

Facility Name & ID Number Danville Care Center

0032862 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	118	Skilled (SNF)	118	43,070	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	29,930	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			4,030	4,030	8
9	SNF/PED					9
10	ICF	29,326	4,118	1,542	34,986	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,326	4,118	5,572	39,016	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.45%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/01/1987

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/01/1987 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 118 and days of care provided 4,030

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Danville Care Center # 0032862 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	193,475	25,607	12,143	231,225		231,225		231,225		1
2	Food Purchase		213,250		213,250		213,250	(225)	213,025		2
3	Housekeeping	178,617	53,002		231,619		231,619	(1,017)	230,602		3
4	Laundry	45,829	15,873		61,702		61,702		61,702		4
5	Heat and Other Utilities			180,834	180,834		180,834		180,834		5
6	Maintenance	60,050	39,140	34,851	134,041		134,041	12,156	146,197		6
7	Other (specify):*										7
8	TOTAL General Services	477,971	346,872	227,828	1,052,671		1,052,671	10,915	1,063,586		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,545,583	54,334	153,249	1,753,166		1,753,166	9,983	1,763,149		10
10a	Therapy	23,469	1,368	1,260	26,097		26,097	(585)	25,512		10a
11	Activities	55,418	2,213		57,631		57,631		57,631		11
12	Social Services	68,852		4,304	73,156		73,156		73,156		12
13	CNA Training										13
14	Program Transportation			40	40		40		40		14
15	Other (specify):*							4,788	4,788		15
16	TOTAL Health Care and Programs	1,693,322	57,915	167,853	1,919,090		1,919,090	14,186	1,933,276		16
	C. General Administration										
17	Administrative	128,310		84,840	213,150		213,150	472	213,622		17
18	Directors Fees										18
19	Professional Services			303,364	303,364	(9,750)	293,614	(259,496)	34,118		19
20	Dues, Fees, Subscriptions & Promotions			27,540	27,540		27,540	(11,267)	16,273		20
21	Clerical & General Office Expenses	89,708	7,203	124,943	221,854		221,854	47,996	269,850		21
22	Employee Benefits & Payroll Taxes			349,321	349,321		349,321		349,321		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,238	2,238		2,238	57	2,295		24
25	Other Admin. Staff Transportation			17,591	17,591		17,591	686	18,277		25
26	Insurance-Prop.Liab.Malpractice			141,312	141,312		141,312	(15,391)	125,921		26
27	Other (specify):*							29,637	29,637		27
28	TOTAL General Administration	218,018	7,203	1,051,149	1,276,370	(9,750)	1,266,620	(207,305)	1,059,315		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,389,311	411,990	1,446,830	4,248,131	(9,750)	4,238,381	(182,205)	4,056,176		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Danville Care Center

#0032862

Report Period Beginning:

01/01/09

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			70,907	70,907		70,907	159,102	230,009			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			64,611	64,611		64,611	453,766	518,377			32
33	Real Estate Taxes			78,114	78,114	9,750	87,864		87,864			33
34	Rent-Facility & Grounds			643,900	643,900		643,900	(634,852)	9,048			34
35	Rent-Equipment & Vehicles			11,683	11,683		11,683	5,100	16,783			35
36	Other (specify):*											36
37	TOTAL Ownership			869,215	869,215	9,750	878,965	(16,884)	862,081			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		308,052	367,252	675,304		675,304		675,304			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):*	35,365			35,365		35,365	(35,365)	0			43
44	TOTAL Special Cost Centers	35,365	308,052	476,752	820,169		820,169	(35,365)	784,804			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,424,676	720,042	2,792,797	5,937,515		5,937,515	(234,453)	5,703,062			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Danville Care Center**

0032862

Report Period Beginning:

01/01/09

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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	(2,848)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,889	30		9
10	Interest and Other Investment Income	(47)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(225)	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	(469)	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	(74,030)	21		24
25	Fund Raising, Advertising and Promotional	(8,766)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,851)	20		28
29	Other-Attach Schedule	(141,796)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (226,142)		\$	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)	(8,311)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (8,311)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (234,453)		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

SEE ACCOUNTANTS' COMPILATION REPORT

BHF USE ONLY							
48		49		50		51	52

Danville Care Center

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Report Period Beginning: 01/01/09

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Purchases Services- Veteran	\$ (12,942)	10	1
2	Marketing	(35,365)	43	2
3	Bank Charges	(4,819)	21	3
4	Theft & Damage Loss	(60)	21	4
5	Non-Allowable Legal	(35,380)	19	5
6	Prior Period Agency Costs	(2,236)	10	6
7	Amortization- Building Co.	(26,667)	31	7
8	Licenses and Permits- Building Co.	(150)	20	8
9	Title Fees- Building Co.	(225)	20	9
10	Additional R&M	14,118	06	10
11	Marketing Travel	(4,632)	25	11
12	Prior Period PT Consultant	(585)	10a	12
13	Prior Period Housekeeping Supply	(1,017)	03	13
14	Prior Period Prog. Liab. Insurance	(17,836)	26	14
15	Non Allowable Interest Expense	(14,000)	32	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	(141,796)		49

Danville Care CenterID# 0032862Report Period Beginning: 01/01/09Ending: 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 Danville Care Center# 0032862

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													1
2	Food Purchase	(225)											(225)	2
3	Housekeeping	(1,017)											(1,017)	3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	11,270		886									12,156	6
7	Other (specify):*													7
8	TOTAL General Services	10,028		886									10,915	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(15,178)		25,161									9,983	10
10a	Therapy	(585)											(585)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			4,788									4,788	15
16	TOTAL Health Care and Programs	(15,763)		29,949									14,186	16
	C. General Administration													
17	Administrative			472									472	17
18	Directors Fees													18
19	Professional Services	(35,380)		(224,116)									(259,496)	19
20	Fees, Subscriptions & Promotions	(11,992)	375	350									(11,267)	20
21	Clerical & General Office Expenses	(79,378)		127,374									47,996	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			57									57	24
25	Other Admin. Staff Transportation	(4,632)		5,318									686	25
26	Insurance-Prop.Liab.Malpractice	(17,836)		2,445									(15,391)	26
27	Other (specify):*			29,637									29,637	27
28	TOTAL General Administration	(149,218)	375	(58,462)									(207,305)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(154,953)	375	(27,627)									(182,205)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Danville Care Center

0032862

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	4,889	152,666	1,547									159,102	30
31	Amortization of Pre-Op. & Org.	(26,667)	26,667											31
32	Interest	(14,047)	467,813										453,766	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(643,900)	9,048									(634,852)	34
35	Rent-Equipment & Vehicles			5,100									5,100	35
36	Other (specify):*													36
37	TOTAL Ownership	(35,825)	3,246	15,695									(16,884)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(35,365)											(35,365)	43
44	TOTAL Special Cost Centers	(35,365)											(35,365)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(226,142)	3,621	(11,932)									(234,453)	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		Certified Health Management	Skokie	
				Danville Care Ctr.	Skokie	Management

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	34 Rent	\$ 643,900	Danville Care Center, LLC		\$	(643,900)	1	
2	V	31 Amortization		Danville Care Center, LLC		26,667	26,667	2	
3	V	32 Interest- Mortgage		Danville Care Center, LLC		457,167	457,167	3	
4	V	32 Interest- Addtl Note		Danville Care Center, LLC		10,646	10,646	4	
5	V	20 Licenses and Permits		Danville Care Center, LLC		150	150	5	
6	V	20 Title Fees		Danville Care Center, LLC		225	225	6	
7	V	30 Depreciation		Danville Care Center, LLC		152,666	152,666	7	
8	V							8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 643,900			\$ 647,521	\$ *	3,621	14

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

Facility Name & ID Number Danville Care Center# 0032862Report Period Beginning: 01/01/09Ending: 12/31/09

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 AUTO REPAIRS	\$	CERTIFIED HEALTH MANAGEMENT	100.00%	\$ 886	\$	886	15
16	V	10 NURSING				25,161		25,161	16
17	V	15 EMP. BEN. HEALTHCARE				4,788		4,788	17
18	V	20 DUES, FEES, SUBSCRIPTIONS				350		350	18
19	V	21 SALARIES - CLERICAL				110,365		110,365	19
20	V	21 OFFICE EXPENSES				17,009		17,009	20
21	V	24 SEMINAR EXPENSE				57		57	21
22	V	25 AUTO & TRAVEL EXPENSE				5,318		5,318	22
23	V	26 INSURANCE				2,445		2,445	23
24	V	27 EMP. BEN. GEN. ADMIN.				17,125		17,125	24
25	V	30 DEPRECIATION				1,547		1,547	25
26	V	34 RENT				9,048		9,048	26
27	V	35 AUTO LEASE				5,100		5,100	27
28	V								28
29	V	17 ADMIN COMP - B. ALTER				77,187		77,187	29
30	V	17 ADMIN COMP - H. GELLER				8,125		8,125	30
31	V	27 EMP. BEN. - B. ALTER				12,512		12,512	31
32	V								32
33	V								33
34	V								34
35	V	17 MANAGEMENT FEES	84,840					(84,840)	35
36	V	19 BOOKEEPING FEES	198,864					(198,864)	36
37	V	19 ADMIN.-CONSULT FEES	25,252					(25,252)	37
38	V								38
39	Total		\$ 308,956			\$ 297,024	\$ *	(11,932)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	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.

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.

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.

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.

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.

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

Danville Care Center

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0032862

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	Bradley Alter	Owner	Administration	22.83%	See Attached	19.00	39.58%	Alloc Sal.	\$ 77,188	17-7	1
2	Howard Geller	Relative	Administration	0.00%	See Attached	5.00	12.50%	Mgmt. Fees	8,125	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 85,313		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 Danville Care Center

0032862

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 Danville Care Center

0032862

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 CERTIFIED HEALTH MANAGEMENT
 Street Address 3856 W. OAKTON
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 674-4700
 Fax Number (847) 674-4733

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	AUTO REPAIRS	PATIENT DAYS	155,231	4	\$ 3,526	\$ 39,016	\$ 886	1	
2	10	NURSING	PATIENT DAYS	155,231	4	100,106	100,106	39,016	25,161	2
3	15	EMP. BEN. HEALTHCARE	PATIENT DAYS	155,231	4	19,050	39,016	4,788	3	
4	20	DUES, FEES, SUBSCRIPTIONS	PATIENT DAYS	155,231	4	1,394	39,016	350	4	
5	21	SALARIES - CLERICAL	PATIENT DAYS	155,231	4	439,103	439,103	39,016	110,365	5
6	21	OFFICE EXPENSES	PATIENT DAYS	155,231	4	67,675	39,016	17,009	6	
7	24	SEMINAR EXPENSE	PATIENT DAYS	155,231	4	228	39,016	57	7	
8	25	AUTO & TRAVEL EXPENSE	PATIENT DAYS	155,231	4	21,157	39,016	5,318	8	
9	26	INSURANCE	PATIENT DAYS	155,231	4	9,727	39,016	2,445	9	
10	27	EMP. BEN. GEN. ADMIN.	PATIENT DAYS	155,231	4	68,135	39,016	17,125	10	
11	30	DEPRECIATION	PATIENT DAYS	155,231	4	6,155	39,016	1,547	11	
12	34	RENT	PATIENT DAYS	155,231	4	36,000	39,016	9,048	12	
13	35	AUTO LEASE	PATIENT DAYS	155,231	4	20,290	20,290	39,016	5,100	13
14									14	
15	17	ADMIN COMP - B. ALTER	AVG. HOURS WORKED	48	4	195,000	195,000	19	77,187	15
16	17	ADMIN COMP - H. GELLER	AVG. HOURS WORKED	40	4	65,000		5	8,125	16
17	27	EMP. BEN. - B. ALTER	AVG. HOURS WORKED	48	4	31,608		19	12,512	17
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,084,155	\$ 754,499	\$ 297,024	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center

0032862

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

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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

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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

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Facility Name & ID Number Danville Care Center

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Report Period Beginning:

01/01/09

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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

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Report Period Beginning:

01/01/09

Ending: 12/31/09

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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

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Report Period Beginning:

01/01/09

Ending: 12/31/09

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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 Danville Care Center

0032862 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 Danville Care Center

0032862

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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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

Danville Care Center

0032862

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	Enloe		X	Notes Payable			\$	\$ 241,675		\$ 14,824	1								
2	Rehab Care		X	Notes Payable				166,228		3,334	2								
3	Barry Kirschenbaum		X	Mortgage Payable				5,192,135		467,813	3								
4											4								
5	See Supplemental Schedule										5								
Working Capital																			
6	Bank Financial		X	Line Of Credit				446,841		29,830	6								
7											7								
8	See Supplemental Schedule									2,623	8								
9	TOTAL Facility Related						\$	\$ 6,046,879		\$ 518,424	9								
B. Non-Facility Related*																			
10	Interest Income		X							(47)	10								
11											11								
12											12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related						\$	\$		(47)	14								
15	TOTALS (line 9+line14)						\$	\$ 6,046,879		\$ 518,377	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Danville Care Center

0032862

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										7									
Working Capital																				
8	Insurance Financing		X							2,623	8									
9											9									
10											10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital										2,623	14								
B. Non-Facility Related*																				
15											15									
16											16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related										20									

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

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 Danville Care Center

0032862 Report Period Beginning:

01/01/09 Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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).

N/A

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center

0032862

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		
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	Various		1989	34,167		20	854	854	34,167	9
10	Various		1990	17,344		20	867	867	17,344	10
11	Various		1991	45,376		20	2,269	2,269	41,973	11
12	Various		1992	12,043		20	602	602	10,588	12
13	Various		1993	9,213		20	461	461	7,601	13
14	Various		1994	8,304		20	415	415	6,436	14
15	Various		1995	39,047		20	1,952	1,952	27,984	15
16	Various		1996	44,007		20	2,201	2,201	29,518	16
17	Various		1997	28,811		20	1,441	1,441	18,007	17
18	Various		1998	394,658		20	19,733	19,733	236,795	18
19	Various		1999	42,329		20	2,117	2,117	22,223	19
20	Various		2000	51,980		20	2,599	2,599	24,852	20
21	Various		2001	1,377		20	69	69	585	21
22	Various		2002	11,592		20	580	580	4,130	22
23	Various		2003	122,592		20	6,130	6,130	39,855	23
24	Various		2004	68,558		20	3,428	3,428	18,376	24
25	Various		2005	83,307		20	4,167	4,167	18,963	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)	2,954,225	152,666		152,666		1,831,998	67
68	Related Party Allocations (Pages 12H & 12I)	23,682	607		1,184	577	15,393	68
69	Financial Statement Depreciation		70,907			(70,907)		69
70	TOTAL (lines 4 thru 69)	\$ 3,992,612	\$ 224,180		\$ 203,735	\$ (20,445)	\$ 2,406,788	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Danville Care Center

0032862

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		\$ 3,992,612	\$ 224,180		\$ 203,735	\$ (20,445)	\$ 2,406,788	1
2	Sidewalks	2006	6,658		20	333	333	1,165	2
3	Door Replacement	2006	12,000		20	600	600	2,100	3
4	Roof Repairs	2006	5,000		20	250	250	875	4
5	Concrete Replacement North Bldg	2006	1,900		20	95	95	333	5
6	Handrails In Hallways	2006	6,103		20	305	305	1,068	6
7	Thru Wall Ac Units	2006	1,631		20	82	82	285	7
8	Generator Repair / Upgrade	2006	2,550		20	128	128	446	8
9	Rooftop A/C Unit	2006	6,908		20	345	345	1,209	9
10	Hot/Cold Water Line / Mixing Valve	2006	10,702		20	535	535	1,873	10
11	Adjustment To State Database	2006	(6,659)		20	(333)	(333)	(1,027)	11
12	Steel Entry Doors	2007	1,800		20	90	90	270	12
13	Steel Entry Doors	2007	1,859		20	93	93	279	13
14	Steel Entry Doors	2007	1,482		20	74	74	222	14
15	Steel Entry Doors	2007	1,039		20	52	52	156	15
16	Water Heater	2008	5,520		20	276	276	506	16
17	Glass Replacement In Doors	2008	938		20	47	47	78	17
18	Blower Motor, Capacitor, Circuit Board	2008	668		20	33	33	50	18
19	Vinyl Fence And Materials	2008	5,398		20	270	270	382	19
20	Water Guages/Sprinkler Heads	2008	641		20	32	32	45	20
21	Compressor For Cooler	2008	675		20	135	135	225	21
22	2 Hollow Metal Doors	2008	1,155		20	58	58	82	22
23	1 Kitchen Hood	2009	10,500		20	525	525	525	23
24	Roof Repairs	2009	24,407		20	915	915	915	24
25	Refrigeration & Heating -Hood & Exhaust Fan	2009	10,500		20	1,400	1,400	1,400	25
26	Security Cameras	2009	11,025		20	184	184	184	26
27	Phone System	2009	3,115		20	156	156	156	27
28	Fence	2009	6,480		20	180	180	180	28
29	Concrete Work	2009	2,600		20	116	116	116	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,129,207	\$ 224,180		\$ 210,711	\$ (13,469)	\$ 2,420,886	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		\$ 4,129,207	\$ 224,180		\$ 210,711	\$ (13,469)	\$ 2,420,886	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)	\$ 4,129,207	\$ 224,180		\$ 210,711	\$ (13,469)	\$ 2,420,886	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		\$ 4,129,207	\$ 224,180		\$ 210,711	\$ (13,469)	\$ 2,420,886
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)	\$ 4,129,207	\$ 224,180		\$ 210,711	\$ (13,469)	\$ 2,420,886

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		\$ 4,129,207	\$ 224,180		\$ 210,711	\$ (13,469)	\$ 2,420,886
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)	\$ 4,129,207	\$ 224,180		\$ 210,711	\$ (13,469)	\$ 2,420,886

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	Danville Care Center, LLC	1974	2,954,225	152,666		152,666		1,831,998	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		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 2,954,225	\$ 152,666		\$ 152,666	\$	\$ 1,831,998

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									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocation- CHM	1997	23,682	607		1,184	577	15,393	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 (12H & 12I lines 1 thru 33)	\$ 23,682	\$ 607		\$ 1,184	\$ 577	\$ 15,393	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Danville Care Center

0032862

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	\$ 203,973	\$ 940	\$ 15,776	\$ 14,836	10	\$ 163,969	71
72	Current Year Purchases	14,098		1,954	1,954	10	1,954	72
73	Fully Depreciated Assets	776,738				10	776,738	73
74								74
75	TOTALS	\$ 994,809	\$ 940	\$ 17,730	\$ 16,790		\$ 942,661	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		FORD VAN	1994	\$ 19,594	\$	\$	\$	5	\$ 19,594	76
77		LIFT/TIE DOWNS	2007	8,783		1,568	1,568	5	5,125	77
78		VEHICLE	2000	21,907				5	21,907	78
79										79
80	TOTALS			\$ 50,284	\$	\$ 1,568	\$ 1,568		\$ 46,626	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)	\$ 5,174,300	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 225,120	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 230,009	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,889	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,410,173	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	Allocation- CHM				9,048			5
6								6
7	TOTAL				\$ 9,048			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: \$ 6,254 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	Patient Transport	2005 Ford Wagon Van	\$	\$ 5,429	17
18	Allocation-CHM			5,100	18
19					19
20					20
21	TOTAL		\$	\$ 10,529	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.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

* 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 Drop-outs	2 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	\$		\$	208,029	\$			\$	208,029	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				23,450					23,450	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39 - 03	hrs				164,248					164,248	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				(28,475)		157,391			128,916	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Other (specify):												12	
13	Other (specify): <u>See Supplemental</u>								150,661			150,661	13	
14	TOTAL			\$			\$	367,252	\$	308,052		\$	675,304	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 Danville Care Center# 0032862Report 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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$ 155	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,237,574	1,237,574	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,904	53,904	6
7	Other Prepaid Expenses	16,102	16,102	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	179,180	579,180	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,486,760	\$ 1,886,915	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		350,000	13
14	Buildings, at Historical Cost		5,954,225	14
15	Leasehold Improvements, at Historical Cost	1,161,268	1,161,268	15
16	Equipment, at Historical Cost	700,042	1,000,042	16
17	Accumulated Depreciation (book methods)	(1,052,098)	(3,184,126)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(320,043)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 809,212	\$ 4,961,366	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,295,972	\$ 6,848,281	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 663,348	\$ 663,348	26
27	Officer's Accounts Payable	932,090	932,090	27
28	Accounts Payable-Patient Deposits	94,669	94,669	28
29	Short-Term Notes Payable	750,556	750,556	29
30	Accrued Salaries Payable	110,531	110,531	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,188	12,188	31
32	Accrued Real Estate Taxes(Sch.IX-B)	76,650	76,650	32
33	Accrued Interest Payable	14,134	14,134	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	918,112	626,053	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,572,278	\$ 3,280,219	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	104,188	104,188	39
40	Mortgage Payable		5,192,135	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)	\$ 104,188	\$ 5,296,323	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,676,466	\$ 8,576,542	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,380,494)	\$ (1,728,261)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,295,972	\$ 6,848,281	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,482,296)	1
2	Restatements (describe):		2
3	Workers Comp Ins./ Bad Debt Exp.	(1,812)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,484,108)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	103,614	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)	\$ 103,614	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)	\$ (1,380,494)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center# 0032862Report Period Beginning: 01/01/09Ending: 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	\$ 5,898,026	1
2	Discounts and Allowances for all Levels	(662,082)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,235,944	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	479,390	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 479,390	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	162,495	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,972	19
20	Radiology and X-Ray		20
21	Other Medical Services	150,281	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 325,748	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	47	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 47	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,041,129	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,052,671	31
32	Health Care	1,919,090	32
33	General Administration	1,276,370	33
B. Capital Expense			
34	Ownership	869,215	34
C. Ancillary Expense			
35	Special Cost Centers	710,669	35
36	Provider Participation Fee	109,500	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,937,515	40
41	Income before Income Taxes (line 30 minus line 40)**	103,614	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 103,614	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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 **Danville Care Center**

0032862

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	1,960	2,080	\$ 65,511	\$ 31.50	1
2	Assistant Director of Nursing	1,840	1,880	49,088	26.11	2
3	Registered Nurses	18,156	19,003	497,728	26.19	3
4	Licensed Practical Nurses	7,683	7,907	155,174	19.62	4
5	CNAs & Orderlies	64,072	66,131	685,509	10.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,091	2,267	23,469	10.35	8
9	Activity Director	1,896	2,080	26,957	12.96	9
10	Activity Assistants	3,564	3,564	28,461	7.99	10
11	Social Service Workers	3,969	4,272	44,204	10.35	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,080	33,168	15.95	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,572	7,043	67,171	9.54	15
16	Dishwashers	10,620	10,998	93,136	8.47	16
17	Maintenance Workers	3,927	4,141	60,050	14.50	17
18	Housekeepers	18,617	21,626	178,617	8.26	18
19	Laundry	4,914	5,315	45,829	8.62	19
20	Administrator	1,864	2,080	65,179	31.34	20
21	Assistant Administrator	1,928	2,620	63,131	24.10	21
22	Other Administrative					22
23	Office Manager	1,716	2,080	28,992	13.94	23
24	Clerical	6,989	7,237	60,716	8.39	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	1,850	2,102	26,685	12.70	31
32	Other Health Care(plan coord)	3,038	3,142	65,888	20.97	32
33	Other(specify <u>See Supplemental</u>)	3,037	3,200	60,013	18.75	33
34	TOTAL (lines 1 - 33)	172,287	182,848	\$ 2,424,676 *	\$ 13.26	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	303	\$ 12,143	01-03	35
36	Medical Director	Monthly	9,000	09-03	36
37	Medical Records Consultant	37	1,356	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,400	10-03	39
40	Physical Therapy Consultant	12	585	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	15	675	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	123	4,304	12-03	45
46	Other(specify)				46
47	<u>Psychiatric Consultant</u>	Monthly	2,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	489	\$ 32,463		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	445	\$ 20,936	10-03	50
51	Licensed Practical Nurses	3,272	126,557	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,717	\$ 147,493		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center

0032862

Report Period Beginning: 01/01/09

Ending: 12/31/09

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	
Amy Weir	Administrator	0	\$ 65,179	Workers' Compensation Insurance	\$ 62,969	IDPH License Fee	\$	
Angela Pankey	Asst. Admin.	0	63,131	Unemployment Compensation Insurance	26,841	Advertising: Employee Recruitment	11,816	
				FICA Taxes	179,694	Health Care Worker Background Check		
				Employee Health Insurance	68,830	(Indicate # of checks performed <u>173</u>)	1,908	
				Employee Meals		Patient Background Checks	64	
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	160	
				Pension Contribution	10,987	Licenses & Permits	1,403	
						Advertising	8,766	
						Yellow Page Advertising	2,851	
						See Supplemental Schedule	350	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(8,766)	
						Yellow page advertising	(2,851)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 128,310	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 349,321		\$ 16,273		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees- Certified Health Management			\$ 84,840				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 84,840				Seminar Expense	2,238
							Allocation - CHM	57
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 2,295
C. Professional Services				TOTAL				
Vendor/Payee	Type	Amount						
Paychex	Payroll Processing	\$ 9,757						
Certified Health Management	Clerical Services	198,864						
Certified Health Management	Admin. Consulting	25,252						
Frost, Ruttenberg, & Rothblatt	Accounting	9,200						
Richard Peelo	Accounting	3,750						
Krupnick, Bokor, Brooks, Kagda	Accounting	1,400						
Legal Fees	Adj on Page 5A	35,380						
Personnel Planners	Unemployment Consult.	4,171						
Ehealth Data Solutions	MDS Consulting	4,343						
LTC Solutions	MDS Software	1,500						
Wellspring Partners	Appraisal	9,750						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 303,367	\$				

* 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

