



Facility Name & ID Number Imperial of Hazel Crest

# 0048702 Report Period Beginning: 01/01/10 Ending: 12/31/10

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>199</u>	Skilled (SNF)	<u>199</u>	<u>72,635</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>199</u>	TOTALS	<u>199</u>	<u>72,635</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF		<u>1,544</u>	<u>3,136</u>	<u>4,680</u>	8	
9	SNF/PED					9	
10	ICF	<u>58,585</u>			<u>58,585</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>58,585</u>	<u>1,544</u>	<u>3,136</u>	<u>63,265</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.10%

D. How many bed-hold days during this year were paid by the Department? 319 (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 01/01/07

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 01/01/07 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 199 and days of care provided 1,898

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Imperial of Hazel Crest # 0048702 Report Period Beginning: 01/01/10 Ending: 12/31/10

**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	260,550	44,389	14,474	319,413		319,413	1,359	320,772		1
2	Food Purchase		333,933		333,933		333,933	377	334,310		2
3	Housekeeping	187,876	59,886	74	247,836		247,836	(3,062)	244,774		3
4	Laundry	65,363	24,289	931	90,583		90,583	(1,015)	89,568		4
5	Heat and Other Utilities			244,013	244,013		244,013	1,472	245,485		5
6	Maintenance	87,108		193,761	280,869		280,869	(16,464)	264,405		6
7	Other (specify):*							3,000	3,000		7
8	<b>TOTAL General Services</b>	<b>600,897</b>	<b>462,497</b>	<b>453,253</b>	<b>1,516,647</b>		<b>1,516,647</b>	<b>(14,334)</b>	<b>1,502,313</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			25,500	25,500		25,500		25,500		9
10	Nursing and Medical Records	2,264,500	142,190	26,061	2,432,751		2,432,751	(10,081)	2,422,670		10
10a	Therapy	161,459		3,500	164,959		164,959	4,524	169,483		10a
11	Activities	143,320	26,961		170,281		170,281		170,281		11
12	Social Services	312,539	804	20,967	334,310		334,310	3,237	337,547		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							10,392	10,392		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,881,818</b>	<b>169,955</b>	<b>76,028</b>	<b>3,127,801</b>		<b>3,127,801</b>	<b>8,072</b>	<b>3,135,873</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	146,970		18,000	164,970		164,970	58,057	223,027		17
18	Directors Fees										18
19	Professional Services			722,565	722,565	(20,750)	701,815	(556,309)	145,506		19
20	Dues, Fees, Subscriptions & Promotions			28,309	28,309		28,309	(3,023)	25,286		20
21	Clerical & General Office Expenses	92,994	30,430	193,709	317,133		317,133	36,932	354,065		21
22	Employee Benefits & Payroll Taxes			688,611	688,611		688,611	(21,308)	667,303		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,961	7,961		7,961	1,717	9,678		24
25	Other Admin. Staff Transportation			4,107	4,107		4,107	557	4,664		25
26	Insurance-Prop.Liab.Malpractice			310,831	310,831		310,831	1,094	311,925		26
27	Other (specify):*							34,552	34,552		27
28	<b>TOTAL General Administration</b>	<b>239,964</b>	<b>30,430</b>	<b>1,974,093</b>	<b>2,244,487</b>	<b>(20,750)</b>	<b>2,223,737</b>	<b>(447,731)</b>	<b>1,776,006</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,722,679</b>	<b>662,882</b>	<b>2,503,374</b>	<b>6,888,935</b>	<b>(20,750)</b>	<b>6,868,185</b>	<b>(453,993)</b>	<b>6,414,192</b>		<b>29</b>

\*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 Imperial of Hazel Crest

#0048702

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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			41,133	41,133		41,133	274,742	315,875			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			64,333	64,333		64,333	710,047	774,380			32
33	Real Estate Taxes			250,421	250,421	20,750	271,171	2,133	273,304			33
34	Rent-Facility & Grounds			604,536	604,536		604,536	(598,680)	5,856			34
35	Rent-Equipment & Vehicles			30,210	30,210		30,210	(7,747)	22,463			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			990,633	990,633	20,750	1,011,383	380,495	1,391,878			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		288,817	166,748	455,565		455,565	(8,598)	446,967			39
40	Barber and Beauty Shops			257	257		257		257			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,953	108,953		108,953		108,953			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		288,817	275,958	564,775		564,775	(8,598)	556,177			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,722,679	951,699	3,769,965	8,444,343		8,444,343	(82,097)	8,362,246			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imperial of Hazel Crest

# 0048702

Report Period Beginning:

01/01/10

Ending:

12/31/10

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(32,296)	30		9
10	Interest and Other Investment Income	(74,031)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(81)	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	(27,046)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(69,896)	21		24
25	Fund Raising, Advertising and Promotional	(6,664)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,800)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(146,687)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (361,502)		\$	30

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	279,405		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 279,405		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (82,097)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Imperial of Hazel Crest

ID# 0048702

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Revenue - Jury Duty	\$ (116)	10	1
2	Patient Clothing	(562)	10	2
3	Theft Loss	(323)	21	3
4	Collection Expense	(458)	21	4
5	Veterans Expenses	(37,439)	10	5
6	Medical Records Income	(23)	10	6
7	Out of Period Computer Services	(2,391)	19	7
8	Out of Period Legal Fees	(14,027)	19	8
9	Building Co - Legal Fees	(20,237)	19	9
10	Capitalized R&M	(28,671)	06	10
11	Building Co - Bank Charges	(760)	21	11
12	Building Co - Msc. Admin. Expenses	(250)	21	12
13	Building Co - Current Loan Expenses	(26,138)	21	13
14	Building Co - Amortization	(2,127)	36	14
15	Prior Period Adjustment - Computer Expense	(2,262)	21	15
16	Prior Period Adjustment - Penalties & Fines	(10,624)	21	16
17	Marketing Auto Expense	(279)	25	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>	(146,687)		49

Imperial of Hazel Crest

ID# 0048702

Report Period Beginning: 01/01/10

Ending: 12/31/10

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 Imperial of Hazel Crest# 0048702

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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			164		4,862		(3,664)			(3)		1,359	1
2	Food Purchase	(81)		458									377	2
3	Housekeeping			588		65					(3,715)		(3,062)	3
4	Laundry										(1,015)		(1,015)	4
5	Heat and Other Utilities			1,335		137							1,472	5
6	Maintenance	(28,671)		3,838	8,233	136							(16,464)	6
7	Other (specify):*				1,959	681	360						3,000	7
8	<b>TOTAL General Services</b>	<b>(28,752)</b>		<b>6,383</b>	<b>10,192</b>	<b>5,881</b>	<b>360</b>	<b>(3,664)</b>			<b>(4,733)</b>		<b>(14,334)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(38,140)				31,287					(3,228)		(10,081)	10
10a	Therapy					4,524							4,524	10a
11	Activities													11
12	Social Services					3,237							3,237	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					5,473	4,919						10,392	15
16	<b>TOTAL Health Care and Programs</b>	<b>(38,140)</b>				<b>44,521</b>	<b>4,919</b>				<b>(3,228)</b>		<b>8,072</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			2,719	10,561	44,777							58,057	17
18	Directors Fees													18
19	Professional Services	(36,655)	20,237	(434,877)		(105,014)							(556,309)	19
20	Fees, Subscriptions & Promotions	(6,664)		3,448		193							(3,023)	20
21	Clerical & General Office Expenses	(142,557)	27,148	16,110	128,008	8,223							36,932	21
22	Employee Benefits & Payroll Taxes				(15,739)		(5,279)				(290)		(21,308)	22
23	Inservice Training & Education													23
24	Travel and Seminar			168		1,549							1,717	24
25	Other Admin. Staff Transportation	(279)		836									557	25
26	Insurance-Prop.Liab.Malpractice			918		176							1,094	26
27	Other (specify):*				27,378	7,174							34,552	27
28	<b>TOTAL General Administration</b>	<b>(186,155)</b>	<b>47,385</b>	<b>(410,678)</b>	<b>150,208</b>	<b>(42,922)</b>	<b>(5,279)</b>				<b>(290)</b>		<b>(447,731)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(253,047)</b>	<b>47,385</b>	<b>(404,295)</b>	<b>160,400</b>	<b>7,480</b>		<b>(3,664)</b>			<b>(8,252)</b>		<b>(453,993)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Imperial of Hazel Crest# 0048702

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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>D. Ownership</b>													
30	Depreciation	(32,296)	301,143	4,958		937							274,742	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(74,031)	756,747	9,461		17,870							710,047	32
33	Real Estate Taxes			1,921		212							2,133	33
34	Rent-Facility & Grounds		(600,000)	1,320									(598,680)	34
35	Rent-Equipment & Vehicles			2,367								(10,114)	(7,747)	35
36	Other (specify):*	(2,127)	2,127											36
37	<b>TOTAL Ownership</b>	<b>(108,454)</b>	<b>460,017</b>	<b>20,027</b>		<b>19,019</b>						<b>(10,114)</b>	<b>380,495</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(3,098)	11,857	(5,664)	(6,574)	(5,119)	(8,598)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>							<b>(3,098)</b>	<b>11,857</b>	<b>(5,664)</b>	<b>(6,574)</b>	<b>(5,119)</b>	<b>(8,598)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(361,502)	507,402	(384,268)	160,400	26,499		(6,763)	11,857	(5,664)	(14,825)	(15,233)	(82,097)	45

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Imperial Real Estate		Building Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 600,000	Imperial Real Estate	100.00%	\$	\$ (600,000)	1
2	V	33 Property Taxes	267,462	Imperial Real Estate	100.00%		(267,462)	2
3	V	19 Legal Fees		Imperial Real Estate	100.00%	20,237	20,237	3
4	V							4
5	V	21 Bank Charges		Imperial Real Estate	100.00%	760	760	5
6	V	21 Misc. Admin. Expenses		Imperial Real Estate	100.00%	250	250	6
7	V	30 Depreciation		Imperial Real Estate	100.00%	301,143	301,143	7
8	V	36 Amortization		Imperial Real Estate	100.00%	2,127	2,127	8
9	V	33 Real Estate Tax Expense		Imperial Real Estate	100.00%	267,462	267,462	9
10	V	32 Interest		Imperial Real Estate	100.00%	756,747	756,747	10
11	V	21 Current Loan Expenses		Imperial Real Estate	100.00%	26,138	26,138	11
12	V							12
13	V							13
14	Total		\$ 867,462			\$ 1,374,864	\$ * 507,402	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%	\$ 164	\$	164	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	458		458	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	588		588	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,335		1,335	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	3,838		3,838	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	2,719		2,719	20
21	V	19 Professional Fees	446,214	Extended Care Consulting, LLC	100.00%	11,337		(434,877)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,448		3,448	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	16,110		16,110	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	168		168	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	836		836	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	918		918	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	4,958		4,958	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	9,461		9,461	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,921		1,921	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	1,320		1,320	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	2,367		2,367	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 446,214			\$ 61,946	\$ *	(384,268)	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%	8,233	\$	8,233	15
16	V	06 Maintenance (Direct)	3,831	Extended Care Consulting, LLC	100.00%	3,831			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,376		1,376	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	583		583	18
19	V	12 Admission (Direct)		Extended Care Consulting, LLC	100.00%				19
20	V	15 Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%				20
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	10,561		10,561	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	128,008		128,008	22
23	V	21 Office and Clerical (Direct)	27,721	Extended Care Consulting, LLC	100.00%	27,721			23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	23,156		23,156	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,222		4,222	25
26	V	22 Employee Benefits	15,739	Extended Care Consulting, LLC	100.00%			(15,739)	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		\$ 47,291			\$ 207,691	\$ *	160,400	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%	\$ 65	\$	65	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	137		137	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	136		136	17
18	V	19 Professional Fees	112,612	Extended Care Clinical, LLC	100.00%	7,598		(105,014)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	193		193	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	1,814		1,814	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,549		1,549	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	176		176	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	937		937	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	17,870		17,870	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	212		212	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	4,862		4,862	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	681		681	27
28	V	10 Nursing Salary		Extended Care Clinical, LLC	100.00%	31,287		31,287	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	4,524		4,524	29
30	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%	3,237		3,237	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	5,473		5,473	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	44,777		44,777	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	6,409		6,409	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	7,174		7,174	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 112,612			\$ 139,111	\$ *	26,499	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	01 Dietary Salary	\$ 2,908	Extended Care Clinical, LLC	100.00%	\$ 2,908	\$	15
16	V	07 Emp. Ben. - General		Extended Care Clinical, LLC	100.00%	360	360	16
17	V	10 Nursing Salary	18,724	Extended Care Clinical, LLC	100.00%	18,724		17
18	V	12 Social Service Salary	20,966	Extended Care Clinical, LLC	100.00%	20,966		18
19	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	4,919	4,919	19
20	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%			20
21	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%			21
22	V	22 Employee Benefits	5,279	Extended Care Clinical, LLC	100.00%		(5,279)	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		\$ 47,877			\$ 47,877	\$ *	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 Supplies, Supplements	\$ 8,249	Care Centers Health Systems, Inc.	100.00%	\$ 4,585	\$ (3,664)
16	V	10 Nursing Supplies		Care Centers Health Systems, Inc.	100.00%		
17	V	39 Ancillary Expense	6,975	Care Centers Health Systems, Inc.	100.00%	3,876	(3,098)
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		\$ 15,224			\$ 8,461	\$ * (6,763)

\* 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	\$ 153,950	TriCare Rehab	100.00%	\$ 165,807	\$ 11,857	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 153,950			\$ 165,807	\$ * 11,857	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	6 R&M - Equipment	\$	Reliable Medical of the Midwest, LLC	100.00%	\$	\$	15
16	V	10 Nursing Supplies		Reliable Medical of the Midwest, LLC	100.00%			16
17	V	39 Ancillary Expense	72,251	Reliable Medical of the Midwest, LLC	100.00%	66,586	(5,664)	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 72,251			\$ 66,586	\$ *	(5,664) 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	\$ 45	Xcel Supply, LLC	100.00%	\$ 42	\$ (3)
16	V	3 Housekeeping	55,753	Xcel Supply, LLC	100.00%	52,037	(3,715)
17	V	4 Laundry	15,224	Xcel Supply, LLC	100.00%	14,210	(1,015)
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%		
19	V	10 Nursing	48,447	Xcel Supply, LLC	100.00%	45,219	(3,228)
20	V	11 Activities		Xcel Supply, LLC	100.00%		
21	V	12 Social Service		Xcel Supply, LLC	100.00%		
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%		
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%		
24	V	22 Employee Benefits	4,356	Xcel Supply, LLC	100.00%	4,066	(290)
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%		
26	V	39 Ancillary	98,647	Xcel Supply, LLC	100.00%	92,073	(6,574)
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		\$ 222,472			\$ 207,647	\$ * (14,825)

\* 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	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 43,548	\$	43,548	15
16	V								16
17	V								17
18	V								18
19	V	22 Employee Health Insurance	43,548	CCS Employee Benefits Group	100.00%			(43,548)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	35 Matrix Leasing	\$ 18,819	Vent Lease LLC	100.00%	\$ 8,705		(10,114)	27
28	V	39 Ventilator Equipment	9,525	Vent Lease LLC	100.00%	4,406		(5,119)	28
29	V	39 Other Ancillary		Vent Lease LLC	100.00%				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		\$ 71,892			\$ 56,659	\$ *	(15,233)	39

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

Facility Name &amp; ID Number

Imperial of Hazel Crest

# 0048702

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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	Relative	Administrative	0.00%	See Attached	1.57	3.38%		\$	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.3	4.18%	Alloc. Salary	6,688	17-7
3	Adam Vales	Shareholder	Clerical	3.43%	See Attached	0.23	0.58%	Alloc. Salary	400	22-7
4	G.Matt Silvers	Relative	Administrative	0.00%	See Attached	0.39	1.75%	Alloc. Salary	1,323	17-7
5										5
6										6
7										7
8										8
9										9
10										10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by									
12	the IL Dept of HFS									
13								TOTAL	\$ 8,411	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 Imperial of Hazel Crest

# 0048702

Report Period Beginning:

01/01/10

Ending: 12/31/10

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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 Imperial of Hazel Crest

# 0048702

Report Period Beginning:

01/01/10

Ending: 12/31/10

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	1,512,273	34	\$ 3,931	\$ 63,265	\$ 164	1
2	02	Food	Patient Days	1,512,273	34	10,940	63,265	458	2
3	03	Housekeeping	Patient Days	1,512,273	34	14,059	63,265	588	3
4	05	Utilities	Patient Days	1,512,273	34	31,923	63,265	1,335	4
5	06	Maintenance	Patient Days	1,512,273	34	91,744	63,265	3,838	5
6	17	Administrative	Patient Days	1,512,273	34	65,000	63,265	2,719	6
7	19	Professional Fees	Patient Days	1,512,273	34	271,007	63,265	11,337	7
8	20	Dues and Subscriptions	Patient Days	1,512,273	34	82,419	63,265	3,448	8
9	21	Office and Clerical	Patient Days	1,512,273	34	385,083	63,265	16,110	9
10	24	Seminar and Travel	Patient Days	1,512,273	34	4,022	63,265	168	10
11	25	Other Staff Admin. Trans.	Patient Days	1,512,273	34	19,982	63,265	836	11
12	26	Insurance	Patient Days	1,512,273	34	21,934	63,265	918	12
13	30	Depreciation	Patient Days	1,512,273	34	118,510	63,265	4,958	13
14	32	Interest	Patient Days	1,512,273	34	226,162	63,265	9,461	14
15	33	Real Estate Taxes	Patient Days	1,512,273	34	45,910	63,265	1,921	15
16	34	Rent - Building	Patient Days	1,512,273	34	31,555	63,265	1,320	16
17	35	Rent - Equipment & Auto	Patient Days	1,512,273	34	56,569	63,265	2,367	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,480,749	\$	\$ 61,946	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imperial of Hazel Crest

# 0048702

Report Period Beginning:

01/01/10

Ending: 12/31/10

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	06	Maintenance (Pooled)	Patient Days	34	196,794	196,794	63,265	8,233	1
2	06	Maintenance (Direct)	Direct	34	32,478	32,478		3,831	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	34	32,885		63,265	1,376	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct	34	3,607			583	4
5	12	Admission (Direct)	Direct	34	52,036	52,036			5
6	15	Emp. Ben. - Nursing (Direct)	Direct	34	5,270				6
7	17	Administrative (Pooled)	Patient Days	34	252,448	252,448	63,265	10,561	7
8	21	Office and Clerical (Pooled)	Patient Days	34	3,059,876	3,059,876	63,265	128,008	8
9	21	Office and Clerical (Direct)	Direct	34	771,063	771,063		27,721	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	34	553,505		63,265	23,156	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct	34	94,865			4,222	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				\$ 5,054,827	\$ 4,364,695		\$ 207,691	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imperial of Hazel Crest

# 0048702

Report Period Beginning:

01/01/10

Ending: 12/31/10

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	34	\$ 1,549	\$	63,265	\$ 65	1
2	05	Utilities	Patient Days	34	3,268		63,265	137	2
3	06	Maintenance	Patient Days	34	3,240		63,265	136	3
4	19	Professional Fees	Patient Days	34	181,624		63,265	7,598	4
5	20	Dues and Subscriptions	Patient Days	34	4,624		63,265	193	5
6	21	Office & Clerical	Patient Days	34	43,370		63,265	1,814	6
7	24	Travel and Seminar	Patient Days	34	37,025		63,265	1,549	7
8	26	Insurance	Patient Days	34	4,213		63,265	176	8
9	30	Depreciation	Patient Days	34	22,389		63,265	937	9
10	32	Interest	Patient Days	34	427,165		63,265	17,870	10
11	33	Real Estate Taxes	Patient Days	34	5,058		63,265	212	11
12	01	Dietary Salary	Patient Days	34	116,221	116,221	63,265	4,862	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	34	16,288		63,265	681	13
14	10	Nursing Salary	Patient Days	34	747,870	747,870	63,265	31,287	14
15	10a	Rehab Salary	Patient Days	34	108,151	108,151	63,265	4,524	15
16	12	Social Service Salary	Patient Days	34	77,377	77,377	63,265	3,237	16
17	15	Emp. Ben. - Healthcare	Patient Days	34	130,816		63,265	5,473	17
18	17	Administration Salary	Patient Days	34	1,070,339	1,070,339	63,265	44,777	18
19	21	Office Salary	Patient Days	34	153,206	153,206	63,265	6,409	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	34	171,480		63,265	7,174	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,325,274	\$ 2,273,164		\$ 139,111	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imperial of Hazel Crest

# 0048702

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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	01	Dietary Salary	Direct Allocation		\$ 15,960	\$ 15,960		\$ 2,908	1
2	07	Emp. Ben. - General	Direct Allocation		1,662			360	2
3	10	Nursing Salary	Direct Allocation		495,330	495,330		18,724	3
4	12	Social Service Salary	Direct Allocation		274,597	274,597		20,966	4
5	15	Emp. Ben. - Healthcare	Direct Allocation		94,697			4,919	5
6	17	Administration Salary	Direct Allocation		82,389	82,389			6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation		10,053				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				\$ 974,688	\$ 868,276		\$ 47,877	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imperial of Hazel Crest

# 0048702

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary Supplies, Supplements	Direct Allocation			\$		\$ 4,585	1
2	10	Nursing Supplies	Direct Allocation						2
3	39	Ancillary Expense	Direct Allocation					3,876	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					\$		\$ 8,461	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imperial of Hazel Crest

# 0048702

Report Period Beginning:

01/01/10

Ending: 12/31/10

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		\$	\$		\$ 165,807	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				\$	\$		\$ 165,807	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imperial of Hazel Crest

# 0048702

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Reliable Medical of the Midwest, LLC  
 Street Address 200 Howard Avenue  
 City / State / Zip Code Des Plaines, Illinois 60018-5909  
 Phone Number ( 847) 566-0800  
 Fax Number ( )

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	6	R&M - Equipment	Direct Allocation		\$	\$		\$	1
2	10	Nursing Supplies	Direct Allocation						2
3	39	Ancillary Expense	Direct Allocation					66,586	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				\$	\$		\$	66,586

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imperial of Hazel Crest

# 0048702 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			\$		\$ 42	1
2	3	Housekeeping	Direct Allocation					52,037	2
3	4	Laundry	Direct Allocation					14,210	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					45,219	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					4,066	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					92,073	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					\$		\$ 207,647	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imperial of Hazel Crest

# 0048702

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CCS Emp Ben Group / Vent Lease LLC  
 Street Address 2201 Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847)905-4000 / (847) 674-1180  
 Fax Number ( 847)905-4040 / (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	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 43,548	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11	35	Matrix Leasing	Direct Allocation		\$	\$		\$ 8,705	11
12	39	Ventilator Equipment	Direct Allocation					4,406	12
13	39	Other Ancillary	Direct Allocation						13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 56,659	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Imperial of Hazel Crest

# 0048702

Report Period Beginning:

01/01/10

Ending:

12/31/10

**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	Bank of America Loan		X	Mortgage						\$ 626,952	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
<b>Working Capital</b>																			
6	Diawa Loan		X	Line of Credit						64,333	6								
7	B.I. Silverberg Ir. Trust		X	Note Payable			2,500,000			129,795	7								
8	See Supplemental Schedule									27,331	8								
9	<b>TOTAL Facility Related</b>						\$ 2,500,000			\$ 848,411	9								
<b>B. Non-Facility Related*</b>																			
10	Interest Income		X							(74,031)	10								
11											11								
12											12								
13	See Supplemental Schedule										13								
14	<b>TOTAL Non-Facility Related</b>									\$ (74,031)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 2,500,000			\$ 774,380	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Imperial of Hazel Crest

# 0048702

Report Period Beginning:

01/01/10

Ending:

12/31/10

**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		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	Alloated From EC Consult.		X			\$	\$			\$	9,461	8						
9	Allocated From EC Clinical		X								17,870	9						
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Working Capital</b>										27,331	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.)

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2009 report.		\$	<b>542,364</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>388,857</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(153,507)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>406,061</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>20,750</b>	<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>273,304</b>	<b>7</b>

  

Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2005	<b>446,327</b>	<b>8</b>	
	2006	<b>472,263</b>	<b>9</b>	
	2007	<b>485,369</b>	<b>10</b>	
	2008	<b>516,542</b>	<b>11</b>	
	2009	<b>386,724</b>	<b>12</b>	
<b>2010 Accrual = \$386,724 x 1.05 = \$406,061</b>				
<b>Allocated From Extended Care Consulting: \$1,921</b>				
<b>Allocated From Extended Care Clinical: \$212</b>				

  

	<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2009	\$		<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$		<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$		<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$		<b>16</b>

**NOTES:**

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

**SEE ACCOUNTANTS' COMPILATION REPORT**





Facility Name & ID Number Imperial of Hazel Crest

# 0048702

Report Period Beginning:

01/01/10

Ending:

12/31/10

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 80,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>75,625</u>		<u>\$ 405,826</u>	<u>1</u>
2	<u>Allocated from EC Consulting/EC Clinical 2201 Main</u>			<u>15,354</u>	<u>2</u>
3	<b>TOTALS</b>	<u>75,625</u>		<u>\$ 421,180</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imperial of Hazel Crest

# 0048702

Report Period Beginning:

01/01/10

Ending:

12/31/10

**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	Accumulated Depreciation
4				\$	\$		\$	\$
5								
6								
7								
8								
<b>Improvement Type**</b>								
9	Various		1993	24,011		20		
10	Various		1994	37,537		20		
11	Various		1995	43,870		20		
12	Various		1996	23,309		20		
13	Various		1997	66,453		20		
14	Various		1998	11,973		20		
15	Various		1999	42,183		20		
16	Various		2000	101,986		20		
17	Various		2001	25,167		20		
18	Various		2002	11,959		20		
19	Various		2003	40,144		20		
20	Various		2004	20,200		20		
21	Various		2005	23,843		20		
22	Various		2006	53,018		20		
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34								
35								
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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		6,867,883	301,143		176,100	(125,043)	682,387	67
68		61,876	4,214		4,214		29,490	68
69			41,131			(41,131)		69
70		\$ 7,455,412	\$ 346,488		\$ 180,314	\$ (166,174)	\$ 711,877	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Imperial of Hazel Crest

# 0048702

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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>		\$ 7,455,412	\$ 346,488		\$ 180,314	\$ (166,174)	\$ 711,877	1
2	Renovations	2007	23,364		20			23,364	2
3	Replaced Parking Lot	2007	29,370		20	1,469	1,469	5,507	3
4	Hvac Work - Exhaust For Smoking Rooms	2007	14,900		20	745	745	2,794	4
5	New Exterior Doors	2007	4,970		20	249	249	911	5
6	Bathroom Renovations	2007	67,947		20	4,530	4,530	16,609	6
7	Replace Valve & Pump System	2007	13,800		20	690	690	2,530	7
8	New Roof	2007	18,740		20	937	937	3,123	8
9	Doors & Frames	2007	3,052		20	153	153	509	9
10	Sheet Rock Ceiling	2007	6,500		20	325	325	1,029	10
11	Renovations	2008	7,479		20			7,479	11
12	Hvac Work For Laundry Room	2008	5,850		20	293	293	878	12
13	Awning Sprinklers	2008	14,675		20	734	734	2,018	13
14	Locks	2008	3,327		20	166	166	457	14
15	Laundry Room Renovations	2008	4,200		20	210	210	543	15
16	New Nursing Station Tops	2008	7,400		20	370	370	925	16
17	Renovations	2008	8,804		20			8,804	17
18	Renovations	2008	1,761		20			1,761	18
19	Elevator Renovations	2008	3,937		20	197	197	476	19
20	Hvac Re: Ac	2008	2,570		20	129	129	300	20
21	Roof Renovations	2008	1,800		20	90	90	203	21
22	Dishroom	2008	13,500		20	675	675	1,463	22
23	Renovations	2008	5,758		20			5,758	23
24	Emergency Generator Repair	2008	3,265		20	163	163	476	24
25	Painting	2009	40,299		20	2,015	2,015	3,358	25
26	Painting	2009	5,532		20	277	277	346	26
27	Flashings	2009	2,500		20	125	125	198	27
28	Locks & Door Patches	2009	3,220		20	161	161	201	28
29	Painting	2009	9,985		20	8,321	8,321	9,985	29
30	Heat Exchanger	2009	3,551		20	178	178	207	30
31	Replace Sprinkler Heads	2010	39,630		20	2,123	2,123	2,123	31
32	Drywall, Piping, Drains, Plumbing, Light Fixtures In Shower Room	2010	33,000		20	379	379	379	32
33	Gazebo Construction	2010	15,139		20	442	442	442	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,875,237	\$ 346,488		\$ 206,456	\$ (140,032)	\$ 817,031	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>Totals from Page 12B, Carried Forward</b>		\$ 7,875,237	\$ 346,488		\$ 206,456	\$ (140,032)	\$ 817,031	1
2	Rooftop Unit Replacement'	2010	7,500		20	188	188	188	2
3	Generator	2010	5,974		20	498	498	498	3
4	Steel Doors	2010	2,900		20	36	36	36	4
5	Painting	2010	24,121		20	1,206	1,206	1,206	5
6	Roofing Repairs	2010	4,550		20	228	228	228	6
7	Drywall, Piping, Drains, Plumbing, Light Fixtures In Shower Room	2010	3,000		20	150	150	150	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 (lines 1 thru 33)</b>		\$ 7,923,283	\$ 346,488		\$ 208,761	\$ (137,727)	\$ 819,336	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		\$ 7,923,283	\$ 346,488		\$ 208,761	\$ (137,727)	\$ 819,336	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)	\$ 7,923,283	\$ 346,488		\$ 208,761	\$ (137,727)	\$ 819,336	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		\$ 7,923,283	\$ 346,488		\$ 208,761	\$ (137,727)	\$ 819,336	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		\$ 7,923,283	\$ 346,488		\$ 208,761	\$ (137,727)	\$ 819,336	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	204 Bed Facility	1970	6,867,883	301,143	39	176,100	(125,043)	682,387	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

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	TOTAL (12F & 12G lines 1 thru 33)	\$ 6,867,883	\$ 301,143		\$ 176,100	\$ (125,043)	\$ 682,387	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	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>Related Party Information</b>		\$	\$		\$	\$		1
2	<b>Buildings:</b>								2
3	Allocated from Extended Care Consulting 2201 Main	2002	19,058	489	39	489		4,052	3
4	Allocated from Extended Care Clinical 2201 Main	2002	2,100	54	39	54		446	4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Allocated from Extended Care Consulting	2007	192	10	20	10		38	9
10	Allocated from Extended Care Consulting	2009	115	6	20	6		12	10
11	Allocated from Extended Care Consulting	2010	1,129	56	20	56		56	11
12									12
13	Allocated from Extended Care Consulting 2201 Main	2002	15,743	1,439	20	1,439		10,085	13
14	Allocated from Extended Care Consulting 2201 Main	2003	18,553	1,696	20	1,696		11,885	14
15	Allocated from Extended Care Consulting 2201 Main	2005	922	98	20	98		430	15
16	Allocated from Extended Care Consulting 2201 Main	2009	166	8	20	8		17	16
17									17
18	Allocated from Extended Care Clinical 2201 Main	2002	1,734	159	20	159		1,111	18
19	Allocated from Extended Care Clinical 2201 Main	2003	2,044	187	20	187		1,309	19
20	Allocated from Extended Care Clinical 2201 Main	2005	102	11	20	11		47	20
21	Allocated from Extended Care Clinical 2201 Main	2009	18	1	20	1		2	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								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 (12H & 12I lines 1 thru 33)		\$ 61,876	\$ 4,214		\$ 4,214	\$ 29,490	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	\$ 1,054,266	\$ 944	\$ 106,211	\$ 105,267	10	\$ 743,785	71
72	Current Year Purchases	3,895	61	225	164	10	225	72
73	Fully Depreciated Assets	124,211				10	124,211	73
74								74
75	TOTALS	\$ 1,182,372	\$ 1,005	\$ 106,436	\$ 105,431		\$ 868,221	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. Extended Care Consult.	2010	\$ 13,452	\$ 210	\$ 210		5	\$ 13,032	76
77		Alloc. Extended Care Clinical	2010	2,338	468	468		5	1,091	77
78										78
79										79
80	TOTALS			\$ 15,790	\$ 678	\$ 678			\$ 14,123	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)	\$ 9,542,625	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 348,171	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 315,875	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (32,296)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,701,680	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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	Storage Rental				4,536			5
6	Allocated From Extended Care Consulting				1,320			6
7	TOTAL				\$ 5,856			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: \$ 22,350 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	Facility		\$	\$ 114	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 114	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. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 85,922	\$		\$ 85,922	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			3,389			3,389	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			64,639			64,639	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				106,066		106,066	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>					12,798	182,751		195,549	13
14	<b>TOTAL</b>			\$		\$ 166,748	\$ 288,817		\$ 455,565	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 **Imperial of Hazel Crest**

# **0048702**

Report Period Beginning: **01/01/10**

Ending: **12/31/10**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/10**

(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	\$ 2,000	\$ 22,440	1
2	Cash-Patient Deposits	48,022	48,022	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	142,001	142,001	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	368,802	368,802	6
7	Other Prepaid Expenses	1,658	9,058	7
8	Accounts Receivable (owners or related parties)	145,000	534,387	8
9	Other(specify): <u>See Attached Schedule</u>	1,248,904	1,248,904	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,956,387	\$ 2,373,614	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		405,826	13
14	Buildings, at Historical Cost		6,867,883	14
15	Leasehold Improvements, at Historical Cost	445,704	566,432	15
16	Equipment, at Historical Cost	25,094	1,062,087	16
17	Accumulated Depreciation (book methods)	(143,675)	(1,032,335)	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>	1,750	14,664	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 328,873	\$ 7,884,557	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,285,260	\$ 10,258,171	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,391,136	\$ 1,391,135	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,963	45,963	28
29	Short-Term Notes Payable		2,500,000	29
30	Accrued Salaries Payable	132,391	132,391	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,533	5,533	31
32	Accrued Real Estate Taxes(Sch.IX-B)	406,061	406,061	32
33	Accrued Interest Payable		218,391	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	581,285	6,649,885	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,562,369	\$ 11,349,359	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			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>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,562,369	\$ 11,349,359	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (277,109)	\$ (1,091,188)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,285,260	\$ 10,258,171	48

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(321,246)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Medicare Settlements</b>	<b>13,866</b>	<b>3</b>
<b>4</b>	<b>Rounding</b>	<b>5</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>(307,375)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>30,266</b>	<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	( )	<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>30,266</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>(277,109)</b>	<b>24</b> *

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

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# 0048702

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**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	\$ 8,317,036	1
2	Discounts and Allowances for all Levels	(806,713)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 7,510,323</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	587,619	6
7	Oxygen	15,302	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 602,921</b>	8
<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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	131,987	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,784	19
20	Radiology and X-Ray	810	20
21	Other Medical Services	143,453	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 282,034</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	74,031	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 74,031</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	5,300	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 5,300</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 8,474,609</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,516,647	31
32	Health Care	3,127,801	32
33	General Administration	2,244,487	33
<b>B. Capital Expense</b>			
34	Ownership	990,633	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	455,822	35
36	Provider Participation Fee	108,953	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>\$ 8,444,343</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>30,266</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 30,266</b>	43

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

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

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

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

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,658	1,861	\$ 75,283	\$ 40.45	1
2	Assistant Director of Nursing	1,901	2,190	77,100	35.21	2
3	Registered Nurses	9,585	10,432	273,131	26.18	3
4	Licensed Practical Nurses	36,824	39,203	978,630	24.96	4
5	CNAs & Orderlies	80,389	86,149	827,342	9.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,635	10,996	161,459	14.68	8
9	Activity Director	2,257	2,497	33,425	13.39	9
10	Activity Assistants	11,033	11,914	109,895	9.22	10
11	Social Service Workers	15,232	16,833	312,539	18.57	11
12	Dietician	1,844	2,064	31,861	15.44	12
13	Food Service Supervisor	1,926	2,106	42,516	20.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,651	6,333	66,051	10.43	15
16	Dishwashers	12,808	13,935	120,122	8.62	16
17	Maintenance Workers	6,362	6,842	87,108	12.73	17
18	Housekeepers	18,283	19,893	187,876	9.44	18
19	Laundry	6,235	6,924	65,363	9.44	19
20	Administrator	2,016	2,141	81,666	38.14	20
21	Assistant Administrator	1,938	2,145	65,304	30.44	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,577	7,298	92,994	12.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,146	2,381	33,014	13.87	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	234,300	254,137	\$ 3,722,679 *	\$ 14.65	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	229	\$ 11,566	01-03	35
36	Medical Director	Monthly	25,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,337	10-03	39
40	Physical Therapy Consultant	63	3,500	10a-03	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	See Attached - Extended Care Allocation		42,599		47
48					48
49	TOTAL (lines 35 - 48)	292	\$ 90,502		49

C. CONTRACT NURSES

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

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**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	
Bonzetta Williams(1/15/10-10/31/10)	Administrator		\$ 47,099	Workers' Compensation Insurance	\$ 109,981	IDPH License Fee	\$		
Shanon Deckinga (7/30/10-12/31/10)	Administrator		34,566	Unemployment Compensation Insurance	97,047	Advertising: Employee Recruitment		15,003	
Linda Williams (1/15/10-10/31/10)	Assist. Admin.		65,304	FICA Taxes	263,767	Health Care Worker Background Check			
				Employee Health Insurance	147,629	(Indicate # of checks performed )		4,013	
				Employee Meals		Patient Background Checks	247		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions		664	
				Employee Physicals	6,640	Licenses & Fees		1,965	
				Pension Expense	28,265	Allocated From Ext. Care Consulting		3,448	
				Other Employee Welfare	10,624	Allocated From Ext. Care Clinical		193	
				Holiday Expense	3,350				
						Less: Public Relations Expense	(		
						Non-allowable advertising	(		
						Yellow page advertising	(		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 146,969	TOTAL (agree to Schedule V,	\$ 667,303	TOTAL (agree to Sch. V,	\$	25,286	
(List each licensed administrator separately.)				line 22, col.8)		line 20, col. 8)			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees - Joe Zimmerman			\$ 18,000				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 18,000	TOTAL		\$	Seminar Expense	7,961	
(Attach a copy of any management service agreement)							Allocated From Ext. Care Consulting	168	
C. Professional Services							Allocated From Ext. Care Clinical		1,549
Vendor/Payee	Type		Amount				Entertainment Expense	(	
Frost, Ruttenberg & Rothblatt	Accounting		\$ 24,290				(agree to Sch. V,		
See Attached	Legal		56,990				line 24, col. 8)		
Personnel Planners	Unemployment Tax Consult.		3,555				TOTAL	\$ 9,678	
Paycor	Payroll Processing		13,504						
Ehealth Data Solutions	MDS Software		2,385						
AIS Assesment & Intelligence	Computer Services		1,878						
National Datacare Corporation	Data Processing		2,783						
Vision Share	Computer Services		1,756						
Out of Period	Adj. p.5A		2,391						
Extended Care Consulting	Home Office Expense		446,214						
Extended Care Clinical	Home Office Expense		112,615						
See Supplemental Schedule			54,204						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 722,565						
(If total legal fees exceed \$5,000, attach copy of invoices.)									

\* 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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? 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? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,468 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. \$ 108,953  
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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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. \$ No
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ No**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.