

Facility Name & ID Number Oak Park Healthcare Center

0044602 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	204	Skilled (SNF)	204	74,460	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	204	TOTALS	204	74,460	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF		441	5,790	6,231	8
9	SNF/PED					9
10	ICF	48,484	544		49,028	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,484	985	5,790	55,259	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.21%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 11/1/1999

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/1/1999 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 204 and days of care provided 5,790

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Oak Park Healthcare Center # 0044602 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
	A. General Services										
1	Dietary	240,751	43,162	14,828	298,741		298,741	980	299,721		1
2	Food Purchase		248,744		248,744	(15,440)	233,305	356	233,660		2
3	Housekeeping	178,997	35,931		214,928		214,928	558	215,486		3
4	Laundry	51,463	15,870		67,333		67,333	(521)	66,812		4
5	Heat and Other Utilities			189,809	189,809		189,809	1,285	191,094		5
6	Maintenance	107,993	3	108,733	216,729		216,729	7,746	224,475		6
7	Other (specify):*							1,797	1,797		7
8	TOTAL General Services	579,204	343,710	313,370	1,236,284	(15,440)	1,220,845	12,200	1,233,045		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,759,333	91,335	24,808	2,875,476		2,875,476	24,577	2,900,053		10
10a	Therapy	89,487	563		90,050		90,050	3,952	94,002		10a
11	Activities	115,767	4,626	1,248	121,641		121,641		121,641		11
12	Social Services	147,256	311	10,266	157,833		157,833	2,827	160,660		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							5,754	5,754		15
16	TOTAL Health Care and Programs	3,111,843	96,835	48,322	3,257,000		3,257,000	37,110	3,294,110		16
	C. General Administration										
17	Administrative	187,445			187,445		187,445	91,905	279,350		17
18	Directors Fees										18
19	Professional Services			612,331	612,331		612,331	(465,017)	147,314		19
20	Dues, Fees, Subscriptions & Promotions			36,984	36,984		36,984	(3,663)	33,321		20
21	Clerical & General Office Expenses	77,485	34,188	2,757,985	2,869,658		2,869,658	(2,561,057)	308,601		21
22	Employee Benefits & Payroll Taxes			736,472	736,472	15,440	751,912	(29,187)	722,724		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,875	2,875		2,875	1,500	4,375		24
25	Other Admin. Staff Transportation			7,043	7,043		7,043	730	7,773		25
26	Insurance-Prop.Liab.Malpractice			140,922	140,922		140,922	955	141,877		26
27	Other (specify):*							34,235	34,235		27
28	TOTAL General Administration	264,930	34,188	4,294,612	4,593,730	15,440	4,609,170	(2,929,600)	1,679,570		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,955,977	474,733	4,656,304	9,087,014		9,087,014	(2,880,289)	6,206,725		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Oak Park Healthcare Center

#0044602

Report Period Beginning:

01/01/10

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			2,704	2,704		2,704	82,495	85,199			30
31	Amortization of Pre-Op. & Org.			650	650		650	(650)				31
32	Interest			52,759	52,759		52,759	23,869	76,628			32
33	Real Estate Taxes			544,074	544,074		544,074	1,863	545,937			33
34	Rent-Facility & Grounds			609,923	609,923		609,923	1,153	611,076			34
35	Rent-Equipment & Vehicles			61,871	61,871		61,871	2,067	63,938			35
36	Other (specify):*											36
37	TOTAL Ownership			1,271,981	1,271,981		1,271,981	110,797	1,382,778			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		358,483	471,181	829,664		829,664	(83,891)	745,773			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,690	111,690		111,690		111,690			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		358,483	582,871	941,354		941,354	(83,891)	857,463			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,955,977	833,216	6,511,156	11,300,349		11,300,349	(2,853,383)	8,446,966			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 **Oak Park Healthcare Center**

0044602

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	77,347	30		9
10	Interest and Other Investment Income	(4)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(44)	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	(19,631)	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	(2,644,000)	21		24
25	Fund Raising, Advertising and Promotional	(6,844)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(223,925)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,817,101)		\$	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)	(36,282)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (36,282)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,853,383)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Oak Park Healthcare Center

ID# 0044602

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Patient Clothing	\$ (293)	10	1
2	Theft Loss	(903)	21	2
3	Collection Expense	(377)	21	3
4	Non-Allowable Amortization	(650)	31	4
5	Bank Charges	(25,462)	21	5
6	Additional Legal Fees	280	19	6
7	Capitalized R&M	(2,915)	06	7
8	Non-Allowable Expense	(3,747)	21	8
9	Prior Year Income	(6,021)	22	9
10	Non-Allowable Legal	(183,837)	19	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(223,925)		49

Oak Park Healthcare Center

ID# 0044602

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 Oak Park Healthcare Center# 0044602

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			144		4,247		(3,411)					980	1
2	Food Purchase	(44)		400									356	2
3	Housekeeping			514		57					(13)		558	3
4	Laundry										(521)		(521)	4
5	Heat and Other Utilities			1,166		119							1,285	5
6	Maintenance	(2,915)		3,352	7,191	118							7,746	6
7	Other (specify):*				1,202	595							1,797	7
8	TOTAL General Services	(2,959)		5,576	8,393	5,136		(3,411)			(534)		12,200	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(293)				27,327					(2,457)		24,577	10
10a	Therapy					3,952							3,952	10a
11	Activities													11
12	Social Services					2,827							2,827	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					4,780	974						5,754	15
16	TOTAL Health Care and Programs	(293)				38,886	974				(2,457)		37,110	16
	C. General Administration													
17	Administrative			2,375	9,225	39,111	41,194						91,905	17
18	Directors Fees													18
19	Professional Services	(183,557)		(226,097)		(55,363)							(465,017)	19
20	Fees, Subscriptions & Promotions	(6,844)		3,012		169							(3,663)	20
21	Clerical & General Office Expenses	(2,694,120)		14,071	111,809	7,183							(2,561,057)	21
22	Employee Benefits & Payroll Taxes	(6,021)			(16,968)		(6,091)				(108)		(29,187)	22
23	Inservice Training & Education													23
24	Travel and Seminar			147		1,353							1,500	24
25	Other Admin. Staff Transportation			730									730	25
26	Insurance-Prop.Liab.Malpractice			801		154							955	26
27	Other (specify):*				22,852	6,266	5,117						34,235	27
28	TOTAL General Administration	(2,890,542)		(204,961)	126,918	(1,127)	40,220				(108)		(2,929,600)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,893,795)		(199,385)	135,311	42,895	41,194	(3,411)			(3,099)		(2,880,289)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oak Park Healthcare Center# 0044602

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	77,347		4,330		818							82,495	30
31	Amortization of Pre-Op. & Org.	(650)											(650)	31
32	Interest	(4)		8,264		15,609							23,869	32
33	Real Estate Taxes			1,678		185							1,863	33
34	Rent-Facility & Grounds			1,153									1,153	34
35	Rent-Equipment & Vehicles			2,067									2,067	35
36	Other (specify):*													36
37	TOTAL Ownership	76,693		17,492		16,612							110,797	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(1,456)	(68,641)	(197)	(2,126)	(11,470)	(83,891)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers							(1,456)	(68,641)	(197)	(2,126)	(11,470)	(83,891)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,817,101)		(181,893)	135,311	59,507	41,194	(4,867)	(68,641)	(197)	(5,225)	(11,470)	(2,853,383)	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		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	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%	\$ 144	\$	144	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	400		400	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	514		514	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,166		1,166	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	3,352		3,352	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	2,375		2,375	20
21	V	19 Professional Fees	261,025	Extended Care Consulting, LLC	100.00%	9,903		(226,097)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,012		3,012	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	14,071		14,071	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	147		147	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	730		730	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	801		801	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	4,330		4,330	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	8,264		8,264	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,678		1,678	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	1,153		1,153	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	2,067		2,067	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 261,025			\$ 54,107	\$ *	(181,893)	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%	7,191	\$	7,191	15
16	V	06 Maintenance (Direct)		Extended Care Consulting, LLC	100.00%				16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,202		1,202	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%				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%	9,225		9,225	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	111,809		111,809	22
23	V	21 Office and Clerical (Direct)	30,109	Extended Care Consulting, LLC	100.00%	30,109			23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	20,225		20,225	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	2,627		2,627	25
26	V	22 Employee Benefits	16,968	Extended Care Consulting, LLC	100.00%			(16,968)	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		\$ 47,077			\$ 182,388	\$ *	135,311	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 57	\$	57	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	119		119	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	118		118	17
18	V	19 Professional Fees	62,957	Extended Care Clinical, LLC	100.00%	6,637		(55,363)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	169		169	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	1,585		1,585	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,353		1,353	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	154		154	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	818		818	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	15,609		15,609	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	185		185	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	4,247		4,247	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	595		595	27
28	V	10 Nursing Salary		Extended Care Clinical, LLC	100.00%	27,327		27,327	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	3,952		3,952	29
30	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%	2,827		2,827	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	4,780		4,780	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	39,111		39,111	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	5,598		5,598	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	6,266		6,266	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 62,957			\$ 121,507	\$ *	59,507	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	\$	Extended Care Clinical, LLC	100.00%	\$	\$	15
16	V	07 Emp. Ben. - General		Extended Care Clinical, LLC	100.00%			16
17	V	10 Nursing Salary	16,254	Extended Care Clinical, LLC	100.00%	16,254		17
18	V	12 Social Service Salary	10,265	Extended Care Clinical, LLC	100.00%	10,265		18
19	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	974	974	19
20	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	41,194	41,194	20
21	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	5,117	5,117	21
22	V	22 Employee Benefits	6,091	Extended Care Clinical, LLC	100.00%		(6,091)	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		\$ 32,610			\$ 73,804	\$ * 41,194	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	\$ 7,678	Care Centers Health Systems, Inc.	100.00%	\$ 4,267	\$ (3,411)
16	V	10 Nursing Supplies		Care Centers Health Systems, Inc.	100.00%		
17	V	39 Ancillary Expense	3,278	Care Centers Health Systems, Inc.	100.00%	1,822	(1,456)
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		\$ 10,956			\$ 6,089	\$ * (4,867)

* 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	\$ 364,996	TriCare Rehab	100.00%	\$ 296,355	\$ (68,641)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 364,996			\$ 296,355	\$ * (68,641)

* 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	2,514	Reliable Medical of the Midwest, LLC	100.00%	2,317	(197)	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		\$ 2,514			\$ 2,317	\$ *	(197) 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	197	Xcel Supply, LLC	100.00%	184	(13)	16
17	V	4 Laundry	7,824	Xcel Supply, LLC	100.00%	7,302	(521)	17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	36,868	Xcel Supply, LLC	100.00%	34,411	(2,457)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	1,615	Xcel Supply, LLC	100.00%	1,508	(108)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	31,910	Xcel Supply, LLC	100.00%	29,783	(2,126)	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		\$ 78,413			\$ 73,188	\$ * (5,225)	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	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 96,563	\$	96,563	15
16	V								16
17	V								17
18	V								18
19	V	22 Employee Health Insurance	96,563	CCS Employee Benefits Group	100.00%			(96,563)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	39 Matrix Leasing	\$ 17,221	Vent Lease LLC	100.00%	\$ 7,966	\$	(9,255)	26
27	V	39 Ventilator Equipment	4,122	Vent Lease LLC	100.00%	1,907		(2,215)	27
28	V	39 Other Ancillary		Vent Lease LLC	100.00%				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		\$ 117,905			\$ 106,435	\$ *	(11,470)	39

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

Facility Name & ID Number

Oak Park Healthcare Center

0044602

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	Shareholder	Administrative	90.00%	See Attached	1.19	2.56%	Mgmt. Fees	\$		1
2	Mark Steinberg	Relative	Administrative		See Attached	2.01	3.65%	Al. Salary/Fees	5,842	17-7	2
3	Adam Vales	Relative	Clerical		See Attached	0.51	1.28%	Alloc. Salary	887	22-7	3
4	G. Matt Silvers	Relative	Administrative		See Attached	0.14	0.63%	Alloc. Salary	466	17-7	4
5											5
6											6
7											7
8											8
9	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										9
10	IL Dept. of HFS.										10
11											11
12											12
13								TOTAL	\$ 7,195		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 Oak Park Healthcare Center

0044602

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Park Healthcare Center

0044602

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,512,273	34	\$ 3,931	\$ 55,259	\$ 144	1
2	02	Food	Patient Days	1,512,273	34	10,940	55,259	400	2
3	03	Housekeeping	Patient Days	1,512,273	34	14,059	55,259	514	3
4	05	Utilities	Patient Days	1,512,273	34	31,923	55,259	1,166	4
5	06	Maintenance	Patient Days	1,512,273	34	91,744	55,259	3,352	5
6	17	Administrative	Patient Days	1,512,273	34	65,000	55,259	2,375	6
7	19	Professional Fees	Patient Days	1,512,273	34	271,007	55,259	9,903	7
8	20	Dues and Subscriptions	Patient Days	1,512,273	34	82,419	55,259	3,012	8
9	21	Office and Clerical	Patient Days	1,512,273	34	385,083	55,259	14,071	9
10	24	Seminar and Travel	Patient Days	1,512,273	34	4,022	55,259	147	10
11	25	Other Staff Admin. Trans.	Patient Days	1,512,273	34	19,982	55,259	730	11
12	26	Insurance	Patient Days	1,512,273	34	21,934	55,259	801	12
13	30	Depreciation	Patient Days	1,512,273	34	118,510	55,259	4,330	13
14	32	Interest	Patient Days	1,512,273	34	226,162	55,259	8,264	14
15	33	Real Estate Taxes	Patient Days	1,512,273	34	45,910	55,259	1,678	15
16	34	Rent - Building	Patient Days	1,512,273	34	31,555	55,259	1,153	16
17	35	Rent - Equipment & Auto	Patient Days	1,512,273	34	56,569	55,259	2,067	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,480,749	\$	\$ 54,107	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Park Healthcare Center

0044602

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	55,259	7,191	1
2	06	Maintenance (Direct)	Direct	34	32,478	32,478			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	34	32,885		55,259	1,202	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct	34	3,607				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	55,259	9,225	7
8	21	Office and Clerical (Pooled)	Patient Days	34	3,059,876	3,059,876	55,259	111,809	8
9	21	Office and Clerical (Direct)	Direct	34	771,063	771,063		30,109	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	34	553,505		55,259	20,225	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct	34	94,865			2,627	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		\$ 182,388	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Park Healthcare Center

0044602

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	\$	55,259	\$ 57	1
2	05	Utilities	Patient Days	34	3,268		55,259	119	2
3	06	Maintenance	Patient Days	34	3,240		55,259	118	3
4	19	Professional Fees	Patient Days	34	181,624		55,259	6,637	4
5	20	Dues and Subscriptions	Patient Days	34	4,624		55,259	169	5
6	21	Office & Clerical	Patient Days	34	43,370		55,259	1,585	6
7	24	Travel and Seminar	Patient Days	34	37,025		55,259	1,353	7
8	26	Insurance	Patient Days	34	4,213		55,259	154	8
9	30	Depreciation	Patient Days	34	22,389		55,259	818	9
10	32	Interest	Patient Days	34	427,165		55,259	15,609	10
11	33	Real Estate Taxes	Patient Days	34	5,058		55,259	185	11
12	01	Dietary Salary	Patient Days	34	116,221	116,221	55,259	4,247	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	34	16,288		55,259	595	13
14	10	Nursing Salary	Patient Days	34	747,870	747,870	55,259	27,327	14
15	10a	Rehab Salary	Patient Days	34	108,151	108,151	55,259	3,952	15
16	12	Social Service Salary	Patient Days	34	77,377	77,377	55,259	2,827	16
17	15	Emp. Ben. - Healthcare	Patient Days	34	130,816		55,259	4,780	17
18	17	Administration Salary	Patient Days	34	1,070,339	1,070,339	55,259	39,111	18
19	21	Office Salary	Patient Days	34	153,206	153,206	55,259	5,598	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	34	171,480		55,259	6,266	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,325,274	\$ 2,273,164		\$ 121,507	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Park Healthcare Center

0044602

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 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

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		\$	1
2	07	Emp. Ben. - General	Direct Allocation		1,662				2
3	10	Nursing Salary	Direct Allocation		495,330	495,330		16,254	3
4	12	Social Service Salary	Direct Allocation		274,597	274,597		10,265	4
5	15	Emp. Ben. - Healthcare	Direct Allocation		94,697			974	5
6	17	Administration Salary	Direct Allocation		82,389	82,389		41,194	6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation		10,053			5,117	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		\$ 73,804	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Park Healthcare Center

0044602

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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	Dietary Supplies, Supplements	Direct Allocation		\$	\$		4,267	1
2	10	Nursing Supplies	Direct Allocation						2
3	39	Ancillary Expense	Direct Allocation					1,822	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				\$	\$		6,089	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Park Healthcare Center

0044602

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		\$	\$		\$ 296,355	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				\$	\$		\$ 296,355	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Park Healthcare Center

0044602

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					2,317	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				\$	\$		\$	2,317

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Park Healthcare Center

0044602

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			\$		\$	1	
2	3	Housekeeping	Direct Allocation					184	2	
3	4	Laundry	Direct Allocation					7,302	3	
4	6	Repairs & Maintenance	Direct Allocation						4	
5	10	Nursing	Direct Allocation					34,411	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					1,508	10	
11	24	Seminars & Education	Direct Allocation						11	
12	39	Ancillary	Direct Allocation					29,783	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					\$		\$	73,188	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Park Healthcare Center

0044602

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 96,563	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11	39	Matrix Leasing	Direct Allocation		\$	\$		\$ 7,966	11
12	39	Ventilator Equipment	Direct Allocation					1,907	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				\$	\$		\$ 106,435	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Oak Park Healthcare Center

0044602

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			
A. Directly Facility Related																			
Long-Term																			
1										1									
2										2									
3										3									
4										4									
5	See Supplemental Schedule																		
Working Capital																			
6	First Bank	X	Line of Credit						52,759	6									
7	Note Payable ST		Line of Credit			4,181,541				7									
8	See Supplemental Schedule																		
9	TOTAL Facility Related					\$ 5,511,541			\$ 76,632	9									
B. Non-Facility Related*																			
10	Interest Income	X							(4)	10									
11										11									
12										12									
13	See Supplemental Schedule																		
14	TOTAL Non-Facility Related					\$			\$ (4)	14									
15	TOTALS (line 9+line14)					\$ 5,511,541			\$ 76,628	15									

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

Oak Park Healthcare Center

0044602

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
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term																		
	Working Capital																		
8	Alloc from Ext Care Const, Inc		X				\$	\$			\$	8,264	8						
9	Alloc from Ext Care Clinical		X									15,609	9						
10	Shareholder Loan		X					1,330,000					10						
11													11						
12													12						
13													13						
14	TOTAL Working Capital																		
	B. Non-Facility Related*																		
15							\$	\$			\$		15						
16													16						
17													17						
18													18						
19													19						
20	TOTAL Non-Facility Related																		

* 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 **Oak Park Healthcare Center**

0044602

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

Ending: **12/31/10**

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.		\$	917,469	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	495,328	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(422,141)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	968,078	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	545,937	7

Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2005	360,382	8	
	2006	369,715	9	
	2007	379,379	10	
	2008	523,106	11	
	2009	493,465	12	
Allocation from Extended Care Consulting Building Alloc. \$1,678				
Allocation from Extended Care Clinical Building Alloc. \$185				

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

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 Oak Park Healthcare Center

0044602

Report Period Beginning:

01/01/10

Ending:

12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,926 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2	<u>Alloc. from Ext. Care Conslt/ Ext Care Clinical 2201 Main</u>			<u>13,411</u>	2
3	TOTALS			\$ 13,411	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various		1999	74,653		20	1,914	1,914	21,149
10	Various		2000	229,115		20	8,799	8,799	93,289
11	Various		2001	33,776		20	1,229	1,229	11,691
12	Various		2002	62,212		20	2,266	2,266	19,267
13	Various		2003	16,526		20	603	603	4,679
14	Various		2004	78,815		20	2,865	2,865	18,001
15	Various		2005	502,693		20	18,784	18,784	99,675
16	Various		2006	22,383		20	813	813	3,855
17									
18									
19									
20									
21									
22									
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								67
68			54,045		3,678	3,678		25,760
69					2,704		(2,704)	
70			\$ 1,074,218		\$ 6,382	\$ 40,951	\$ 34,569	\$ 297,366

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	Totals from Page 12A, Carried Forward		\$ 1,074,218	\$ 6,382		\$ 40,951	\$ 34,569	\$ 297,366	1
2	Rooftop A/C Pump	2007	4,059		20	148	148	536	2
3	Parking Lot Paving, Window Treatments	2007	5,887		20	393	393	1,375	3
4	Elevator Power Unit, Roof Exhausts, Pipes, Kickplate	2008	20,387		20	742	742	1,934	4
5	Remodeling Showers, Drywall, Floors	2008	108,483		20	3,944	3,944	9,368	5
6	Concrete	2008	1,600		20	107	107	267	6
7	Doors, Sidelites, Electric, Elevator Care Sill	2009	12,722		20	280	280	560	7
8	Carpeting	2010	3,197		20	160	160	160	8
9	Replace Water Heater	2010	8,161		20	408	408	408	9
10	Roto-Surcs	2010	5,665		20	283	283	283	10
11	A/C Startup Repair	2010	2,657		20	133	133	133	11
12	Annex A/C Repair	2010	3,344		20	167	167	167	12
13	Provide & Install 30 P-Tac Units For Annex Resident Rms	2010	42,637		20	2,132	2,132	2,132	13
14	Replace Cable, Switchboard, Install 30 Circuits & Outlets	2010	53,000		20	2,650	2,650	2,650	14
15	Architect Fees-Hvac Renovations	2010	8,483		20	424	424	424	15
16	Architect Fees-Hvac Renovations	2010	14,700		20	735	735	735	16
17	30 Sleeves For P-Tac Units	2010	5,750		20	288	288	288	17
18	Elevator Repair	2010	2,818		20	141	141	141	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)		\$ 1,377,767	\$ 6,382		\$ 54,086	\$ 47,704	\$ 318,927	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		\$ 1,377,767	\$ 6,382		\$ 54,086	\$ 47,704	\$ 318,927	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)	\$ 1,377,767	\$ 6,382		\$ 54,086	\$ 47,704	\$ 318,927	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		\$ 1,377,767	\$ 6,382		\$ 54,086	\$ 47,704	\$ 318,927	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)	\$ 1,377,767	\$ 6,382		\$ 54,086	\$ 47,704	\$ 318,927	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		\$ 1,377,767	\$ 6,382		\$ 54,086	\$ 47,704	\$ 318,927
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 1,377,767	\$ 6,382		\$ 54,086	\$ 47,704	\$ 318,927

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	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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)	\$	\$		\$	\$	\$	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	Related Party Information		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocated from Extended Care Consulting, 2201 Main LLC	2002	16,646	427	39	427		3,539	3
4	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	1,834	47	39	47		390	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting	2007	168	8	20	8		34	9
10	Allocated from Extended Care Consulting	2009	100	5	20	5		10	10
11	Allocated from Extended Care Consulting	2010	986	49	20	49		49	11
12									12
13	Allocated from Extended Care Consulting, 2201 Main LLC	2002	13,751	1,257	20	1,257		8,809	13
14	Allocated from Extended Care Consulting, 2201 Main LLC	2003	16,205	1,481	20	1,481		10,381	14
15	Allocated from Extended Care Consulting, 2201 Main LLC	2005	805	86	20	86		376	15
16	Allocated from Extended Care Consulting, 2201 Main LLC	2009	145	7	20	7		15	16
17									17
18	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	1,515	138	20	138		970	18
19	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2003	1,785	163	20	163		1,144	19
20	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2005	89	9	20	9		41	20
21	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2009	16	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							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 54,045	\$ 3,678		\$ 3,678	\$	\$ 25,760

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oak Park Healthcare Center

0044602

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	\$ 369,014	\$ 825	\$ 28,130	\$ 27,305	10	\$ 169,189	71
72	Current Year Purchases	23,921	53	2,392	2,339	10	2,392	72
73	Fully Depreciated Assets	103,571				10	103,571	73
74								74
75	TOTALS	\$ 496,506	\$ 878	\$ 30,522	\$ 29,644		\$ 275,152	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated From EC Consulting	2010	\$ 11,750	\$ 184	\$ 184		5	\$ 11,383	76
77		Allocated From EC Clinical	2010	2,042	408	408		5	953	77
78										78
79										79
80	TOTALS			\$ 13,792	\$ 592	\$ 592			\$ 12,336	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)	\$ 1,901,476	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 7,852	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 85,199	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 77,347	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 606,414	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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:			\$ <u>609,923</u>			3
4	Additions						4
5	<u>Allocated from Extended Care Consulting, LLC</u>			<u>1,153</u>			5
6							6
7	TOTAL			\$ <u>611,076</u>			7

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

16. Rental Amount for movable equipment: \$ 51,492 Description: See Attached Schedule YES NO

(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	<u>Facility</u>	<u>2003 Chevy E35P</u>	\$ _____	\$ <u>1,597</u>	17
18	<u>Facility</u>	<u>2006 Chev Tahoe</u>	_____	<u>3,712</u>	18
19	<u>Facility</u>	<u>2006 BMW X5</u>	_____	<u>7,137</u>	19
20					20
21	TOTAL		\$ _____	\$ <u>12,445</u>	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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	184,613	\$		\$	184,613	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				15,182				15,182	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				266,177				266,177	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					260,825			260,825	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>						5,209	97,658			102,867	13
14	TOTAL			\$		\$	471,181	\$	358,483	\$	829,664	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 Oak Park Healthcare Center# 0044602Report Period Beginning: 01/01/10Ending: 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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits	62,463		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,318,950		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,527		6
7	Other Prepaid Expenses	6,043		7
8	Accounts Receivable (owners or related parties)	252,894		8
9	Other(specify): <u>See Attached Schedule</u>	681,688		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,351,565	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	138,928		15
16	Equipment, at Historical Cost	32,456		16
17	Accumulated Depreciation (book methods)	(2,704)		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>	5,198		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 173,878	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,525,443	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,368,617	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,551		28
29	Short-Term Notes Payable	5,511,541		29
30	Accrued Salaries Payable	286,706		30
31	Accrued Taxes Payable (excluding real estate taxes)	359,867		31
32	Accrued Real Estate Taxes(Sch.IX-B)	968,078		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	4,512,908		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 14,053,268	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,053,268	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (10,527,825)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,525,443	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (8,037,881)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (8,037,881)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,489,944)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,489,944)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (10,527,825)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Park Healthcare Center# 0044602Report Period Beginning: 01/01/10Ending: 12/31/10

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,645,069	1
2	Discounts and Allowances for all Levels	(854,190)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,790,879	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	829,507	6
7	Oxygen	4,877	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 834,384	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	160,072	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,658	19
20	Radiology and X-Ray		20
21	Other Medical Services	20,408	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 185,138	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,810,405	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,236,284	31
32	Health Care	3,257,000	32
33	General Administration	4,593,730	33
B. Capital Expense			
34	Ownership	1,271,981	34
C. Ancillary Expense			
35	Special Cost Centers	829,664	35
36	Provider Participation Fee	111,690	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,300,349	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,489,944)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,489,944)	43

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

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

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

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

Facility Name & ID Number **Oak Park Healthcare Center**

0044602

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	1,805	2,020	\$ 80,813	\$ 40.01	1
2	Assistant Director of Nursing	2,293	2,481	88,564	35.70	2
3	Registered Nurses	11,834	13,715	364,753	26.60	3
4	Licensed Practical Nurses	40,112	44,569	1,098,910	24.66	4
5	CNAs & Orderlies	86,606	102,076	1,097,821	10.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,307	4,811	89,487	18.60	8
9	Activity Director	2,228	2,380	40,726	17.11	9
10	Activity Assistants	6,299	7,315	75,041	10.26	10
11	Social Service Workers	6,678	7,539	147,256	19.53	11
12	Dietician					12
13	Food Service Supervisor	1,846	1,978	34,874	17.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,062	19,929	205,877	10.33	15
16	Dishwashers					16
17	Maintenance Workers	5,401	5,985	107,993	18.04	17
18	Housekeepers	15,678	18,170	178,997	9.85	18
19	Laundry	3,747	4,390	51,463	11.72	19
20	Administrator	2,103	2,464	98,123	39.82	20
21	Assistant Administrator	2,048	2,086	89,322	42.82	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,207	8,751	77,485	8.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,999	2,307	28,472	12.34	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	219,253	252,966	\$ 3,955,977 *	\$ 15.64	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	296	\$ 14,828	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,554	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,248	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	<u>See Attached</u>	840	26,520		48
49	TOTAL (lines 35 - 48)	1,160	\$ 63,150		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Park Healthcare Center

0044602

Report Period Beginning: 01/01/10

Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Konstantinos Stavropoulos	Administrator	0.00	\$ 98,123	Workers' Compensation Insurance	\$ 71,942	IDPH License Fee	\$ 3,900		
Richard Taylor	Assist. Admin	0.00	89,322	Unemployment Compensation Insurance	111,212	Advertising: Employee Recruitment	9,039		
				FICA Taxes	297,558	Health Care Worker Background Check	3,353		
				Employee Health Insurance	179,076	(Indicate # of checks performed <u>105</u>)			
				Employee Meals	15,440	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	48		
				Employee Physicals	916	Licenses, Inspections & Permits	13,800		
				Holiday Expense	2,500	Advertising & Promotions	6,844		
				Other Employee Welfare	776	Alloc from Extended Care Consulting	3,012		
				Pension Expense	43,303	See Supplemental Schedule	169		
						Less: Public Relations Expense	()		
						Non-allowable advertising	(6,844)		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 187,445	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)			
							\$ 33,321		
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	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Seminar Expense	2,875	
C. Professional Services							Allocated From EC Consulting		147
Vendor/Payee	Type		Amount				Allocated From EC Clinical		1,353
Krupnick, Bokor, Kagda	Accounting		\$ 28,000				Entertainment Expense		()
Denise Carnes	Accounting		2,483				(agree to Sch. V, line 24, col. 8)		
Personnel Planners	Unemployment Consult		4,358				TOTAL		\$ 4,375
Prospect Resources	Natural Gas Procurement		3,000						
Richard Peelo	Medicare Cost Report		4,800						
AIS-Assessment & Intelligence	Software		1,841						
National Datacare Corporation	Resident Fund Processing		(73)						
Honkamp Krueger & Co.	Work Opportunity Tax Credit		360						
Extended Care Consulting	Home Office Expense		261,025						
Extended Care Clinical	Home Office Expense		62,957						
3 C Healthcare Consulting	Risk Management		2,825						
See Supplemental Schedule			240,755						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 612,331						

* 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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Park Healthcare Center# 0044602

Report Period Beginning:

01/01/10

Ending:

12/31/10**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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,957 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 111,690
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. \$ 15,440 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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: 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.