

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	34,612	6,990	8,095	49,697	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,612	6,990	8,095	49,697	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.77%

D. How many bed-hold days during this year were paid by the Department? 11 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 02/01/2003

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/01/2003 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 150 and days of care provided 7,608

Medicare Intermediary National Government Service

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Chateau Nursing & Rehab Center # 0046177 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	333,284	66,904	14,245	414,433		414,433	1,595	416,028		1
2	Food Purchase		297,537		297,537		297,537	(2,069)	295,468		2
3	Housekeeping	180,948	56,714		237,662		237,662	(3,203)	234,459		3
4	Laundry	46,152	30,681		76,833		76,833	(1,275)	75,558		4
5	Heat and Other Utilities			261,637	261,637		261,637	1,156	262,793		5
6	Maintenance	142,736		252,475	395,211		395,211	11,886	407,097		6
7	Other (specify):*							1,815	1,815		7
8	TOTAL General Services	703,120	451,836	528,357	1,683,313		1,683,313	9,904	1,693,217		8
	B. Health Care and Programs										
9	Medical Director			43,000	43,000		43,000		43,000		9
10	Nursing and Medical Records	3,303,783	268,982	56,587	3,629,352		3,629,352	12,179	3,641,531		10
10a	Therapy	199,806			199,806		199,806	3,554	203,360		10a
11	Activities	173,009	40,274		213,283		213,283		213,283		11
12	Social Services	168,764	565	25,829	195,158		195,158	2,543	197,701		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							11,346	11,346		15
16	TOTAL Health Care and Programs	3,845,362	309,821	125,416	4,280,599		4,280,599	29,622	4,310,221		16
	C. General Administration										
17	Administrative	132,891			132,891		132,891	45,606	178,497		17
18	Directors Fees										18
19	Professional Services			472,380	472,380		472,380	(375,698)	96,682		19
20	Dues, Fees, Subscriptions & Promotions			32,066	32,066		32,066	(6,556)	25,510		20
21	Clerical & General Office Expenses	131,361	36,719	127,123	295,203		295,203	72,177	367,380		21
22	Employee Benefits & Payroll Taxes			671,766	671,766		671,766	(22,970)	648,796		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,182	7,182		7,182	1,349	8,531		24
25	Other Admin. Staff Transportation			8,934	8,934		8,934	657	9,591		25
26	Insurance-Prop.Liab.Malpractice			180,472	180,472		180,472	859	181,331		26
27	Other (specify):*							25,839	25,839		27
28	TOTAL General Administration	264,252	36,719	1,499,923	1,800,894		1,800,894	(258,737)	1,542,157		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,812,734	798,376	2,153,696	7,764,806		7,764,806	(219,211)	7,545,595		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	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			56,639	56,639		56,639	73,653	130,292			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							620,197	620,197			32
33	Real Estate Taxes			106,653	106,653		106,653	1,674	108,327			33
34	Rent-Facility & Grounds			492,750	492,750		492,750	(491,713)	1,037			34
35	Rent-Equipment & Vehicles			49,393	49,393		49,393	(5,578)	43,815			35
36	Other (specify):*											36
37	TOTAL Ownership			705,435	705,435		705,435	198,233	903,668			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		679,814	640,938	1,320,752		1,320,752	(100,172)	1,220,580			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):*			127,479	127,479		127,479	(127,479)				43
44	TOTAL Special Cost Centers		679,814	850,542	1,530,356		1,530,356	(227,651)	1,302,705			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,812,734	1,478,190	3,709,673	10,000,597		10,000,597	(248,628)	9,751,969			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	(2,011)	02		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	(13,734)	30		9
10	Interest and Other Investment Income	(21,920)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(418)	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	(17,355)	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	(28,236)	21		24
25	Fund Raising, Advertising and Promotional	(9,166)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(150)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(150,486)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (243,477)		\$	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)	(5,151)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (5,151)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (248,628)		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

Chateau Nursing & Rehab Center

ID# 0046177

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc. Income - Misc. Office Rev	\$ (59)	21	1
2	Misc. Income - PY Professional Fees Refund	(47)	21	2
3	Misc. Income - Dividend Income	(4,593)	32	3
4	Theft Loss	(1,911)	21	4
5	Annual Report	(250)	20	5
6	Non-allowable Legal Expenses	(14,870)	19	6
7	Non-allowable Expense	(127,479)	43	7
8	Bldg. Co. - Legal Fees	(1,685)	19	8
9	Bldg. Co. - Filing Fee	(250)	20	9
10	Bldg. Co. - Amortization	(1,840)	31	10
11	Additional R&M	2,497	06	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(150,486)		49

Chateau Nursing & Rehab Center

ID# 0046177

Report Period Beginning: 01/01/10

Ending: 12/31/10

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chateau Nursing & Rehab Center# 0046177

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			129		3,819		(2,348)			(5)		1,595	1
2	Food Purchase	(2,429)		360									(2,069)	2
3	Housekeeping			462		51					(3,716)		(3,203)	3
4	Laundry										(1,275)		(1,275)	4
5	Heat and Other Utilities			1,049		107							1,156	5
6	Maintenance	2,497		3,015	6,467	106					(199)		11,886	6
7	Other (specify):*				1,280	535							1,815	7
8	TOTAL General Services	68		5,015	7,747	4,618		(2,348)			(5,196)		9,904	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records					24,577					(12,398)		12,179	10
10a	Therapy					3,554							3,554	10a
11	Activities													11
12	Social Services					2,543							2,543	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					4,299	7,047						11,346	15
16	TOTAL Health Care and Programs					34,973	7,047				(12,398)		29,622	16
	C. General Administration													
17	Administrative			2,136	8,296	35,174							45,606	17
18	Directors Fees													18
19	Professional Services	(16,554)	1,685	(283,995)		(76,834)							(375,698)	19
20	Fees, Subscriptions & Promotions	(9,666)	250	2,708		152							(6,556)	20
21	Clerical & General Office Expenses	(47,758)	265	12,655	100,555	6,460							72,177	21
22	Employee Benefits & Payroll Taxes				(15,808)		(7,047)				(115)		(22,970)	22
23	Inservice Training & Education													23
24	Travel and Seminar			132		1,217							1,349	24
25	Other Admin. Staff Transportation			657									657	25
26	Insurance-Prop.Liab.Malpractice			721		138							859	26
27	Other (specify):*				20,204	5,635							25,839	27
28	TOTAL General Administration	(73,978)	2,200	(264,986)	113,247	(28,058)	(7,047)				(115)		(258,737)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(73,911)	2,200	(259,971)	120,994	11,533		(2,348)			(17,708)		(219,211)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chateau Nursing & Rehab Center# 0046177

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(13,734)	82,756	3,895		736							73,653	30
31	Amortization of Pre-Op. & Org.	(1,840)	1,840											31
32	Interest	(26,513)	625,240	7,432		14,038							620,197	32
33	Real Estate Taxes		(1)	1,509		166							1,674	33
34	Rent-Facility & Grounds		(492,750)	1,037									(491,713)	34
35	Rent-Equipment & Vehicles			1,859								(7,437)	(5,578)	35
36	Other (specify):*													36
37	TOTAL Ownership	(42,087)	217,085	15,732		14,940						(7,437)	198,233	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(2,684)	(67,670)	(5,404)	(4,392)	(20,022)	(100,172)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(127,479)											(127,479)	43
44	TOTAL Special Cost Centers	(127,479)						(2,684)	(67,670)	(5,404)	(4,392)	(20,022)	(227,651)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(243,477)	219,285	(244,239)	120,994	26,473		(5,032)	(67,670)	(5,404)	(22,099)	(27,459)	(248,628)	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		
				Chateau Willowbrook 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	\$ 492,750	Chateau Willowbrook Property, LLC	100.00%	\$	(492,750)	1
2	V	32 Interest	6,400	Chateau Willowbrook Property, LLC	100.00%	631,640	625,240	2
3	V	33 RE Taxes	106,653	Chateau Willowbrook Property, LLC	100.00%	106,652	(1)	3
4	V	31 Amortization		Chateau Willowbrook Property, LLC	100.00%	1,840	1,840	4
5	V	30 Depreciation		Chateau Willowbrook Property, LLC	100.00%	82,756	82,756	5
6	V	21 Bank Charges		Chateau Willowbrook Property, LLC	100.00%	265	265	6
7	V	19 Legal		Chateau Willowbrook Property, LLC	100.00%	1,685	1,685	7
8	V	20 Filing Fee		Chateau Willowbrook Property, LLC	100.00%	250	250	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 605,803			\$ 825,088	\$ * 219,285	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%	\$ 129	\$	129	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	360		360	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	462		462	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,049		1,049	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	3,015		3,015	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	2,136		2,136	20
21	V	19 Professional Fees	292,901	Extended Care Consulting, LLC	100.00%	8,906		(283,995)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,708		2,708	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	12,655		12,655	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	132		132	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	657		657	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	721		721	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	3,895		3,895	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	7,432		7,432	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,509		1,509	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	1,037		1,037	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,859		1,859	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 292,901			\$ 48,662	\$ *	(244,239)	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%	6,467	\$	6,467	15
16	V	06 Maintenance (Direct)	2,004	Extended Care Consulting, LLC	100.00%	2,004			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,081		1,081	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	199		199	18
19	V	12 Admission (Direct)		Extended Care Consulting, LLC	100.00%				19
20	V	15 Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%				20
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	8,296		8,296	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	100,555		100,555	22
23	V	21 Office and Clerical (Direct)	20,237	Extended Care Consulting, LLC	100.00%	20,237			23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	18,190		18,190	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	2,014		2,014	25
26	V	22 Employee Benefits	15,808	Extended Care Consulting, LLC	100.00%			(15,808)	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		\$ 38,049			\$ 159,043	\$ *	120,994	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%	\$ 51	\$	51	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	107		107	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	106		106	17
18	V	19 Professional Fees	82,803	Extended Care Clinical, LLC	100.00%	5,969		(76,834)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	152		152	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	1,425		1,425	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,217		1,217	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	138		138	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	736		736	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	14,038		14,038	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	166		166	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	3,819		3,819	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	535		535	27
28	V	10 Nursing Salary		Extended Care Clinical, LLC	100.00%	24,577		24,577	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	3,554		3,554	29
30	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%	2,543		2,543	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	4,299		4,299	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	35,174		35,174	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	5,035		5,035	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	5,635		5,635	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 82,803			\$ 109,276	\$ *	26,473	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary Salary	\$ -	Extended Care Clinical, LLC	100.00%	\$ -	\$ -	15
16	V	07 Emp. Ben. - General		Extended Care Clinical, LLC	100.00%	-	-	16
17	V	10 Nursing Salary	35,268	Extended Care Clinical, LLC	100.00%	35,268	-	17
18	V	12 Social Service Salary	25,233	Extended Care Clinical, LLC	100.00%	25,233	-	18
19	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	7,047	7,047	19
20	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	-	-	20
21	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	-	-	21
22	V	22 Employee Benefits	7,047	Extended Care Clinical, LLC	100.00%		(7,047)	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		\$ 67,548			\$ 67,548	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary Supplies, Supplements	\$ 5,286	Care Centers Health Systems, Inc.	100.00%	\$ 2,938	\$ (2,348)
16	V	10 Nursing Supplies		Care Centers Health Systems, Inc.	100.00%		
17	V	39 Ancillary Expense	6,041	Care Centers Health Systems, Inc.	100.00%	3,358	(2,684)
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 11,327			\$ 6,296	\$ * (5,032)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Therapy	\$ 631,383	TriCare Rehab	100.00%	\$ 563,713	\$ (67,670)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 631,383			\$ 563,713	\$ * (67,670)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 R&M - Equipment	\$	Reliable Medical of the Midwest, LLC	100.00%	\$	\$	15	
16	V	10 Nursing Supplies		Reliable Medical of the Midwest, LLC	100.00%			16	
17	V	39 Ancillary Expense	68,934	Reliable Medical of the Midwest, LLC	100.00%	63,530	(5,404)	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		\$ 68,934			\$ 63,530	\$ *	(5,404)	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	\$ 77	Xcel Supply, LLC	100.00%	\$ 72	\$ (5) 15
16	V	3 Housekeeping	55,771	Xcel Supply, LLC	100.00%	52,054	(3,716) 16
17	V	4 Laundry	19,136	Xcel Supply, LLC	100.00%	17,861	(1,275) 17
18	V	6 Repairs & Maintenance	2,984	Xcel Supply, LLC	100.00%	2,785	(199) 18
19	V	10 Nursing	186,043	Xcel Supply, LLC	100.00%	173,645	(12,398) 19
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	1,719	Xcel Supply, LLC	100.00%	1,604	(115) 24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%		
26	V	39 Ancillary	65,901	Xcel Supply, LLC	100.00%	61,509	(4,392) 26
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		\$ 331,630			\$ 309,530	\$ * (22,099) 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 161,699	\$ 161,699
16	V						
17	V						
18	V						
19	V	22 Employee Health Insurance	161,699	CCS Employee Benefits Group	100.00%		(161,699)
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V	35 Matrix Leasing	\$ 13,837	Vent Lease LLC	100.00%	\$ 6,401	(7,437)
27	V	39 Ventilator Equipment	37,255	Vent Lease LLC	100.00%	17,233	(20,022)
28	V	39 Other Ancillary		Vent Lease LLC	100.00%		
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 212,791			\$ 185,333	\$ * (27,459)

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

Facility Name & ID Number

Chateau Nursing & Rehab Center

0046177

Report Period Beginning:

01/01/10

Ending:

12/31/10

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Shareholder	Administrative	1.00%	See Attached	1.23	2.65%		\$		1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	1.81	3.29%	Alloc. Salary	5,254	17-7	2
3	Adam Vales	Relative	Clerical	N/A	See Attached	0.85	2.13%	Alloc. Salary	1,485	22-7	3
4	G. Matt Silvers	Relative	Administrative	N/A	See Attached	0.58	2.60%	Alloc. Salary	1,972	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 8,711		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 Chateau Nursing & Rehab Center

0046177

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,512,273	34	\$ 3,931	\$ 49,697	\$ 129	1
2	02	Food	Patient Days	1,512,273	34	10,940	49,697	360	2
3	03	Housekeeping	Patient Days	1,512,273	34	14,059	49,697	462	3
4	05	Utilities	Patient Days	1,512,273	34	31,923	49,697	1,049	4
5	06	Maintenance	Patient Days	1,512,273	34	91,744	49,697	3,015	5
6	17	Administrative	Patient Days	1,512,273	34	65,000	49,697	2,136	6
7	19	Professional Fees	Patient Days	1,512,273	34	271,007	49,697	8,906	7
8	20	Dues and Subscriptions	Patient Days	1,512,273	34	82,419	49,697	2,708	8
9	21	Office and Clerical	Patient Days	1,512,273	34	385,083	49,697	12,655	9
10	24	Seminar and Travel	Patient Days	1,512,273	34	4,022	49,697	132	10
11	25	Other Staff Admin. Trans.	Patient Days	1,512,273	34	19,982	49,697	657	11
12	26	Insurance	Patient Days	1,512,273	34	21,934	49,697	721	12
13	30	Depreciation	Patient Days	1,512,273	34	118,510	49,697	3,895	13
14	32	Interest	Patient Days	1,512,273	34	226,162	49,697	7,432	14
15	33	Real Estate Taxes	Patient Days	1,512,273	34	45,910	49,697	1,509	15
16	34	Rent - Building	Patient Days	1,512,273	34	31,555	49,697	1,037	16
17	35	Rent - Equipment & Auto	Patient Days	1,512,273	34	56,569	49,697	1,859	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,480,749	\$	\$ 48,662	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	34	196,794	196,794	49,697	6,467	1
2	06	Maintenance (Direct)	Direct	34	32,478	32,478		2,004	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	34	32,885		49,697	1,081	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct	34	3,607			199	4
5	12	Admission (Direct)	Direct	34	52,036	52,036			5
6	15	Emp. Ben. - Nursing (Direct)	Direct	34	5,270				6
7	17	Administrative (Pooled)	Patient Days	34	252,448	252,448	49,697	8,296	7
8	21	Office and Clerical (Pooled)	Patient Days	34	3,059,876	3,059,876	49,697	100,555	8
9	21	Office and Clerical (Direct)	Direct	34	771,063	771,063		20,237	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	34	553,505		49,697	18,190	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct	34	94,865			2,014	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,054,827	\$ 4,364,695		\$ 159,043	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	1,512,273	34	\$ 1,549	\$ 49,697	\$ 51	1
2	05	Utilities	Patient Days	1,512,273	34	3,268	49,697	107	2
3	06	Maintenance	Patient Days	1,512,273	34	3,240	49,697	106	3
4	19	Professional Fees	Patient Days	1,512,273	34	181,624	49,697	5,969	4
5	20	Dues and Subscriptions	Patient Days	1,512,273	34	4,624	49,697	152	5
6	21	Office & Clerical	Patient Days	1,512,273	34	43,370	49,697	1,425	6
7	24	Travel and Seminar	Patient Days	1,512,273	34	37,025	49,697	1,217	7
8	26	Insurance	Patient Days	1,512,273	34	4,213	49,697	138	8
9	30	Depreciation	Patient Days	1,512,273	34	22,389	49,697	736	9
10	32	Interest	Patient Days	1,512,273	34	427,165	49,697	14,038	10
11	33	Real Estate Taxes	Patient Days	1,512,273	34	5,058	49,697	166	11
12	01	Dietary Salary	Patient Days	1,512,273	34	116,221	49,697	3,819	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,512,273	34	16,288	49,697	535	13
14	10	Nursing Salary	Patient Days	1,512,273	34	747,870	49,697	24,577	14
15	10a	Rehab Salary	Patient Days	1,512,273	34	108,151	49,697	3,554	15
16	12	Social Service Salary	Patient Days	1,512,273	34	77,377	49,697	2,543	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,512,273	34	130,816	49,697	4,299	17
18	17	Administration Salary	Patient Days	1,512,273	34	1,070,339	49,697	35,174	18
19	21	Office Salary	Patient Days	1,512,273	34	153,206	49,697	5,035	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,512,273	34	171,480	49,697	5,635	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,325,274	\$ 2,273,164	\$ 109,276	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Extended Care Clinical, LLC

Street Address

2201 West Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905-3000

Fax Number

(847) 905-3030

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Direct Allocation		\$ 15,960	\$ 15,960		\$	1
2	07	Emp. Ben. - General	Direct Allocation		1,662				2
3	10	Nursing Salary	Direct Allocation		495,330	495,330		35,268	3
4	12	Social Service Salary	Direct Allocation		274,597	274,597		25,233	4
5	15	Emp. Ben. - Healthcare	Direct Allocation		94,697			7,047	5
6	17	Administration Salary	Direct Allocation		82,389	82,389			6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation		10,053				7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 974,688	\$ 868,276		\$ 67,548	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary Supplies, Supplements	Direct Allocation		\$	\$		2,938	1
2	10	Nursing Supplies	Direct Allocation						2
3	39	Ancillary Expense	Direct Allocation					3,358	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		6,296	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization TriCare Rehab
 Street Address 150 Fencil Lane
 City / State / Zip Code Hillside, IL 60162
 Phone Number (773) 449-9400
 Fax Number (773) 449-9700

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy	Direct Allocation		\$	\$		\$ 563,713	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				\$	\$		\$ 563,713	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	R&M - Equipment	Direct Allocation		\$	\$		\$	1
2	10	Nursing Supplies	Direct Allocation						2
3	39	Ancillary Expense	Direct Allocation					63,530	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				\$	\$		\$ 63,530	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			\$		\$ 72	1
2	3	Housekeeping	Direct Allocation					52,054	2
3	4	Laundry	Direct Allocation					17,861	3
4	6	Repairs & Maintenance	Direct Allocation					2,785	4
5	10	Nursing	Direct Allocation					173,645	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					1,604	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					61,509	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					\$		\$ 309,531	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

CCS Emp. Ben. Group / Vent Lease LLC

Street Address

2201 Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847)905-4000 / (847) 674-1180

Fax Number

(847)905-4040 / (847-673-7741

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 161,699	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11	35	Matrix Leasing	Direct Allocation		\$	\$		\$ 6,401	11
12	39	Ventilator Equipment	Direct Allocation					17,233	12
13	39	Other Ancillary	Direct Allocation						13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 185,333	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Chateau Nursing & Rehab Center

0046177

Report Period Beginning:

01/01/10

Ending:

12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6	7	8	9	10											
											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	Business Partners (Net)		X	Mortgage			\$	\$ 3,189,431			\$ 631,640	1									
2												2									
3												3									
4												4									
5	See Supplemental Schedule											5									
	Working Capital																				
6	DAIWA LOC		X	LOC								6									
7												7									
8	See Supplemental Schedule										21,470	8									
9	TOTAL Facility Related						\$	\$ 3,189,431			\$ 653,110	9									
	B. Non-Facility Related*																				
10	Interest Income		X								(21,920)	10									
11	Interest Income (Bldg Co.)		X								(6,400)	11									
12												12									
13	See Supplemental Schedule										(4,593)	13									
14	TOTAL Non-Facility Related						\$	\$			\$ (32,913)	14									
15	TOTALS (line 9+line14)						\$	\$ 3,189,431			\$ 620,197	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 Chateau Nursing & Rehab Center

0046177

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

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

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
6											6							
7	TOTAL Long-Term										7							
Working Capital																		
8	Alloc from Ext Care Cnsult		X			\$	\$			\$	7,432	8						
9	Alloc from Ext Care Clinical		X								14,038	9						
10												10						
11												11						
12												12						
13												13						
14	TOTAL Working Capital										21,470	14						
B. Non-Facility Related*																		
15	Dividend Income		X			\$	\$			\$	(4,593)	15						
16												16						
17												17						
18												18						
19												19						
20	TOTAL Non-Facility Related										(4,593)	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 Chateau Nursing & Rehab Center

0046177

Report Period Beginning:

01/01/10

Ending:

12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,447 B. General Construction Type: Exterior Brick Frame Masonry & Steel Number of Stories 1

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>273,121</u>	<u>2003</u>	<u>\$ 295,367</u>	<u>1</u>
2	<u>Allocated from CCI/ECC</u>			<u>12,061</u>	<u>2</u>
3	TOTALS	273,121		\$ 307,428	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various		2003	51,953		20	3,457	3,457	32,208
10	Various		2004	98,684		20	4,847	4,847	36,447
11	Various		2005	69,862		20	3,493	3,493	18,164
12	Various		2006	50,399		20	3,226	3,226	14,452
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		2,896,943	82,756		80,094	(2,662)	1,187,390	67
68		48,606	3,310		3,310		23,166	68
69			56,639			(56,639)		69
70		\$ 3,216,447	\$ 142,705		\$ 98,427	\$ (44,278)	\$ 1,311,827	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,216,447	\$ 142,705		\$ 98,427	\$ (44,278)	\$ 1,311,827	1
2	Tile For 2Nd Floor	2007	30,108		20	1,505	1,505	5,771	2
3	Air Conditioners	2007	6,284		20	524	524	1,964	3
4	New Doors	2007	11,675		20	584	584	2,092	4
5	Tiles - Shower	2007	10,725		20	715	715	2,562	5
6	Door Installation	2007	9,500		20	475	475	1,702	6
7	Elevator Repairs	2007	37,450		20	1,873	1,873	6,710	7
8	Pot Hole Patching, Sealcoating	2007	6,510		20	326	326	1,058	8
9	Install 7 New Actuators	2007	5,297		20	265	265	839	9
10	Sprinkler System Repair	2007	2,890		20	145	145	458	10
11	Landscaping	2007	6,290		20	315	315	970	11
12	Filter Replacement	2008	4,113		20	206	206	617	12
13	Parking Lot Repair	2008	16,571		20	1,105	1,105	2,946	13
14	Power Lines For Washer/Dryer	2008	4,900		20	245	245	613	14
15	Generator Maint	2008	3,246		20	162	162	406	15
16	Adj #207 - Refund	2008	(2,675)		20	(134)	(134)	(401)	16
17	Replace Self Priming Sewage Ejector	2008	4,389		20	219	219	512	17
18	Painting (Transfer From Home Office)	2008	7,129		20			7,129	18
19	Painting (Transfer From Home Office)	2008	1,426		20			1,426	19
20	Water Heater	2009	6,710		20	1,342	1,342	2,125	20
21	Flooring	2009	15,616		20	781	781	846	21
22	Generator	2009	3,256		20	163	163	176	22
23	Heat Exchanger	2010	5,600		20	257	257	257	23
24	Tile Flooring	2010	4,001		20	245	245	245	24
25	Doors In Kitchen	2010	3,170		20	40	40	40	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,420,628	\$ 142,705		\$ 109,782	\$ (32,923)	\$ 1,352,885	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		\$ 3,420,628	\$ 142,705		\$ 109,782	\$ (32,923)	\$ 1,352,885	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)	\$ 3,420,628	\$ 142,705		\$ 109,782	\$ (32,923)	\$ 1,352,885	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		\$ 3,420,628	\$ 142,705		\$ 109,782	\$ (32,923)	\$ 1,352,885	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)	\$ 3,420,628	\$ 142,705		\$ 109,782	\$ (32,923)	\$ 1,352,885	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		\$ 3,420,628	\$ 142,705		\$ 109,782	\$ (32,923)	\$ 1,352,885	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)	\$ 3,420,628	\$ 142,705		\$ 109,782	\$ (32,923)	\$ 1,352,885	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

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

1	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	Chateau Willowbrook Property, LLC	1987	2,658,301		39	68,162	68,162	1,128,100	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Life Safety Code Improvements (Net of Settlement)	2005	231,242		20	11,562	11,562	57,810	9
10	Professional Fees-Architect	2007	7,400		20	370	370	1,480	10
11	Book Depreciation Expense			82,756			(82,756)		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	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 Continued		\$	\$		\$	\$	\$	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)		\$ 2,896,943	\$ 82,756		\$ 80,094	\$ (2,662)	\$ 1,187,390	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party Information		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocated from Extended Care Clinical, 2201 Main LLC	2002	1,649	42	39	42		351	3
4	Allocated from Extended Care Consulting, 2201 Main LLC	2002	14,971	384	39	384		3,183	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, 2201 Main LLC	2002	12,367	1,130	20	1,130		7,922	9
10	Allocated from Extended Care Consulting, 2201 Main LLC	2003	14,574	1,332	20	1,332		9,336	10
11	Allocated from Extended Care Consulting, 2201 Main LLC	2005	724	77	20	77		338	11
12	Allocated from Extended Care Consulting, 2201 Main LLC	2009	131	7	20	7		13	12
13									13
14									14
15	Allocated from Extended Care Consulting, LLC	2007	151	8	20	8		30	15
16	Allocated from Extended Care Consulting, LLC	2009	90	5	20	5		9	16
17	Allocated from Extended Care Consulting, LLC	2010	887	44	20	44		44	17
18									18
19	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	1,362	125	20	125		873	19
20	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2003	1,606	147	20	147		1,029	20
21	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2005	80	8	20	8		37	21
22	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2009	14	1	20	1		1	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)		\$ 48,606	\$ 3,310		\$ 3,310	\$	23,166	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 128,648	\$ 742	\$ 17,552	\$ 16,810	10	\$ 92,765	71
72	Current Year Purchases	479	48	48		10	48	72
73	Fully Depreciated Assets	460,543				10	460,543	73
74								74
75	TOTALS	\$ 589,670	\$ 790	\$ 17,600	\$ 16,810		\$ 553,356	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		2003 FORD ECONO VAN	2003	\$ 33,833	\$	\$ 2,246	\$ 2,246	5	\$ 33,833	76
77		TRUCK REPAIR	2004	1,083		133	133	5	1,017	77
78		Alloc. From EC Clinical	2010	1,837	367	367		5	857	78
79		Alloc. From ECC	2010	10,567	165	165		5	10,237	79
80	TOTALS			\$ 47,320	\$ 532	\$ 2,911	\$ 2,379		\$ 45,944	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 4,365,046	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 144,027	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 130,293	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (13,734)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,952,185	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>Alloc from Ext Care Consulting, LLC</u>				<u>1,037</u>			5
6	<u>Alloc from Care Centers Health Systems</u>							6
7	TOTAL				\$ <u>1,037</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: \$ 43,813 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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 220,984	\$		\$ 220,984	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			81,566			81,566	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			328,833			328,833	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				416,986		416,986	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>					9,555	262,828		272,383	13
14	TOTAL			\$		\$ 640,938	\$ 679,814		\$ 1,320,752	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 Chateau Nursing & Rehab Center# 0046177Report Period Beginning: 01/01/10Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 500	\$ 2,595	1
2	Cash-Patient Deposits	52,540	52,540	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	569,678	569,678	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	289,790	289,790	6
7	Other Prepaid Expenses	2,911	7,536	7
8	Accounts Receivable (owners or related parties)	1,100,627	896,598	8
9	Other(specify): <u>See Attached Schedule</u>	1,142,466	1,242,466	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,158,512	\$ 3,061,203	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		295,367	13
14	Buildings, at Historical Cost		3,805,411	14
15	Leasehold Improvements, at Historical Cost	408,040	408,040	15
16	Equipment, at Historical Cost	233,566	233,566	16
17	Accumulated Depreciation (book methods)	(372,251)	(2,027,914)	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>		(39,557)	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 269,355	\$ 2,674,913	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,427,867	\$ 5,736,116	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,218,151	\$ 1,218,153	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,360	39,360	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	271,109	271,109	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,727	12,727	31
32	Accrued Real Estate Taxes(Sch.IX-B)	85,529	85,529	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>		60,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,626,876	\$ 1,686,878	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,189,431	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)	\$	\$ 3,189,431	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,626,876	\$ 4,876,309	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,800,991	\$ 859,807	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,427,867	\$ 5,736,116	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,778,208	1
2	Restatements (describe):		2
3	Depreciation	1,925	3
4	Rev Settlements	(6,392)	4
5	Rounding Error	3	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,773,744	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	55,784	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	(28,537)	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)	\$ 27,247	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)	\$ 1,800,991	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

Report Period Beginning: 01/01/10

Ending: 12/31/10

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,871,212	1
2	Discounts and Allowances for all Levels	(2,644,070)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,227,142	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,143,520	6
7	Oxygen	4,327	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,147,847	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	4,555	13
14	Non-Patient Meals	2,011	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	424,616	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	57,120	19
20	Radiology and X-Ray	8,549	20
21	Other Medical Services	157,319	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 654,170	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	21,920	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 21,920	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	5,302	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,302	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,056,381	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,683,313	31
32	Health Care	4,280,599	32
33	General Administration	1,800,894	33
B. Capital Expense			
34	Ownership	705,435	34
C. Ancillary Expense			
35	Special Cost Centers	1,448,231	35
36	Provider Participation Fee	82,125	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,000,597	40
41	Income before Income Taxes (line 30 minus line 40)**	55,784	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 55,784	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 **Chateau Nursing & Rehab Center**

0046177

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,661	1,834	\$ 85,076	\$ 46.39	1
2	Assistant Director of Nursing	1,894	2,143	80,735	37.67	2
3	Registered Nurses	22,726	25,054	776,962	31.01	3
4	Licensed Practical Nurses	36,409	40,422	1,060,667	26.24	4
5	CNAs & Orderlies	94,847	105,077	1,264,294	12.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,966	12,294	199,806	16.25	8
9	Activity Director	1,933	2,106	32,630	15.49	9
10	Activity Assistants	11,384	12,678	140,379	11.07	10
11	Social Service Workers	7,281	8,066	168,764	20.92	11
12	Dietician	1,977	2,178	36,246	16.64	12
13	Food Service Supervisor	1,950	2,130	43,155	20.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,716	6,072	74,896	12.33	15
16	Dishwashers	18,507	20,068	178,987	8.92	16
17	Maintenance Workers	8,157	9,069	142,736	15.74	17
18	Housekeepers	17,494	19,378	180,948	9.34	18
19	Laundry	4,471	4,981	46,152	9.27	19
20	Administrator	1,974	2,216	85,528	38.60	20
21	Assistant Administrator	1,714	1,885	47,363	25.13	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,425	8,242	131,361	15.94	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	1,960	2,144	36,049	16.81	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	260,446	288,037	\$ 4,812,734 *	\$ 16.71	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	244	\$ 14,245	01-03	35
36	Medical Director	Monthly	43,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	226	9,060	10-03	38
39	Pharmacist Consultant	Monthly	7,712	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	11	595	12-03	45
46	Other(specify)				46
47					47
48	<u>See Attached</u>	1,425	60,501		48
49	TOTAL (lines 35 - 48)	1,905	\$ 135,113		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	56	\$ 2,273	10-03	50
51	Licensed Practical Nurses	56	2,275	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	112	\$ 4,548		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

Report Period Beginning: 01/01/10

Ending: 12/31/10

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 71,611 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. \$ 82,125
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,011
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.