemont Property, LLC		\$	(519,030)	1
2	V	33 Real Estate Tax Expense	428,959	Lemont Property, LLC		428,959		2
3	V	30 Depreciation Expense		Lemont Property, LLC		138,198	138,198	3
4	V	32 Interest Expenses- Business Partners		Lemont Property, LLC		555,843	555,843	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 947,989			\$ 1,123,000	\$ * 175,011	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 251	\$	251	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	558		558	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	521		521	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	2,135		2,135	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	3,314		3,314	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	2,445		2,445	20
21	V	19 Professional Fees	367,453	Extended Care Consulting, LLC	100.00%	10,575		(356,878)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,092		2,092	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	17,125		17,125	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	65		65	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	382		382	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	840		840	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	4,280		4,280	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	62,916		62,916	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,064		2,064	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	3,580		3,580	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	2,528		2,528	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 367,453			\$ 115,671	\$ *	(251,782)	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	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	8,119	\$	8,119	15
16	V	06 Maintenance (Direct)	437	Extended Care Consulting, LLC	100.00%	437			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,389		1,389	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	45		45	18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	8,864		8,864	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	133,322		133,322	20
21	V	21 Office and Clerical (Direct)	14,472	Extended Care Consulting, LLC	100.00%	14,472			21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	22,811		22,811	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,474		1,474	23
24	V	22 Employee Benefits	2,982	Extended Care Consulting, LLC	100.00%			(2,982)	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		\$ 17,891			\$ 190,933	\$ *	173,042	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	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 57	\$	57	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	137		137	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	18		18	17
18	V	19 Professional Fees	91,539	Extended Care Clinical, LLC	100.00%	1,189		(90,350)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	8		8	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	1,011		1,011	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,003		1,003	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	50		50	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	948		948	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	11,451		11,451	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	224		224	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	4,353		4,353	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	631		631	27
28	V	10 Nursing Salary	28,726	Extended Care Clinical, LLC	100.00%	58,356		29,630	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	1,704		1,704	29
30	V	12 Social Service Salary	4,431	Extended Care Clinical, LLC	100.00%	13,595		9,164	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	8,786		8,786	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	38,649		38,649	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	7,656		7,656	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	6,715		6,715	34
35	V	22 Employee Benefits	6,631	Extended Care Clinical, LLC	100.00%			(6,631)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 131,327			\$ 156,541	\$ *	25,214	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	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	41,925	Xcel Supply, LLC	100.00%	38,075	(3,850)	16
17	V	4 Laundry	11,068	Xcel Supply, LLC	100.00%	10,052	(1,016)	17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	99,755	Xcel Supply, LLC	100.00%	90,594	(9,161)	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	2,669	Xcel Supply, LLC	100.00%	2,424	(245)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	191,592	Xcel Supply, LLC	100.00%	173,998	(17,594)	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		\$ 347,010			\$ 315,143	\$ * (31,867)	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	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 162,687	\$ 162,687	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	162,687	CCS Employee Benefits Group	100.00%		(162,687)	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		\$ 162,687			\$ 162,687	\$ *	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	06 Repairs	\$	Vent Lease, LLC.	100.00%	\$ 2,844	\$	2,844	15
16	V	19 Professional Fees		Vent Lease, LLC.	100.00%	156		156	16
17	V	21 Office and Clerical		Vent Lease, LLC.	100.00%	241		241	17
18	V	25 Auto Expense / Travel		Vent Lease, LLC.	100.00%	13		13	18
19	V	26 Insurance		Vent Lease, LLC.	100.00%	161		161	19
20	V	30 Depreciation		Vent Lease, LLC.	100.00%	7,402		7,402	20
21	V	32 Interest		Vent Lease, LLC.	100.00%	1,247		1,247	21
22	V	30 Depreciation - Matrix		Vent Lease, LLC.	100.00%	11,133		11,133	22
23	V	32 Interest - Matrix		Vent Lease, LLC.	100.00%	2,012		2,012	23
24	V	21 Office and Clerical	13,678	Vent Lease, LLC.	100.00%			(13,678)	24
25	V	39 Ancillary	28,905	Vent Lease, LLC.	100.00%			(28,905)	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		\$ 42,583			\$ 25,209	\$ *	(17,374)	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	39 THERAPY	\$ 1,303,436	TRICARE REHAB		\$ 1,116,310	\$ (187,126)
16	V	10A REHAB				20,440	20,440
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,303,436			\$ 1,136,750	\$ * (166,686)

\* 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	01 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 2,068	\$ 2,068	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%	157	157	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	120	120	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	167	167	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	68	68	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	850	850	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	128	128	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	319	319	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	328	328	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%			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%	1,467	1,467	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	16	16	28
29	V	01 Dietary	19,157	Care Centers Health Systems, Inc.	100.00%	7,648	(11,509)	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	22 Employee Benefits		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	12,804	Care Centers Health Systems, Inc.	100.00%	5,111	(7,693)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	4,491	4,491	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	4,585	4,585	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	1,960	1,960	38
39	Total		\$ 31,961			\$ 29,483	\$ * (2,478)	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		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number Lemont Nursing & Rehab Center # 0046201 Report Period Beginning: 01/01/09 Ending: 12/31/09

## 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	1.11	3.70%		\$	1
2	Adam Vales	Relative	Clerical	N/A	See Attached	0.95	2.38%	Alloc. Salary	1,707	22-7
3	Mark Steinberg	Relative	Administrative	N/A	See Attached	2.04	3.71%	Alloc. Salary	6,169	17-7
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 7,876	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:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

# 0046201

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 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	30	\$ 6,770	\$	50,972	\$ 251	1
2	02	Food	Patient Days	30	15,058		50,972	558	2
3	03	Housekeeping	Patient Days	30	14,059		50,972	521	3
4	05	Utilities	Patient Days	30	57,646		50,972	2,135	4
5	06	Maintenance	Patient Days	30	89,465		50,972	3,314	5
6	17	Administrative	Patient Days	30	66,000		50,972	2,445	6
7	19	Professional Fees	Patient Days	30	285,482		50,972	10,575	7
8	20	Dues and Subscriptions	Patient Days	30	56,488		50,972	2,092	8
9	21	Office and Clerical	Patient Days	30	462,313		50,972	17,125	9
10	24	Seminar and Travel	Patient Days	30	1,768		50,972	65	10
11	25	Other Staff Admin. Trans.	Patient Days	30	10,309		50,972	382	11
12	26	Insurance	Patient Days	30	22,668		50,972	840	12
13	30	Depreciation	Patient Days	30	115,549		50,972	4,280	13
14	32	Interest	Patient Days	30	1,698,489		50,972	62,916	14
15	33	Real Estate Taxes	Patient Days	30	55,709		50,972	2,064	15
16	34	Rent - Building	Patient Days	30	96,636		50,972	3,580	16
17	35	Rent - Equipment & Auto	Patient Days	30	68,244		50,972	2,528	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,122,653	\$		\$ 115,671	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

# 0046201

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	30	219,177	219,177	50,972	8,119	1
2	06	Maintenance (Direct)	Direct	30	82,905	82,905		437	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	30	37,501		50,972	1,389	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct	30	8,464	8,464		45	4
5	17	Administrative (Pooled)	Patient Days	30	239,303	239,303	50,972	8,864	5
6	21	Office and Clerical (Pooled)	Patient Days	30	3,599,211	3,599,211	50,972	133,322	6
7	21	Office and Clerical (Direct)	Direct	30	654,174			14,472	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	30	615,819	615,819	50,972	22,811	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct	30	73,650	73,650	50,972	1,474	9
10	22	Employee Benefits							10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,530,203	\$ 4,838,529		\$ 190,933	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

# 0046201

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

Extended Care Clinical LLC

Street Address

2201 West Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

( 847) 905-3000

Fax Number

( 847) 905-3030

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	30	\$ 1,549	\$	50,972	\$ 57	1
2	05	Utilities	Patient Days	30	3,693		50,972	137	2
3	06	Maintenance	Patient Days	30	477		50,972	18	3
4	19	Professional Fees	Patient Days	30	32,105		50,972	1,189	4
5	20	Dues and Subscriptions	Patient Days	30	213		50,972	8	5
6	21	Office & Clerical	Patient Days	30	27,296		50,972	1,011	6
7	24	Travel and Seminar	Patient Days	30	27,079		50,972	1,003	7
8	26	Insurance	Patient Days	30	1,342		50,972	50	8
9	30	Depreciation	Patient Days	30	25,586		50,972	948	9
10	32	Interest	Patient Days	30	309,136		50,972	11,451	10
11	33	Real Estate Taxes	Patient Days	30	6,053		50,972	224	11
12	01	Dietary Salary	Patient Days	30	117,506	117,506	50,972	4,353	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	30	17,040		50,972	631	13
14	10	Nursing Salary	Patient Days	30	799,889	799,889	50,972	29,630	14
15	10a	Rehab Salary	Patient Days	30	45,993	45,993	50,972	1,704	15
16	12	Social Service Salary	Patient Days	30	247,396	247,396	50,972	9,164	16
17	15	Emp. Ben. - Healthcare	Patient Days	30	158,537		50,972	5,873	17
18	17	Administration Salary	Patient Days	30	1,043,375	1,043,375	50,972	38,649	18
19	21	Office Salary	Patient Days	30	206,680	206,680	50,972	7,656	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	30	181,271		50,972	6,715	20
21	10	Nursing Salary	Direct Allocation		494,488	494,488	50,972	28,726	21
22	12	Social Service Salary	Direct Allocation		196,033	196,033		4,431	22
23	15	Emp. Ben. - Healthcare	Direct Allocation		82,560			2,913	23
24									24
25	TOTALS				\$ 4,025,296	\$ 3,151,360		\$ 156,541	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

# 0046201

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	Direct Allocation		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					38,075	2
3	4	Laundry	Direct Allocation					10,052	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					90,594	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					2,424	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					173,998	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				\$	\$		\$	315,143

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

# 0046201

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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		\$	\$		\$ 162,687	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				\$	\$		\$ 162,687	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

# 0046201

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	821,185	26	\$ 80,807	\$ 28,905	\$ 2,844	1
2	19	Professional Fees	Direct Billing	821,185	26	4,427	28,905	156	2
3	21	Office and Clerical	Direct Billing	821,185	26	6,852	28,905	241	3
4	25	Auto Expense / Travel	Direct Billing	821,185	26	356	28,905	13	4
5	26	Insurance	Direct Billing	821,185	26	4,573	28,905	161	5
6	30	Depreciation	Direct Billing	821,185	26	218,810	28,905	7,402	6
7	32	Interest	Direct Billing	821,185	26	35,420	28,905	1,247	7
8	30	Depreciation - Matrix	Patient Days	1,376,056	30	300,546	50,972	11,133	8
9	32	Interest - Matrix	Patient Days	1,376,056	30	54,323	50,972	2,012	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					\$ 706,114	\$	\$ 25,209	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

# 0046201

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

TriCare Rehab

Street Address

150 Fencil Lane

City / State / Zip Code

Hillside, IL 60162

Phone Number

( 773) 449-9400

Fax Number

( 773) 449-9700

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.

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	39	THERAPY	DIRECT ALLOCATION		\$	\$		1,116,310	1
2	10A	REHAB	DIRECT ALLOCATION					20,440	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		1,136,750	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

# 0046201

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Care Centers 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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Gross Billable Income	3,421,940	26	72,652	97,411	2,068	1
2	03	Housekeeping	Gross Billable Income	3,421,940	26		97,411		2
3	05	Heat and Other Utilities	Gross Billable Income	3,421,940	26	5,507	97,411	157	3
4	06	Maintenance	Gross Billable Income	3,421,940	26	4,211	97,411	120	4
5	19	Professional Fees	Gross Billable Income	3,421,940	26	5,880	97,411	167	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	3,421,940	26	2,401	97,411	68	6
7	21	Clerical and General Office	Gross Billable Income	3,421,940	26	29,869	97,411	850	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	3,421,940	26	4,509	97,411	128	8
9	26	Insurance	Gross Billable Income	3,421,940	26	11,210	97,411	319	9
10	30	Depreciation	Gross Billable Income	3,421,940	26	11,528	97,411	328	10
11	32	Interest	Gross Billable Income	3,421,940	26		97,411		11
12	33	Real Estate Taxes	Gross Billable Income	3,421,940	26		97,411		12
13	34	Rent - Building	Gross Billable Income	3,421,940	26	51,522	97,411	1,467	13
14	35	Rent - Equipment	Gross Billable Income	3,421,940	26	547	97,411	16	14
15	01	Dietary	Direct Billable Income	206,522	26	82,445	19,157	7,648	15
16	02	Food	Direct Billable Income	2,784	26	1,111			16
17	03	Housekeeping	Direct Billable Income		26				17
18	10	Nursing	Direct Billable Income	5,466	26	2,182			18
19	22	Employee Benefits	Direct Billable Income	411	26	164			19
20	25	Other Admin. Staff Transport.	Direct Billable Income		26				20
21	39	Ancillary	Direct Billable Income	3,206,757	26	1,280,152	12,804	5,111	21
22	17	Administrative	Gross Billable Income	3,421,940	26	157,769	157,769	4,491	22
23	21	Clerical and General Office	Gross Billable Income	3,421,940	26	161,081	161,081	4,585	23
24	27	Employee Benefits	Gross Billable Income	3,421,940	26	68,860	97,411	1,960	24
25	TOTALS					\$ 1,953,599	\$ 318,850	\$ 29,483	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

# 0046201

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center

# 0046201

Report Period Beginning:

01/01/09

Ending:

12/31/09

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	National City Bank		X	Note Payable			\$	\$ 7,835,552		\$ 555,843	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
<b>Working Capital</b>																			
6											6								
7											7								
8	See Supplemental Schedule									77,626	8								
9	TOTAL Facility Related						\$	\$ 7,835,552		\$ 633,469	9								
<b>B. Non-Facility Related*</b>																			
10	Interest Income		X							(243,169)	10								
11											11								
12											12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related						\$	\$		\$ (243,169)	14								
15	TOTALS (line 9+line14)						\$	\$ 7,835,552		\$ 390,300	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 &amp; ID Number

Lemont Nursing &amp; Rehab Center

# 0046201

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>										7									
<b>Working Capital</b>																				
8	Alloc from Ext Care Cnsult		X							\$ 62,916	8									
9	Alloc from Ext Care Clinical		X							11,451	9									
10	Alloc from Vent Lease		X							3,259	10									
11											11									
12											12									
13											13									
14	<b>TOTAL Working Capital</b>										14									
<b>B. Non-Facility Related*</b>																				
15											15									
16											16									
17											17									
18											18									
19											19									
20	<b>TOTAL Non-Facility Related</b>										20									

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)







Facility Name & ID Number Lemont Nursing & Rehab Center

# 0046201

Report Period Beginning:

01/01/09

Ending:

12/31/09

**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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2003</u>	<u>\$ 823,094</u>	<u>1</u>
2	<u>Allocated from ECC</u>			<u>13,595</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 836,689</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		2003		48,664		20	2,442	2,442	20,496	9
10	Various		2004		35,166		20	1,951	1,951	13,858	10
11	Various		2005		7,375		20	369	369	1,813	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

**XI. OWNERSHIP COSTS (continued)**

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		5,391,421	138,198		252,705	114,507	2,081,677	67
68	Related Party Allocations (Pages 12H & 12I)		53,789	3,674		3,674		22,377	68
69	Financial Statement Depreciation			38,150			(38,150)		69
70	TOTAL (lines 4 thru 69)		\$ 5,536,415	\$ 180,022		\$ 261,141	\$ 81,119	\$ 2,140,221	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,536,415	\$ 180,022		\$ 261,141	\$ 81,119	\$ 2,140,221	1
2	Replaced Heat Exchangers	2007	16,500		20	1,100	1,100	3,300	2
3	Painting (Transfer Expense From Home Office)	2007	4,792		20			4,792	3
4	Painting (Transfer Expense From Home Office)	2007	5,091		20			5,091	4
5	Painting (Transfer Expense From Home Office)	2007	19,331		20			19,331	5
6	Roof Repair	2007	2,500		20	125	125	302	6
7	Air Unit, Supply Duct & Registers	2007	4,475		20	224	224	522	7
8	Dorr Wreck Repair	2007	7,200		20	360	360	780	8
9	Repair A/C	2008	4,475		20	224	224	448	9
10	Install New Smoke Dampers	2008	14,039		20	702	702	1,345	10
11	Additions & Alterations	2008	9,341		20	467	467	740	11
12	Heating/Ac Unit Repairs	2008	5,250		20	263	263	394	12
13	Dining Room Remodeling	2008	3,600		20	180	180	240	13
14	Replace Heat Exchangers	2008	6,500		20	325	325	406	14
15	Additions & Alterations	2008	3,520		20	176	176	205	15
16	Sprinkler Repairs	2008	6,104		20	305	305	331	16
17	Sprinkler Repairs	2008	3,311		20	166	166	179	17
18	Fire Pipe Replacement	2008	3,177		20	159	159	225	18
19	Kitchen Vent	2009	2,625		20	525	525	525	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,658,246	\$ 180,022		\$ 266,442	\$ 86,420	\$ 2,179,377	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:

**01/01/09**

Ending:

**12/31/09**

**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	
1		\$ 5,658,246	\$ 180,022		\$ 266,442	\$ 86,420	\$ 2,179,377	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)	\$ 5,658,246	\$ 180,022		\$ 266,442	\$ 86,420	\$ 2,179,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**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	
1		\$ 5,658,246	\$ 180,022		\$ 266,442	\$ 86,420	\$ 2,179,377	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)	\$ 5,658,246	\$ 180,022		\$ 266,442	\$ 86,420	\$ 2,179,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**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	
1		\$ 5,658,246	\$ 180,022		\$ 266,442	\$ 86,420	\$ 2,179,377	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)	\$ 5,658,246	\$ 180,022		\$ 266,442	\$ 86,420	\$ 2,179,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**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	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3	<b>Building</b>	1995	4,683,421		Various	197,159	197,159	1,683,317	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<b>Land Improvements</b>	2003	708,000		Various	55,546	55,546	398,360	9
10									10
11	<b>Building Company Book Depreciation</b>			138,198			(138,198)		11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 5,391,421	\$ 138,198		\$ 252,705	\$ 114,507	\$ 2,081,677

SEE ACCOUNTANTS' COMPILATION REPORT

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

**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	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	1,859	48	39	48		348	3
4	Allocated from Extended Care Consulting, 2201 Main LLC	2002	16,875	433	39	433		3,155	4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9									9
10	Allocated from Extended Care Consulting, 2201 Main LLC	2002	13,940	1,274	20	1274		7,656	10
11	Allocated from Extended Care Consulting, 2201 Main LLC	2003	16,428	1,501	20	1501		9,022	11
12	Allocated from Extended Care Consulting, 2201 Main LLC	2005	816	87	20	87		294	12
13	Allocated from Extended Care Consulting, 2201 Main LLC	2009	147	7	20	7		7	13
14									14
15									15
16	Allocated from Extended Care Consulting, LLC	2007	170	3	20	3		20	16
17	Allocated from Extended Care Consulting, LLC	2009	102	5	20	5		5	17
18									18
19									19
20	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	1,536	140	20	140		843	20
21	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2003	1,810	165	20	165		994	21
22	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2005	90	10	20	10		32	22
23	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2009	16	1	20	1		1	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**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	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	<b>TOTAL (12H &amp; 12I lines 1 thru 33)</b>		\$ 53,789	\$ 3,674		\$ 3,674	\$ 22,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**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	\$ 133,667	\$ 19,223	\$ 17,910	\$ (1,313)	10	\$ 298,760	71
72	Current Year Purchases	23,644	308	3,841	3,533	10	3,841	72
73	Fully Depreciated Assets	332,948				10	332,948	73
74								74
75	<b>TOTALS</b>	\$ 490,259	\$ 19,531	\$ 21,751	\$ 2,220		\$ 635,549	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		Alloc. From EC Clinical	2009	\$ 2,663	\$ 533	\$ 533		5	\$ 1,568	76
77		Alloc. From ECC	2009	11,911	186	186		5	11,353	77
78		Alloc. From CCHS	2009	834	167	167		5	251	78
79										79
80	<b>TOTALS</b>			\$ 15,408	\$ 886	\$ 886			\$ 13,172	80

**E. Summary of Care-Related Assets**

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,000,602	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 200,439	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 289,079	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 88,640	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,828,098	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	<b>TOTALS</b>	\$	\$	\$	91

**G. Construction-in-Progress**

	Description	Cost	
92	Building Imprv, Add, & Alter	\$ 26,940	92
93			93
94			94
95		\$ 26,940	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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>3,580</u>			5
6	<u>Alloc from Care Centers Health Systems</u>			<u>1,467</u>			6
7	TOTAL			\$ <u>5,047</u>			7

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 16,862 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

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. \_\_\_\_\_/2009 \$ \_\_\_\_\_

13. \_\_\_\_\_/2010 \$ \_\_\_\_\_

14. \_\_\_\_\_/2011 \$ \_\_\_\_\_

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

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

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		Contract	Total
		1	2		
		Drop-outs	Completed		
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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

- (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	\$		\$ 575,281	\$		\$ 575,281	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			110,788			110,788	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			746,404			746,404	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				759,447		759,447	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					72,151	280,611		352,762	13
14	TOTAL			\$		\$ 1,504,624	\$ 1,040,058		\$ 2,544,682	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**# **0046201**Report Period Beginning: **01/01/09**

Ending:

**12/31/09****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/09**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 3,494	\$ 76,075	1
2	Cash-Patient Deposits	33,855	33,855	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	872,216	872,216	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	190,838	190,838	6
7	Other Prepaid Expenses	625	625	7
8	Accounts Receivable (owners or related parties)	3,759,284	5,222,427	8
9	Other(specify): <u>See Attached Schedule</u>	5,378,280	5,378,280	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 10,238,592	\$ 11,774,316	10
<b>B. Long-Term Assets</b>				
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	191,944	191,944	15
16	Equipment, at Historical Cost	209,248	209,248	16
17	Accumulated Depreciation (book methods)	(227,032)	(2,326,905)	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>		37,623	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 174,160	\$ 4,525,508	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 10,412,752	\$ 16,299,824	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,122,766	\$ 1,122,766	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,510	32,510	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	244,754	244,754	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,688	6,688	31
32	Accrued Real Estate Taxes(Sch.IX-B)	330,375	330,375	32
33	Accrued Interest Payable		23,725	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	78,560	83,042	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,815,653	\$ 1,843,860	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		7,835,552	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 7,835,552	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,815,653	\$ 9,679,412	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 8,597,099	\$ 6,620,412	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 10,412,752	\$ 16,299,824	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>7,083,790</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<a href="#">See Attached</a>	(424,151)	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>6,659,639</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	2,237,486	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(300,026)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,937,460</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>8,597,099</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Lemont Nursing & Rehab Center**# **0046201**Report Period Beginning: **01/01/09**Ending: **12/31/09**

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 13,488,626	1
2	Discounts and Allowances for all Levels	(6,390,035)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 7,098,591</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,309,564	6
7	Oxygen	1,610	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 5,311,174</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,897	13
14	Non-Patient Meals	144	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	762,694	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	258,196	19
20	Radiology and X-Ray	50,530	20
21	Other Medical Services	151,568	21
22	Laundry	5,013	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 1,230,042</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	243,169	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 243,169</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<a href="#">See Supplemental Schedule</a>	17	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 17</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 13,882,993</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,404,859	31
32	Health Care	4,413,725	32
33	General Administration	2,193,557	33
<b>B. Capital Expense</b>			
34	Ownership	1,000,698	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,546,163	35
36	Provider Participation Fee	86,505	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 11,645,507</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>2,237,486</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 2,237,486</b>	<b>43</b>

\* 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:

**01/01/09**

Ending:

**12/31/09**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,035	2,228	\$ 93,963	\$ 42.17	1
2	Assistant Director of Nursing	1,455	1,710	63,066	36.88	2
3	Registered Nurses	32,650	36,817	1,182,641	32.12	3
4	Licensed Practical Nurses	27,029	29,949	749,614	25.03	4
5	CNAs & Orderlies	96,627	104,956	1,257,113	11.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,782	11,957	187,929	15.72	8
9	Activity Director	1,676	1,914	33,448	17.48	9
10	Activity Assistants	14,012	14,885	153,058	10.28	10
11	Social Service Workers	9,723	10,612	191,628	18.06	11
12	Dietician					12
13	Food Service Supervisor	1,646	1,804	44,767	24.82	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,221	8,680	114,871	13.23	15
16	Dishwashers	12,900	13,961	119,289	8.54	16
17	Maintenance Workers	5,833	6,199	119,143	19.22	17
18	Housekeepers	18,501	20,081	187,912	9.36	18
19	Laundry	6,523	7,169	61,359	8.56	19
20	Administrator	1,715	1,967	87,444	44.46	20
21	Assistant Administrator	1,859	2,037	56,341	27.66	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,933	9,110	145,810	16.01	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	3,211	3,733	49,203	13.18	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,086	2,311	35,533	15.38	33
34	TOTAL (lines 1 - 33)	266,417	292,080	\$ 4,934,132 *	\$ 16.89	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	409	\$ 20,715	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>See Attached</u>		4,431		47
48	<u>See Attached</u>		28,726		48
49	TOTAL (lines 35 - 48)	409	\$ 95,242		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	203	\$ 12,085	10-03	50
51	Licensed Practical Nurses	1,396	56,081	10-03	51
52	Certified Nurse Assistants/Aides	363	8,627	10-03	52
53	TOTAL (lines 50 - 52)	1,961	\$ 76,793		53

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
Wendy Janulis	Administrator		\$ 80,723	Workers' Compensation Insurance	\$ 190,495	IDPH License Fee	\$		
Sandra Erickson 11/09 - 12/09	Administrator		5,221	Unemployment Compensation Insurance	42,092	Advertising: Employee Recruitment		21,614	
Sandra Erickson 09/09 - 10/09	Asst. Admin.		8,668	FICA Taxes	366,783	Health Care Worker Background Check			
Lisa Hardaman 10/09 - 12/09	Asst. Admin.		11,072	Employee Health Insurance	83,849	(Indicate # of checks performed <u>937</u> )		11,586	
Mary Ellen Mc Devitt 01/09 - 09/09	Asst. Admin.		38,100	Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues,Subscriptions,Licenses & Permits		5,469	
				Employee Physical	17,984	Alloc from Ext Care Consult.		2,092	
				Other Employee Welfare	10,158	Alloc from Ext Care Clinical		8	
				Holiday Expenses	1,434	Alloc from Care Centers Health Systems		68	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 143,785						
B. Administrative - Other									
Description			Amount						
			\$						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$						
C. Professional Services									
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Frost, Ruttenberg & Rothblatt	Accounting		\$ 20,266			\$	Out-of-State Travel	\$	
Personnel Planners	Unemployment Consult		2,555						
ADP	Payroll Services		1,494						
Paycor	Payroll Services		12,399				In-State Travel		
E-Health Data Solutions	Billing Program System		3,180						
National Datacare Corp	Data Processing		1,269						
Extended Care Consulting, Inc	Home Office Expenses		363,253						
Extended Care Clinical	Home Office Expenses		91,539				Seminar Expense	2,493	
Prospect Resources	Natural Gas Procurement		971				Inservice Expenses	6,456	
Pinnacle Consulting	Customer Satisfaction Surv		238				Alloc from Ext Care Consult	65	
See Attached	Legal		6,000				See Supplemental Schedule	1,003	
See Supplemental Schedule			61,246				Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 564,410	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 10,017	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center# 0046201Report Period Beginning: 01/01/09Ending: 12/31/09**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? 10Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 101,148 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. \$ 86,505  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule 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. \$
- (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?
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.