

Facility Name & ID Number Center Home Hispanic Elderly N

0048520 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	156	TOTALS	156	56,940	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	25,521	457	3,927	29,905	8	
9	SNF/PED					9	
10	ICF	20,276	375		20,651	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	45,797	832	3,927	50,556	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.79%

D. How many bed-hold days during this year were paid by the Department? 259 (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 10/01/2006

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/01/2006 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 98 and days of care provided 3,893

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Center Home Hispanic Elderly N # 0048520 Report Period Beginning: 01/01/09 Ending: 12/31/09

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	255,334	51,582	13,400	320,316		320,316	6,455	326,771		1
2	Food Purchase		243,549		243,549		243,549	513	244,062		2
3	Housekeeping	193,770	49,858		243,628		243,628	(1,199)	242,429		3
4	Laundry	103,179	33,818		136,997		136,997	(1,333)	135,664		4
5	Heat and Other Utilities			152,350	152,350		152,350	2,622	154,972		5
6	Maintenance	154,062		137,252	291,314		291,314	14,850	306,164		6
7	Other (specify):*							2,014	2,014		7
8	TOTAL General Services	706,345	378,807	303,002	1,388,154		1,388,154	23,923	1,412,077		8
	B. Health Care and Programs										
9	Medical Director			24,024	24,024		24,024		24,024		9
10	Nursing and Medical Records	2,765,346	172,959	127,208	3,065,513		3,065,513	19,547	3,085,060		10
10a	Therapy	154,367			154,367		154,367	1,690	156,057		10a
11	Activities	95,864	14,642		110,506		110,506		110,506		11
12	Social Services	130,721		2,336	133,057		133,057	9,089	142,146		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							11,743	11,743		15
16	TOTAL Health Care and Programs	3,146,298	187,601	153,568	3,487,467		3,487,467	42,069	3,529,536		16
	C. General Administration										
17	Administrative	185,289			185,289		185,289	60,106	245,395		17
18	Directors Fees										18
19	Professional Services			400,961	400,961		400,961	(332,345)	68,616		19
20	Dues, Fees, Subscriptions & Promotions			42,826	42,826		42,826	(8,480)	34,346		20
21	Clerical & General Office Expenses	133,750	22,323	392,265	548,338		548,338	(152,568)	395,770		21
22	Employee Benefits & Payroll Taxes			592,431	592,431		592,431	(12,656)	579,775		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,682	8,682		8,682	1,060	9,742		24
25	Other Admin. Staff Transportation			968	968		968	695	1,663		25
26	Insurance-Prop.Liab.Malpractice			160,987	160,987		160,987	1,815	162,802		26
27	Other (specify):*							35,307	35,307		27
28	TOTAL General Administration	319,039	22,323	1,599,120	1,940,482		1,940,482	(407,066)	1,533,416		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,171,682	588,731	2,055,690	6,816,103		6,816,103	(341,074)	6,475,029		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.

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			132,924	132,924		132,924	294,765	427,689			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,703	34,703		34,703	476,398	511,101			32
33	Real Estate Taxes			115,104	115,104		115,104	2,269	117,373			33
34	Rent-Facility & Grounds			660,000	660,000		660,000	(653,003)	6,997			34
35	Rent-Equipment & Vehicles			6,643	6,643		6,643	2,544	9,187			35
36	Other (specify):*											36
37	TOTAL Ownership			949,374	949,374		949,374	122,973	1,072,347			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		364,565	539,521	904,086		904,086	(57,310)	846,776			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,410	85,410		85,410		85,410			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		364,565	624,931	989,496		989,496	(57,310)	932,186			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,171,682	953,296	3,629,995	8,754,973		8,754,973	(275,411)	8,479,562			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	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	(33,005)	30		9
10	Interest and Other Investment Income	(22)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(40)	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	(16,049)	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	(180,987)	21		24
25	Fund Raising, Advertising and Promotional	(8,040)	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	(139,564)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (377,707)		\$	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)	102,296		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 102,296		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (275,411)		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	

SEE ACCOUNTANTS' COMPILATION REPORT

Center Home Hispanic Elderly N

ID# 0048520

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Patient Clothing	\$ (60)	10	1
2	Theft Loss	(622)	21	2
3	Annual Report	(250)	20	3
4	Prior Period Adjustment - Computer Expense	(112,009)	21	4
5	Prior Period Adjustment - Accounting Fees	(6,810)	19	5
6	Prior Period Adjustment - Dues & Subscriptions	(2,434)	20	6
7	Prior Period Adjustment - Other Professional Fees	(1,750)	19	7
8	Prior Period and Non-Allowable Legal Fees	(584)	19	8
9	Misc. Income - Liquid Gas Transfer Service Refund	(1,160)	10	9
10	Misc. Income - Professional Fees	(364)	19	10
11	Misc. Income - Contributions	(200)	21	11
12	Building Company - Bank Charges	(70)	21	12
13	Building Company - Filing Fee	(250)	21	13
14	Building Company - Amortization	(13,001)	36	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	(139,564)		49

Center Home Hispanic Elderly N

ID# 0048520

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Center Home Hispanic Elderly N# 0048520

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			249		4,317	(29)			1,918			6,455	1
2	Food Purchase	(40)		553									513	2
3	Housekeeping			517		57	(1,773)						(1,199)	3
4	Laundry						(1,333)						(1,333)	4
5	Heat and Other Utilities			2,118		136				368			2,622	5
6	Maintenance			3,287	8,053	18	(16)		3,226	282			14,850	6
7	Other (specify):*				1,388	626							2,014	7
8	TOTAL General Services	(40)		6,724	9,441	5,154	(3,150)		3,226	2,568			23,923	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,220)				29,388	(8,621)						19,547	10
10a	Therapy					1,690							1,690	10a
11	Activities													11
12	Social Services					9,089							9,089	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					11,743							11,743	15
16	TOTAL Health Care and Programs	(1,220)				51,910	(8,621)						42,069	16
	C. General Administration													
17	Administrative			2,425	8,792	38,333				10,556			60,106	17
18	Directors Fees													18
19	Professional Services	(9,508)		(238,472)		(84,935)			177	393			(332,345)	19
20	Fees, Subscriptions & Promotions	(10,724)		2,075		8				161			(8,480)	20
21	Clerical & General Office Expenses	(310,187)	320	16,985	132,234	8,596			(13,292)	12,776			(152,568)	21
22	Employee Benefits & Payroll Taxes				(7,238)	(5,371)	(47)						(12,656)	22
23	Inservice Training & Education													23
24	Travel and Seminar			65		995							1,060	24
25	Other Admin. Staff Transportation			379					14	302			695	25
26	Insurance-Prop.Liab.Malpractice			833		49			183	750			1,815	26
27	Other (specify):*				24,040	6,660				4,607			35,307	27
28	TOTAL General Administration	(330,419)	320	(215,710)	157,828	(35,665)	(47)		(12,918)	29,545			(407,066)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(331,679)	320	(208,986)	167,269	21,399	(11,817)		(9,692)	32,113			(341,074)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number

Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
30	D. Ownership												
	Depreciation	(33,005)	302,378	4,245		940			19,436	771			294,765 30
31	Amortization of Pre-Op. & Org.												31
32	Interest	(22)	399,250	62,402		11,358			3,410				476,398 32
33	Real Estate Taxes			2,047		222							2,269 33
34	Rent-Facility & Grounds		(660,000)	3,550						3,447			(653,003) 34
35	Rent-Equipment & Vehicles			2,507						37			2,544 35
36	Other (specify):*	(13,001)	13,001										36
37	TOTAL Ownership	(46,028)	54,629	74,751		12,520			22,846	4,255			122,973 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation												38
39	Ancillary Service Centers						(9,201)		(32,780)	(15,329)			(57,310) 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						(9,201)		(32,780)	(15,329)			(57,310) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(377,707)	54,949	(134,235)	167,269	33,919	(21,019)		(19,626)	21,039			(275,411) 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		
				Center Home Property, LLC		Building Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 660,000	Center Home Property, LLC	100.00%	\$	(660,000)	1
2	V	21 Bank Charges		Center Home Property, LLC	100.00%	70	70	2
3	V	21 Filing Fee		Center Home Property, LLC	100.00%	250	250	3
4	V	30 Depreciation		Center Home Property, LLC	100.00%	302,378	302,378	4
5	V	36 Amortization		Center Home Property, LLC	100.00%	13,001	13,001	5
6	V	33 Real Estate Tax	127,027	Center Home Property, LLC	100.00%	127,027		6
7	V	32 Interest		Center Home Property, LLC	100.00%	399,250	399,250	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 787,027			\$ 841,976	\$ * 54,949	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%	\$ 249	\$	249	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	553		553	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	517		517	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	2,118		2,118	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	3,287		3,287	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	2,425		2,425	20
21	V	19 Professional Fees	248,961	Extended Care Consulting, LLC	100.00%	10,489		(238,472)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,075		2,075	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	16,985		16,985	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	65		65	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	379		379	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	833		833	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	4,245		4,245	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	62,402		62,402	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,047		2,047	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	3,550		3,550	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	2,507		2,507	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 248,961			\$ 114,726	\$ *	(134,235)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	8,053	\$	8,053	15
16	V	06 Maintenance (Direct)	250	Extended Care Consulting, LLC	100.00%	250			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,378		1,378	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	10		10	18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	8,792		8,792	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	132,234		132,234	20
21	V	21 Office and Clerical (Direct)	35,937	Extended Care Consulting, LLC	100.00%	35,937			21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	22,625		22,625	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,415		1,415	23
24	V	22 Employee Benefits	7,238	Extended Care Consulting, LLC	100.00%			(7,238)	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		\$ 43,425			\$ 210,694	\$ *	167,269	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%	136		136	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	18		18	17
18	V	19 Professional Fees	86,115	Extended Care Clinical, LLC	100.00%	1,180		(84,935)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	8		8	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	1,003		1,003	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	995		995	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	49		49	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	940		940	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	11,358		11,358	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	222		222	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	4,317		4,317	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	626		626	27
28	V	10 Nursing Salary	24,519	Extended Care Clinical, LLC	100.00%	53,907		29,388	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	1,690		1,690	29
30	V	12 Social Service Salary	2,336	Extended Care Clinical, LLC	100.00%	11,425		9,089	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	11,743		11,743	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	38,333		38,333	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	7,593		7,593	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	6,660		6,660	34
35	V	22 Employee Benefits	5,371	Extended Care Clinical, LLC	100.00%			(5,371)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 118,341			\$ 152,260	\$ *	33,919	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	\$ 315	Xcel Supply, LLC	100.00%	\$ 286	\$ (29)
16	V	3 Housekeeping	19,305	Xcel Supply, LLC	100.00%	17,532	(1,773)
17	V	4 Laundry	14,510	Xcel Supply, LLC	100.00%	13,178	(1,333)
18	V	6 Repairs & Maintenance	171	Xcel Supply, LLC	100.00%	155	(16)
19	V	10 Nursing	93,876	Xcel Supply, LLC	100.00%	85,256	(8,621)
20	V	11 Activities		Xcel Supply, LLC	100.00%		
21	V	12 Social Service		Xcel Supply, LLC	100.00%		
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%		
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%		
24	V	22 Employee Benefits	507	Xcel Supply, LLC	100.00%	460	(47)
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%		
26	V	39 Ancillary	100,199	Xcel Supply, LLC	100.00%	90,998	(9,201)
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		\$ 228,883			\$ 207,865	\$ * (21,019)

* 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%	\$ 149,041	\$ 149,041
16	V						
17	V						
18	V						
19	V	22 Employee Health Insurance	149,041	CCS Employee Benefits Group	100.00%		(149,041)
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		\$ 149,041			\$ 149,041	\$ *

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	06 Repairs	\$	Vent Lease, LLC.	100.00%	\$ 3,226	\$ 3,226
16	V	19 Professional Fees		Vent Lease, LLC.	100.00%	177	177
17	V	21 Office and Clerical		Vent Lease, LLC.	100.00%	274	274
18	V	25 Auto Expense / Travel		Vent Lease, LLC.	100.00%	14	14
19	V	26 Insurance		Vent Lease, LLC.	100.00%	183	183
20	V	30 Depreciation		Vent Lease, LLC.	100.00%	8,394	8,394
21	V	32 Interest		Vent Lease, LLC.	100.00%	1,414	1,414
22	V	30 Depreciation - Matrix		Vent Lease, LLC.	100.00%	11,042	11,042
23	V	32 Interest - Matrix		Vent Lease, LLC.	100.00%	1,996	1,996
24	V	21 Office and Clerical	13,566	Vent Lease, LLC.	100.00%		(13,566)
25	V	39 Ancillary	32,780	Vent Lease, LLC.	100.00%		(32,780)
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		\$ 46,346			\$ 26,720	\$ * (19,626)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 4,861	\$ 4,861	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	368	368	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	282	282	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	393	393	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	161	161	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	1,998	1,998	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	302	302	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	750	750	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	771	771	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%			25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%			26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	3,447	3,447	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	37	37	28
29	V	01 Dietary	4,899	Care Centers Health Systems, Inc.	100.00%	1,956	(2,943)	29
30	V	02 Food		Care Centers Health Systems, Inc.	100.00%			30
31	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			31
32	V	10 Nursing		Care Centers Health Systems, Inc.	100.00%			32
33	V	22 Employee Benefits		Care Centers Health Systems, Inc.	100.00%			33
34	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			34
35	V	39 Ancillary	25,514	Care Centers Health Systems, Inc.	100.00%	10,185	(15,329)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	10,556	10,556	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	10,778	10,778	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	4,607	4,607	38
39	Total		\$ 30,413			\$ 51,452	\$ * 21,039	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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number Center Home Hispanic Elderly N # 0048520 Report Period Beginning: 01/01/09 Ending: 12/31/09

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Shareholder	Administrative	4.50%	See Attached	1.10	3.60%		\$		1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.02	3.60%	Alloc. Salary	6,118	17-7	2
3	Adam Vales	Shareholder	Clerical	7.05%	See Attached	0.87	2.10%	Alloc. Salary	1,564	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 7,682		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 Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N # 0048520 Report Period Beginning: 01/01/09 Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Extended Care 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

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	30	\$ 6,770	\$	50,556	\$ 249	1
2	02	Food	Patient Days	30	15,058		50,556	553	2
3	03	Housekeeping	Patient Days	30	14,059		50,556	517	3
4	05	Utilities	Patient Days	30	57,646		50,556	2,118	4
5	06	Maintenance	Patient Days	30	89,465		50,556	3,287	5
6	17	Administrative	Patient Days	30	66,000		50,556	2,425	6
7	19	Professional Fees	Patient Days	30	285,482		50,556	10,489	7
8	20	Dues and Subscriptions	Patient Days	30	56,488		50,556	2,075	8
9	21	Office and Clerical	Patient Days	30	462,313		50,556	16,985	9
10	24	Seminar and Travel	Patient Days	30	1,768		50,556	65	10
11	25	Other Staff Admin. Trans.	Patient Days	30	10,309		50,556	379	11
12	26	Insurance	Patient Days	30	22,668		50,556	833	12
13	30	Depreciation	Patient Days	30	115,549		50,556	4,245	13
14	32	Interest	Patient Days	30	1,698,489		50,556	62,402	14
15	33	Real Estate Taxes	Patient Days	30	55,709		50,556	2,047	15
16	34	Rent - Building	Patient Days	30	96,636		50,556	3,550	16
17	35	Rent - Equipment & Auto	Patient Days	30	68,244		50,556	2,507	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,122,653	\$		\$ 114,726	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	06	Maintenance (Pooled)	Patient Days	1,376,056	30	219,177	219,177	50,556	8,053	1
2	06	Maintenance (Direct)	Direct		30	82,905	82,905		250	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,376,056	30	37,501		50,556	1,378	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		30	8,464	8,464		10	4
5	17	Administrative (Pooled)	Patient Days	1,376,056	30	239,303	239,303	50,556	8,792	5
6	21	Office and Clerical (Pooled)	Patient Days	1,376,056	30	3,599,211	3,599,211	50,556	132,234	6
7	21	Office and Clerical (Direct)	Direct		30	654,174			35,937	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,376,056	30	615,819	615,819	50,556	22,625	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		30	73,650	73,650	50,556	1,415	9
10	22	Employee Benefits								10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 5,530,203	\$ 4,838,529		\$ 210,694	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Extended Care Clinical LLC

Street Address

2201 West Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905-3000

Fax Number

(847) 905-3030

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	30	\$ 1,549	\$	50,556	\$ 57	1
2	05	Utilities	Patient Days	30	3,693		50,556	136	2
3	06	Maintenance	Patient Days	30	477		50,556	18	3
4	19	Professional Fees	Patient Days	30	32,105		50,556	1,180	4
5	20	Dues and Subscriptions	Patient Days	30	213		50,556	8	5
6	21	Office & Clerical	Patient Days	30	27,296		50,556	1,003	6
7	24	Travel and Seminar	Patient Days	30	27,079		50,556	995	7
8	26	Insurance	Patient Days	30	1,342		50,556	49	8
9	30	Depreciation	Patient Days	30	25,586		50,556	940	9
10	32	Interest	Patient Days	30	309,136		50,556	11,358	10
11	33	Real Estate Taxes	Patient Days	30	6,053		50,556	222	11
12	01	Dietary Salary	Patient Days	30	117,506	117,506	50,556	4,317	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	30	17,040		50,556	626	13
14	10	Nursing Salary	Patient Days	30	799,889	799,889	50,556	29,388	14
15	10a	Rehab Salary	Patient Days	30	45,993	45,993	50,556	1,690	15
16	12	Social Service Salary	Patient Days	30	247,396	247,396	50,556	9,089	16
17	15	Emp. Ben. - Healthcare	Patient Days	30	158,537		50,556	5,825	17
18	17	Administration Salary	Patient Days	30	1,043,375	1,043,375	50,556	38,333	18
19	21	Office Salary	Patient Days	30	206,680	206,680	50,556	7,593	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	30	181,271		50,556	6,660	20
21	10	Nursing Salary	Direct Allocation		494,488	494,488	50,556	24,519	21
22	12	Social Service Salary	Direct Allocation		196,033	196,033		2,336	22
23	15	Emp. Ben. - Healthcare	Direct Allocation		82,560			5,918	23
24									24
25	TOTALS				\$ 4,025,296	\$ 3,151,360		\$ 152,260	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		\$ 286	1
2	3	Housekeeping	Direct Allocation					17,532	2
3	4	Laundry	Direct Allocation					13,178	3
4	6	Repairs & Maintenance	Direct Allocation					155	4
5	10	Nursing	Direct Allocation					85,256	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					460	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					90,998	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 207,865	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 149,041	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				\$	\$		\$ 149,041	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Vent Lease, LLC

Street Address

2201 W. Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 674-1180

Fax Number

(847) 673-7741

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Repairs	Direct Billing	821,185	26	\$ 80,807	\$ 32,780	\$ 3,226	1
2	19	Professional Fees	Direct Billing	821,185	26	4,427	32,780	177	2
3	21	Office and Clerical	Direct Billing	821,185	26	6,852	32,780	274	3
4	25	Auto Expense / Travel	Direct Billing	821,185	26	356	32,780	14	4
5	26	Insurance	Direct Billing	821,185	26	4,573	32,780	183	5
6	30	Depreciation	Direct Billing	821,185	26	218,810	32,780	8,394	6
7	32	Interest	Direct Billing	821,185	26	35,420	32,780	1,414	7
8	30	Depreciation - Matrix	Patient Days	1,376,056	30	300,546	50,556	11,042	8
9	32	Interest - Matrix	Patient Days	1,376,056	30	54,323	50,556	1,996	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 706,114	\$	\$ 26,720	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Gross Billable Income	3,421,940	26	72,652	228,954	4,861	1
2	03	Housekeeping	Gross Billable Income	3,421,940	26		228,954		2
3	05	Heat and Other Utilities	Gross Billable Income	3,421,940	26	5,507	228,954	368	3
4	06	Maintenance	Gross Billable Income	3,421,940	26	4,211	228,954	282	4
5	19	Professional Fees	Gross Billable Income	3,421,940	26	5,880	228,954	393	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	3,421,940	26	2,401	228,954	161	6
7	21	Clerical and General Office	Gross Billable Income	3,421,940	26	29,869	228,954	1,998	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	3,421,940	26	4,509	228,954	302	8
9	26	Insurance	Gross Billable Income	3,421,940	26	11,210	228,954	750	9
10	30	Depreciation	Gross Billable Income	3,421,940	26	11,528	228,954	771	10
11	32	Interest	Gross Billable Income	3,421,940	26		228,954		11
12	33	Real Estate Taxes	Gross Billable Income	3,421,940	26		228,954		12
13	34	Rent - Building	Gross Billable Income	3,421,940	26	51,522	228,954	3,447	13
14	35	Rent - Equipment	Gross Billable Income	3,421,940	26	547	228,954	37	14
15	01	Dietary	Direct Billable Income	206,522	26	82,445	4,899	1,956	15
16	02	Food	Direct Billable Income	2,784	26	1,111			16
17	03	Housekeeping	Direct Billable Income		26				17
18	10	Nursing	Direct Billable Income	5,466	26	2,182			18
19	22	Employee Benefits	Direct Billable Income	411	26	164			19
20	25	Other Admin. Staff Transport.	Direct Billable Income		26				20
21	39	Ancillary	Direct Billable Income	3,206,757	26	1,280,152	25,514	10,185	21
22	17	Administrative	Gross Billable Income	3,421,940	26	157,769	157,769	10,556	22
23	21	Clerical and General Office	Gross Billable Income	3,421,940	26	161,081	161,081	10,778	23
24	27	Employee Benefits	Gross Billable Income	3,421,940	26	68,860	228,954	4,607	24
25	TOTALS					\$ 1,953,599	\$ 318,850	\$ 51,452	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	US Bank		X	Term Loan				\$ 6,240,000	\$ 4,786,485		\$ 366,788	1							
2												2							
3												3							
4												4							
5	See Supplemental Schedule											5							
Working Capital																			
6	US Bank		X	Line of Credit					897,314			18,756	6						
7	Various		X	Line of Credit					715,000			12,634	7						
8	See Supplemental Schedule								1,697,217			32,462	8						
9	TOTAL Facility Related							\$ 6,240,000	\$ 8,096,016		\$ 430,639	9							
B. Non-Facility Related*																			
10	Interest Income		X									(22)	10						
11	IL Department Employ. Sec.		X									3,314	11						
12	Allocated from EC Consulting		X									62,402	12						
13	See Supplemental Schedule											14,768	13						
14	TOTAL Non-Facility Related							\$	\$		\$	80,462	14						
15	TOTALS (line 9+line14)							\$ 6,240,000	\$ 8,096,016		\$	511,101	15						

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	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	Shareholder Loan		X	Line of Credit			\$	\$ 1,697,217			\$ 32,462	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital																			
	B. Non-Facility Related*																			
15	Allocated from EC Clinical		X				\$	\$			\$ 11,358	15								
16	Allocated from Vent Lease		X								3,410	16								
17												17								
18												18								
19												19								
20	TOTAL Non-Facility Related																			
											14,768	20								

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,149 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>55,145</u>	<u>2006</u>	<u>\$ 104,706</u>	<u>1</u>
2	<u>Allocated from EC Consulting/EC Clinical 2201 Main</u>			<u>13,484</u>	<u>2</u>
3	TOTALS	<u>55,145</u>		<u>\$ 118,190</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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	Related Building Company (Pages 12F & 12G)	5,134,305	131,649		131,649		422,373	67
68	Related Party Allocations (Pages 12H & 12I)	53,350	3,643		3,643		22,197	68
69	Financial Statement Depreciation		132,924			(132,924)		69
70	TOTAL (lines 4 thru 69)	\$ 5,187,655	\$ 268,216		\$ 135,292	\$ (132,924)	\$ 444,570	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,187,655	\$ 268,216		\$ 135,292	\$ (132,924)	\$ 444,570	1
2	Seco Regifrigerator - Walk In Cooler Repair	2006	3,345		20	478	478	1,473	2
3	Repaired Elev Hoist Motor	2007	3,000		20	150	150	363	3
4	Decorative Fixtures	2007	4,769		20	477	477	1,153	4
5	Air Systems	2007	4,984		20	249	249	540	5
6	Carpeting	2007	4,399		20	628	628	1,362	6
7	Reception Station	2007	15,000		20	750	750	1,625	7
8	Boiler Repair	2007	3,020		20	151	151	365	8
9	Phone System	2008	3,864		20	386	386	741	9
10	Painting (Transfer From Home Office)	2008	16,809		20	1,401	1,401	16,809	10
11	Wiring	2008	7,800		20	390	390	683	11
12	Painting (Transfer From Home Office)	2008	9,851		20	2,463	2,463	9,851	12
13	Drive Unit	2008	6,500		20	325	325	569	13
14	Painting (Transfer From Home Office)	2008	16,257		20	5,419	5,419	16,257	14
15	Second Floor Patio	2008	129,000		20	6,450	6,450	10,213	15
16	Painting (Transfer From Home Office)	2008	8,785		20	3,660	3,660	8,785	16
17	Painting (Transfer From Home Office)	2008	8,057		20	4,029	4,029	8,057	17
18	Painting (Transfer From Home Office)	2008	12,827		20	7,482	7,482	12,827	18
19	Painting (Transfer From Home Office)	2008	21,271		20	1,064	1,064	1,418	19
20	Masonry Restoration	2008	29,230		20	1,462	1,462	1,949	20
21	Paint	2008	5,149		20	257	257	343	21
22	Painting (Transfer From Home Office)	2008	6,982		20	349	349	436	22
23	Masonry Restoration	2008	3,820		20	191	191	239	23
24	Roof Repair	2008	2,950		20	148	148	184	24
25	Magnetic Doors	2008	3,300		20	165	165	206	25
26	Painting (Transfer From Home Office)	2008	6,725		20	5,604	5,604	6,725	26
27	Electric Lines	2008	6,575		20	329	329	384	27
28	Painting	2008	3,500		20	2,917	2,917	3,500	28
29	Home Office - Painting	2008	7,359		20	6,746	6,746	7,359	29
30	Tile	2008	30,793		20	2,053	2,053	2,224	30
31	Blinds	2008	7,552		20	755	755	818	31
32	Steam Vacuum Repair	2008	5,400		20	270	270	293	32
33	Painting	2009	7,543		20	7,543	7,543	7,543	33
34	TOTAL (lines 1 thru 33)		\$ 5,594,071	\$ 268,216		\$ 200,033	\$ (68,183)	\$ 444,570	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,594,071	\$ 268,216		\$ 200,033	\$ (68,183)	\$ 444,570	1
2	Tile	2009	5,865		20	293	293	293	2
3	Boiler Repair	2009	10,100		20	505	505	505	3
4	Painting	2009	12,088		20	11,081	11,081	11,081	4
5	Painting	2009	11,210		20	9,342	9,342	9,342	5
6	Painting	2009	5,831		20	4,373	4,373	4,373	6
7	Painting	2009	5,706		20	3,804	3,804	3,804	7
8	Painting	2009	5,185		20	3,025	3,025	3,025	8
9	Wall A/C Unit	2009	3,197		20	373	373	373	9
10	Painting	2009	4,356		20	2,178	2,178	2,178	10
11	Painting	2009	2,544		20	1,060	1,060	1,060	11
12	Drywall, Dropceiling & Light Fixtures	2009	4,400		20	92	92	92	12
13	Painting	2009	4,762		20	642	642	642	13
14	Boiler Repair	2009	4,450		20	93	93	93	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,673,765	\$ 268,216		\$ 236,894	\$ (31,322)	\$ 444,570	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 5,673,765	\$ 268,216		\$ 236,894	\$ (31,322)	\$ 444,570
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)	\$ 5,673,765	\$ 268,216		\$ 236,894	\$ (31,322)	\$ 444,570

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 5,673,765	\$ 268,216		\$ 236,894	\$ (31,322)	\$ 444,570	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,673,765	\$ 268,216		\$ 236,894	\$ (31,322)	\$ 444,570	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	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	Center Home Property, LLC - 156 Bed Facility	1954	5,134,305	131,649	39	131,649		422,373	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)	\$ 5,134,305	\$ 131,649		\$ 131,649	\$	\$ 422,373	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting 2201 Main	2002	16,737	429	39	429		3,129	3
4	Allocated from Extended Care Clinical 2201 Main	2002	1,844	47	39	47		345	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting	2007	169	3	20	3		20	9
10	Allocated from Extended Care Consulting	2009	101	5	20	5		5	10
11									11
12	Allocated from Extended Care Consulting 2201 Main	2002	13,826	1,264	20	1,264		7,594	12
13	Allocated from Extended Care Consulting 2201 Main	2003	16,294	1,489	20	1,489		8,949	13
14	Allocated from Extended Care Consulting 2201 Main	2005	810	86	20	86		292	14
15	Allocated from Extended Care Consulting 2201 Main	2009	146	7	20	7		7	15
16									16
17	Allocated from Extended Care Clinical 2201 Main	2002	1,523	139	20	139		837	17
18	Allocated from Extended Care Clinical 2201 Main	2003	1,795	164	20	164		986	18
19	Allocated from Extended Care Clinical 2201 Main	2005	89	9	20	9		32	19
20	Allocated from Extended Care Clinical 2201 Main	2009	16	1	20	1		1	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 (12H & 12I lines 1 thru 33)	\$ 53,350	\$ 3,643		\$ 3,643	\$	\$ 22,197	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,381,245	\$ 191,357	\$ 186,733	\$ (4,624)	10	\$ 1,035,656	71
72	Current Year Purchases	17,653	16	2,957	2,941	10	27	72
73	Fully Depreciated Assets	116,101				10	104,137	73
74								74
75	TOTALS	\$ 1,514,999	\$ 191,373	\$ 189,690	\$ (1,683)		\$ 1,139,820	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Alloc. Extended Care Consult.	2009	\$ 11,814	\$ 185	\$ 185	\$	5	\$ 11,261	76
77		Alloc. Extended Care Clinical	2009	2,641	528	528		5	1,555	77
78		Alloc. EC Health Systems	2009	1,961	392	392		5	589	78
79										79
80	TOTALS			\$ 16,416	\$ 1,105	\$ 1,105	\$		\$ 13,405	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,323,370	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 460,694	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 427,689	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (33,005)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,597,795	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$ _____			3
4	Additions						4
5	<u>Allocated from EC Consulting</u>			<u>3,550</u>			5
6	<u>Allocated from EC Health Systems</u>			<u>3,447</u>			6
7	TOTAL			\$ <u>6,997</u>			7

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

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

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

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

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

YES NO

16. Rental Amount for movable equipment: \$ 9,188 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1	2		
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	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		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)					Total Cost (Col. 3 + 5 + 6)
			Units of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	206,252	\$			\$	206,252	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				75,050					75,050	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	39 - 03	hrs				204,559					204,559	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						168,172			168,172	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Other (specify):												12
13	Other (specify): See Supplemental						53,660		196,393			250,053	13
14	TOTAL			\$		\$	539,521	\$	364,565	\$		904,086	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 Center Home Hispanic Elderly N# 0048520Report Period Beginning: 01/01/09Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 64,938	\$ 283,278	1
2	Cash-Patient Deposits	49,260	49,260	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,138,221	1,138,221	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	220,762	220,762	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		257,211	8
9	Other(specify): <u>See Attached Schedule</u>	489,492	489,492	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,962,673	\$ 2,438,224	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		104,706	13
14	Buildings, at Historical Cost		5,134,305	14
15	Leasehold Improvements, at Historical Cost	475,123	475,123	15
16	Equipment, at Historical Cost	113,341	1,406,747	16
17	Accumulated Depreciation (book methods)	(225,100)	(1,677,025)	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>	267,583	340,058	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 630,947	\$ 5,783,914	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,593,620	\$ 8,222,138	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 585,548	\$ 585,548	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,547	34,547	28
29	Short-Term Notes Payable	1,612,314	3,309,531	29
30	Accrued Salaries Payable	326,338	326,338	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,312	17,312	31
32	Accrued Real Estate Taxes(Sch.IX-B)	119,606	119,606	32
33	Accrued Interest Payable	11,916	30,971	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	257,211	257,211	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,964,792	\$ 4,681,064	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,786,485	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)	\$	\$ 4,786,485	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,964,792	\$ 9,467,549	46
47	TOTAL EQUITY(page 18, line 24)	\$ (371,172)	\$ (1,245,411)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,593,620	\$ 8,222,138	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (382,625)	1
2	Restatements (describe):		2
3	<u>Real Estate Taxes</u>	3,000	3
4	<u>Rounding</u>	2	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (379,623)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	8,451	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)	\$ 8,451	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)	\$ (371,172)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,529,949	1
2	Discounts and Allowances for all Levels	(1,850,611)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,679,338	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,756,782	6
7	Oxygen	28,637	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,785,419	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	164,304	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,361	19
20	Radiology and X-Ray	6,120	20
21	Other Medical Services	101,136	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 296,921	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	22	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,724	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,724	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,763,424	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,388,154	31
32	Health Care	3,487,467	32
33	General Administration	1,940,482	33
B. Capital Expense			
34	Ownership	949,374	34
C. Ancillary Expense			
35	Special Cost Centers	904,086	35
36	Provider Participation Fee	85,410	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,754,973	40
41	Income before Income Taxes (line 30 minus line 40)**	8,451	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 8,451	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 Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,841	2,071	\$ 85,583	\$ 41.32	1
2	Assistant Director of Nursing	1,071	1,205	41,963	34.82	2
3	Registered Nurses	13,701	15,282	453,702	29.69	3
4	Licensed Practical Nurses	38,335	41,725	1,064,041	25.50	4
5	CNAs & Orderlies	89,843	97,717	1,061,624	10.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,192	9,116	154,367	16.93	8
9	Activity Director	530	718	13,858	19.30	9
10	Activity Assistants	9,113	9,931	82,006	8.26	10
11	Social Service Workers	6,834	7,344	130,721	17.80	11
12	Dietician					12
13	Food Service Supervisor	1,917	2,125	43,668	20.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,822	7,558	84,776	11.22	15
16	Dishwashers	14,344	15,205	126,890	8.35	16
17	Maintenance Workers	7,934	9,069	154,062	16.99	17
18	Housekeepers	20,208	22,024	193,770	8.80	18
19	Laundry	9,056	9,873	103,179	10.45	19
20	Administrator	2,240	2,505	113,378	45.26	20
21	Assistant Administrator	2,016	2,085	71,911	34.49	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,238	10,280	133,750	13.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,945	2,238	34,123	15.25	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,882	2,099	24,310	11.58	33
34	TOTAL (lines 1 - 33)	247,062	270,170	\$ 4,171,682 *	\$ 15.44	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	268	\$ 13,400	01-03	35
36	Medical Director	Monthly	24,024	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,547	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	<u>See Attached - Extended Care Allocation</u>		26,855		48
49	TOTAL (lines 35 - 48)	268	\$ 68,826		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	113	\$ 5,928	10-03	50
51	Licensed Practical Nurses	2,375	92,214	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,488	\$ 98,142		53

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Norme Torres	Administrator	0	\$ 113,378	Workers' Compensation Insurance	\$ 89,876	IDPH License Fee	\$ 1,990	
Angel Aguilar	Assist. Admin.	0	71,911	Unemployment Compensation Insurance	48,537	Advertising: Employee Recruitment	12,364	
				FICA Taxes	315,811	Health Care Worker Background Check		
				Employee Health Insurance	99,648	(Indicate # of checks performed <u>121</u>)	2,522	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		<u>IL Council On LTC</u>	12,340	
				City Payroll Tax	7,828	Dues & Subscriptions	2,328	
				Employee Physicals	507	Licenses & Fees	557	
				Other Employee Welfare	15,580	Allocated from EC Consulting	2,075	
				Holiday Expense	1,989	See Supplemental Schedule	169	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 185,289	TOTAL (agree to Schedule V, line 22, col.8)	\$ 579,775	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 34,345	
(List each licensed administrator separately.)								
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	
							Seminar Expense	8,682
							Allocated from EC Consulting	65
							Allocated from EC Clinical	995
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL	\$ 9,742
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
Frost, Ruttenberg & Rothblatt	Accounting		\$ 20,267					
Paycor	Payroll Processing		11,774					
ADP	Payroll Processing		1,036					
Ehealth Data Solutions	MDS Software		3,180					
XKZero	IT Consulting		228					
National Datacare Corporation	Data Processing		1,206					
Personnel Planners	Unemployment Tax Cons.		3,500					
Allegiance	Employee Compliance		56					
Pinnacle Consulting	Customer Satisfaction		2,857					
Extened Care Consulting	Other Professional Fees		5,600					
US Bank	Appraisal Fee		5,139					
See Supplemental Schedule			346,120					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 400,963					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
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 Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/09

Ending:

12/31/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council On LTC - \$11,840
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 53,211 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 85,410
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.