

Facility Name & ID Number Ridgeview Rehab & Nsg Center

0048470 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>110</u>	Skilled (SNF)	<u>110</u>	<u>40,150</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>26</u>	Intermediate (ICF)	<u>26</u>	<u>9,490</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>136</u>	TOTALS	<u>136</u>	<u>49,640</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	<u>23,739</u>	<u>657</u>	<u>4,493</u>	<u>28,889</u>	8
9	SNF/PED					9
10	ICF	<u>18,873</u>	<u>153</u>	<u>23</u>	<u>19,049</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>42,612</u>	<u>810</u>	<u>4,516</u>	<u>47,938</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.57%

D. How many bed-hold days during this year were paid by the Department? 925 (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)

N/A

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 09/01/2006

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/01/06 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 110 and days of care provided 4,471

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

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 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	215,320	48,415	8,902	272,637		272,637		272,637		1
2	Food Purchase		194,876		194,876		194,876	(33)	194,843		2
3	Housekeeping	192,712	29,510		222,222		222,222		222,222		3
4	Laundry	65,898	14,394		80,292		80,292		80,292		4
5	Heat and Other Utilities			146,082	146,082		146,082	(545)	145,537		5
6	Maintenance	30,375	32,704	58,145	121,224		121,224	434	121,658		6
7	Other (specify):*							644	644		7
8	TOTAL General Services	504,305	319,899	213,129	1,037,333		1,037,333	500	1,037,833		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,649,019	40,635	8,089	1,697,743		1,697,743		1,697,743		10
10a	Therapy	26,018		85	26,103		26,103		26,103		10a
11	Activities	78,559	3,192	2,640	84,391		84,391		84,391		11
12	Social Services	97,683		1,905	99,588		99,588		99,588		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,851,279	43,827	22,319	1,917,425		1,917,425		1,917,425		16
	C. General Administration										
17	Administrative	96,273		442,800	539,073		539,073	(337,634)	201,439		17
18	Directors Fees										18
19	Professional Services			59,220	59,220		59,220	(3,477)	55,744		19
20	Dues, Fees, Subscriptions & Promotions			19,360	19,360		19,360	(5,311)	14,049		20
21	Clerical & General Office Expenses	86,763	36,034	20,186	142,983		142,983	35,444	178,427		21
22	Employee Benefits & Payroll Taxes			419,274	419,274		419,274		419,274		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,311	1,311		1,311	116	1,427		24
25	Other Admin. Staff Transportation			2,060	2,060		2,060	3,370	5,430		25
26	Insurance-Prop.Liab.Malpractice			160,297	160,297		160,297	1,575	161,872		26
27	Other (specify):*							38,822	38,822		27
28	TOTAL General Administration	183,036	36,034	1,124,508	1,343,578		1,343,578	(267,094)	1,076,484		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,538,620	399,760	1,359,956	4,298,336		4,298,336	(266,594)	4,031,742		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

Ridgeview Rehab & Nsg Center

#0048470

Report Period Beginning:

01/01/10

Ending:

12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			11,657	11,657		11,657	273,718	285,375			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			58	58		58	357,889	357,947			32
33	Real Estate Taxes							209,288	209,288			33
34	Rent-Facility & Grounds			2,155,000	2,155,000		2,155,000	(2,155,000)				34
35	Rent-Equipment & Vehicles							10,595	10,595			35
36	Other (specify):*			33,333	33,333		33,333	(1,220)	32,113			36
37	TOTAL Ownership			2,200,048	2,200,048		2,200,048	(1,304,730)	895,318			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		146,026	337,566	483,592		483,592		483,592			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,460	74,460		74,460		74,460			42
43	Other (specify):*			1,910	1,910		1,910	(1,910)				43
44	TOTAL Special Cost Centers		146,026	413,936	559,962		559,962	(1,910)	558,052			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,538,620	545,786	3,973,940	7,058,346		7,058,346	(1,573,234)	5,485,112			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 Ridgeview Rehab & Nsg Center

0048470

Report Period Beginning:

01/01/10

Ending:

12/31/10

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,268)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	36,503	30		9
10	Interest and Other Investment Income	(9,858)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(33)	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				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	(6,387)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(82,989)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (65,032)		\$	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)	(1,508,202)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,508,202)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,573,234)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Ridgeview Rehab & Nsg Center

ID# 0048470

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (463)	21	1
2	Amortization - Goodwill	(33,333)	36	2
3	Replacement Income Tax	(5,923)	21	3
4	Prior Year Legal Fees	(408)	19	4
5	Non-Allowable Legal Fees	(250)	19	5
6	Building Co. - Amortization of Loan Fees	(2,289)	31	6
7	Building Co. - Accounting Fees	(4,825)	19	7
8	Building Co. - Illinois Replacement Tax	(19,424)	21	8
9	Additional Repairs & Maintenance	2,089	06	9
10	Capitalized Repairs & Maintenance	(10,943)	06	10
11	Marketing Expense	(1,910)	43	11
12	COPE Dues	(5,311)	20	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	(82,989)		49

Ridgeview Rehab & Nsg Center

ID# 0048470

Report Period Beginning: 01/01/10

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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 Ridgeview Rehab & Nsg Center# 0048470

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													1
2	Food Purchase	(33)											(33)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(2,268)		1,723									(545)	5
6	Maintenance	(8,854)		3,760	5,528								434	6
7	Other (specify):*				644								644	7
8	TOTAL General Services	(11,155)		5,483	6,172								500	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative			(415,064)	77,430								(337,634)	17
18	Directors Fees													18
19	Professional Services	(5,483)	4,825	(3,052)		233							(3,477)	19
20	Fees, Subscriptions & Promotions	(5,311)											(5,311)	20
21	Clerical & General Office Expenses	(32,197)	19,424	48,217									35,444	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			116									116	24
25	Other Admin. Staff Transportation			3,370									3,370	25
26	Insurance-Prop.Liab.Malpractice			1,318		257							1,575	26
27	Other (specify):*			33,743	5,079								38,822	27
28	TOTAL General Administration	(42,990)	24,249	(331,352)	82,509	490							(267,094)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(54,145)	24,249	(325,869)	88,681	490							(266,594)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Ridgeview Rehab & Nsg Center# 0048470

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	36,503	234,417			2,798							273,718	30
31	Amortization of Pre-Op. & Org.	(2,289)	2,289											31
32	Interest	(9,858)	364,218			3,529							357,889	32
33	Real Estate Taxes		205,870			3,418							209,288	33
34	Rent-Facility & Grounds		(2,155,000)	15,448		(15,448)							(2,155,000)	34
35	Rent-Equipment & Vehicles			10,595									10,595	35
36	Other (specify):*	(33,333)	32,113										(1,220)	36
37	TOTAL Ownership	(8,977)	(1,316,093)	26,043		(5,703)							(1,304,730)	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):*	(1,910)											(1,910)	43
44	TOTAL Special Cost Centers	(1,910)											(1,910)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(65,032)	(1,291,844)	(299,826)	88,681	(5,213)							(1,573,234)	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		
				Ridgeview Rehab Realty, 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:	
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 Income	\$ 2,155,000	Ridgeview Rehab Realty LLC		\$	\$ (2,155,000)	1
2	V	32 Interest Income	144	Ridgeview Rehab Realty LLC			(144)	2
3	V	36 MIP Insurance		Ridgeview Rehab Realty LLC		32,113	32,113	3
4	V	33 Real Estate Taxes		Ridgeview Rehab Realty LLC		205,870	205,870	4
5	V	32 Mortgage Interest		Ridgeview Rehab Realty LLC		364,360	364,360	5
6	V	32 Other Interest		Ridgeview Rehab Realty LLC		2	2	6
7	V	30 Depreciation		Ridgeview Rehab Realty LLC		234,417	234,417	7
8	V	31 Amortization of Loan Fees		Ridgeview Rehab Realty LLC		2,289	2,289	8
9	V	19 Accounting Fees		Ridgeview Rehab Realty LLC		4,825	4,825	9
10	V	21 Illinois Replacement Tax		Ridgeview Rehab Realty LLC		19,424	19,424	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,155,144			\$ 863,300	\$ * (1,291,844)	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	5 UTILITIES	\$	STAYCARE MANAGEMENT, LTD.	100.00%	\$ 1,723	\$	1,723	15
16	V	6 REPAIRS AND MAINT.				3,760		3,760	16
17	V	17 ADMIN. SAL.-NON OWNER				27,736		27,736	17
18	V	19 PROFESSIONAL FEES				3,448		3,448	18
19	V	20 DUES, SUBSCRIPTIONS							19
20	V	21 CLERICAL & GENERAL				48,217		48,217	20
21	V	24 SEMINARS				116		116	21
22	V	25 ADMIN. STAFF TRAVEL				3,370		3,370	22
23	V	26 INSURANCE				1,318		1,318	23
24	V	27 EMPLOYEE BENEFITS				33,743		33,743	24
25	V	30 DEPRECIATION							25
26	V	32 INTEREST							26
27	V	34 BUILDING RENT				15,448		15,448	27
28	V	35 EQUIPMENT RENTAL				10,595		10,595	28
29	V								29
30	V								30
31	V	17 MANAGEMENT FEES	442,800					(442,800)	31
32	V	19 CONSULTING FEES	6,500					(6,500)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 449,300			\$ 149,474	\$ *	(299,826)	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 DIET. COMP - S. WEBSTER	\$	STAY CARE MANAGEMENT, LTD.	100.00%	\$	\$	15
16	V	1 DIET. COMP - D. WENGROW						16
17	V	6 MAINT. COMP. - NON-OWNER				5,528	5,528	17
18	V	7 EMP. BEN. - S. WEBSTER						18
19	V	7 EMP. BEN. - D. WENGROW						19
20	V	7 EMP. BEN. - MAINT. NON-OWNER				644	644	20
21	V	17 ADMIN. COMP - H. WENGROW				15,385	15,385	21
22	V	17 ADMIN. COMP - J. WEBSTER				57,143	57,143	22
23	V	17 ADMIN. COMP - DAVID WENGROW				4,902	4,902	23
24	V	27 EMP. BEN. - H. WENGROW				941	941	24
25	V	27 EMP. BEN. - J. WEBSTER				3,516	3,516	25
26	V	27 EMP. BEN. - DAVID WENGROW				622	622	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		\$			\$ 88,681	\$ * 88,681	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 REPAIRS & MAINTENANCE	\$	DOUBLE YOU REALTY, LLC	100.00%	\$		15
16	V	19 PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		233	233	16
17	V	21 OFFICE EXPENSE		DOUBLE YOU REALTY, LLC				17
18	V	26 INSURANCE		DOUBLE YOU REALTY, LLC		257	257	18
19	V	30 DEPRECIATION		DOUBLE YOU REALTY, LLC		2,798	2,798	19
20	V	32 INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		3,529	3,529	20
21	V	33 REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		3,418	3,418	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V	34 RENT	15,448	DOUBLE YOU REALTY, LLC			(15,448)	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		\$ 15,448			\$ 10,235	\$ * (5,213)	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: 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.

Facility Name & ID Number

Ridgeview Rehab & Nsg Center

0048470

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	Jeffrey Webster	Owner	Administrative	29.41%	See Attached	20.00	28.57%	Alloc. Salary	\$ 57,143	17-07	1
2	Howard Wengrow	Owner	Administrative	29.41%	See Attached	5.00	7.69%	Alloc. Salary	15,385	17-07	2
3	Howard Bernath	Owner	Administrative	2.20%	See Attached	8.37	20.93%	Alloc. Salary	5,528	06-07	3
4	Marcia Morgan	Owner	Administrative	3.67%	See Attached	8.37	20.93%	Alloc. Salary	27,736	17-07	4
5	David Wengrow	Relative	Administrative	0	See Attached	19.35	48.38%	Alloc. Salary	20,820	17-01,17-07	5
6											6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs										9
10	to reflect only amount anticipated to be considered allowable by the IL. Dept of HFS										10
11											11
12											12
13								TOTAL	\$ 126,612		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 Ridgeview Rehab & Nsg Center

0048470

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 Ridgeview Rehab & Nsg Center

0048470

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 STAYCARE MANAGEMENT, LTD.
 Street Address 3737 W ARTHUR AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 679-2121
 Fax Number (847) 679-2122

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	5	UTILITIES	PATIENT DAYS	229,021	6	\$ 8,232	\$ 47,938	\$ 1,723	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	229,021	6	17,963	47,938	3,760	2
3	17	ADMIN. SAL.-NON OWNER	PATIENT DAYS	229,021	6	132,508	132,508	27,736	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	229,021	6	16,472	47,938	3,448	4
5	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	229,021	6	-	47,938		5
6	21	CLERICAL & GENERAL	PATIENT DAYS	229,021	6	230,353	187,575	48,217	6
7	24	SEMINARS	PATIENT DAYS	229,021	6	554	47,938	116	7
8	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	229,021	6	16,100	47,938	3,370	8
9	26	INSURANCE	PATIENT DAYS	229,021	6	6,299	47,938	1,318	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	229,021	6	161,204	47,938	33,743	10
11	30	DEPRECIATION	PATIENT DAYS	229,021	6	-	47,938		11
12	32	INTEREST	PATIENT DAYS	229,021	6	-	47,938		12
13	34	BUILDING RENT	PATIENT DAYS	229,021	6	73,800	47,938	15,448	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	229,021	6	50,616	47,938	10,595	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 714,101	\$ 320,083	\$ 149,474	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeview Rehab & Nsg Center

0048470

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 STAYCARE MANAGEMENT, LTD.
 Street Address 3737 W ARTHUR AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 679-2121
 Fax Number (847) 679-2122

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	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	5	4	10,104	10,104		1
2	1	DIET. COMP - D. WENGROW	AVG. HOURS WORKED	5	4	10,104	10,104		2
3	6	MAINT. COMP. - NON-OWNER	AVG. HOURS WORKED	40	6	26,410	26,410	8	5,528
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	996			4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	996			5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	3,076		8	644
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	200,000	200,000	5	15,385
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	200,000	200,000	20	57,143
9	17	ADMIN. COMP - DAVID WENG	AVG. HOURS WORKED	40	6	23,417	23,417	8	4,902
10	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	12,227		5	941
11	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	12,305		20	3,516
12	27	EMP. BEN. - DAVID WENGROV	AVG. HOURS WORKED	40	6	2,973		8	622
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					\$ 502,608	\$ 470,035	\$	88,681

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeview Rehab & Nsg Center

0048470

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 DOUBLE YOU REALTY, LLC
 Street Address 3737 W. ARTHUR AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 679-2121
 Fax Number (847) 679-2122

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	REPAIRS & MAINTENANCE	PATIENT DAYS	229,021	6	\$ -	47,938	\$	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	229,021	6	1,115	47,938	233	2
3	21	OFFICE EXPENSE	PATIENT DAYS	229,021	6	2	47,938		3
4	26	INSURANCE	PATIENT DAYS	229,021	6	1,227	47,938	257	4
5	30	DEPRECIATION	PATIENT DAYS	229,021	6	13,367	47,938	2,798	5
6	32	INTEREST EXPENSE	PATIENT DAYS	229,021	6	16,859	47,938	3,529	6
7	33	REAL ESTATE TAXES	PATIENT DAYS	229,021	6	16,330	47,938	3,418	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					\$ 48,900	\$	\$ 10,235	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeview Rehab & Nsg Center

0048470

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 Ridgeview Rehab & Nsg Center

0048470

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 Ridgeview Rehab & Nsg Center

0048470

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 Ridgeview Rehab & Nsg Center

0048470

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 Ridgeview Rehab & Nsg Center

0048470

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 Ridgeview Rehab & Nsg Center

0048470

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

Ridgeview Rehab & Nsg Center

0048470

Report Period Beginning:

01/01/10

Ending:

12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Heartland Bank - HUD		X	Mortgage			\$	\$ 6,354,736		\$ 364,360	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
Working Capital																			
6											6								
7											7								
8	See Supplemental Schedule										8								
9	TOTAL Facility Related						\$	\$ 6,354,736		\$ 364,360	9								
B. Non-Facility Related*																			
10	Interest Income		X							(9,800)	10								
11	Interest Income (Bldg. Co.)		X							(142)	11								
12	Allocated from Double You		X							3,529	12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related						\$	\$		\$ (6,413)	14								
15	TOTALS (line 9+line14)						\$	\$ 6,354,736		\$ 357,947	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 32,113 Line # 36

* 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

Ridgeview Rehab & Nsg Center

0048470

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	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										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital									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.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2009 report.		\$	150,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	179,288	2
3. Under or (over) accrual (line 2 minus line 1).		\$	29,288	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	180,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	209,288	7

Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2005		8	
	2006	145,487	9	
	2007	143,934	10	
	2008	145,378	11	
	2009	175,870	12	

2010 R/E Tax Accrual = \$175,870 x 1.02 = \$180,000				
Allocated from Double You = \$3,418				

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

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeview Rehab & Nsg Center

0048470

Report Period Beginning:

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,742 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2006</u>	<u>\$ 600,000</u>	<u>1</u>
2	<u>Allocated from Double You</u>		<u>2003</u>	<u>10,466</u>	<u>2</u>
3	TOTALS			\$ 610,466	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeview Rehab & Nsg Center

0048470

Report Period Beginning:

01/01/10

Ending:

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XI. OWNERSHIP COSTS (continued)

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

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

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		3,807,152	234,417		126,905	(107,512)	508,392	67
68		104,674	2,565		2,797	232	22,165	68
69			11,657			(11,657)		69
70		\$ 3,911,826	\$ 248,639		\$ 129,702	\$ (118,937)	\$ 530,557	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center

0048470

Report Period Beginning:

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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		\$ 3,911,826	\$ 248,639		\$ 129,702	\$ (118,937)	\$ 530,557	1
2	Gate Lock	2007	2,695		20	180	180	607	2
3	Fence	2007	2,700		20	180	180	608	3
4	Concrete Patio, Stairs Entrance	2007	14,115		20	941	941	2,942	4
5	Cable System Installation	2007	12,984		20	1,298	1,298	4,761	5
6	J. Franco Wrought Iron Fence	2007	2,700		20	270	270	945	6
7	Econocare, Inc. - Metal Handrail On Ramp	2008	1,850		20	123	123	308	7
8	Econocare, Inc. - Replace Sliding Door	2008	3,065		20	204	204	511	8
9	Econocare, Inc. - New Patio	2008	9,200		20	614	614	1,534	9
10	Econocare, Inc. - Doors	2008	9,381		20	469	469	1,251	10
11	Econocare, Inc. - Doors	2008	9,210		20	460	460	1,266	11
12	Cable/Satellite America, Inc. - Monitor/Camera	2008	895		20	89	89	246	12
13	Cable/Satellite America, Inc - Monitor/Camera	2008	2,409		20	241	241	662	13
14	Edward Don & Company - Booster Heater	2008	1,953		20	98	98	244	14
15	Pegasus Custom Furniture - Cabinetry	2008	7,250		20	363	363	906	15
16	Econocare, Inc. - Flooring	2008	20,767		20	1,038	1,038	2,596	16
17	Pegasus Custom Furniture - Doors	2008	3,600		20	180	180	450	17
18	Econocare, Inc. - Handrails	2008	8,645		20	432	432	1,009	18
19	Cybor Fire Protection Company - Fire Sprinkler Work	2008	8,500		20	425	425	992	19
20	Pegasus Custom Furniture - Cabinetry	2008	7,250		20	363	363	1,027	20
21	Cable/Satellite America, Inc. - Monitor/Camera	2008	803		20	80	80	241	21
22	Econocare, Inc. - Window Treatment	2008	2,804		20	280	280	608	22
23	3 Ac Units	2008	5,179		20	345	345	719	23
24	Heating Automation System	2009	7,385		20	369	369	708	24
25	Installation Of Light Fixtures	2009	10,458		20	523	523	959	25
26	Plumbing In Basement	2009	2,850		20	143	143	261	26
27	Pegasus Custom Furniture - Doors	2009	4,230		20	212	212	423	27
28	Pegasus Custom Furniture - Doors	2009	8,100		20	405	405	810	28
29	Pegasus Custom Furniture - Doors	2009	8,100		20	405	405	776	29
30	Pegasus Custom Furniture - Crownmolding	2009	4,080		20	204	204	374	30
31	Window Treatments & Drapes	2009	12,425		20	2,485	2,485	4,556	31
32	Pegasus Custom Furniture - Crownmolding	2009	3,480		20	174	174	319	32
33	10 Ac Units	2009	5,795		20	1,159	1,159	1,835	33
34	TOTAL (lines 1 thru 33)		\$ 4,116,684	\$ 248,639		\$ 144,456	\$ (104,183)	\$ 566,010	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center

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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 12B, Carried Forward		\$ 4,116,684	\$ 248,639		\$ 144,456	\$ (104,183)	\$ 566,010	1
2	Plumbing	2009	3,280		20	164	164	246	2
3	Room Signs	2009	2,568		20	128	128	193	3
4	Window Treatments & Drapes	2009	16,715		20	3,343	3,343	3,622	4
5	Pegasus Custom Furniture - 38 Doors	2009	2,990		20	150	150	162	5
6	Pegasus Custom Furniture - Doors	2009	7,650		20	383	383	478	6
7	Pegasus Custom Furniture - Door Trim	2009	7,650		20	383	383	446	7
8	Econocare, Inc. - Flooring	2009	12,958		20	648	648	702	8
9	Pegasus Custom Furniture - Crown Molding West Wing	2009	5,280		20	264	264	286	9
10	Pegasus Custom Furniture - Crown Molding East Wing	2009	5,280		20	264	264	286	10
11	Pegasus Custom Furniture - 38 Door Reface Leminat	2009	5,000		20	250	250	271	11
12	Pegasus Custom Furniture - Doors	2009	4,230		20	212	212	423	12
13	Plumbing	2009	2,850		20	143	143	226	13
14	Cooler Condenser	2009	2,661		20	133	133	177	14
15	Door Locks	2009	3,139		20	157	157	170	15
16	Remodeling Patients Room - Built In Cabinetry	2010	6,750		20	338	338	338	16
17	Remodeling Patients Room - Built In Cabinetry	2010	6,750		20	338	338	338	17
18	Remodeling The Cooridors - Bumper Guard, Handrail, Cove Base	2010	10,145		20	423	423	423	18
19	Remodeling Nursing Station - Cabinetry, Lighting, Floor	2010	9,950		20	498	498	498	19
20	Removal And Installation Of Doors	2010	2,770		20	104	104	104	20
21	Remodel First Floor Tub/Shower Room	2010	53,117		20	1,107	1,107	1,107	21
22	Long Elevator Costs - Controller, Wiring	2010	2,558		20	96	96	96	22
23	Long Elevator Costs - Wire Relays	2010	5,087		20	191	191	191	23
24	Boiler Repair	2010	7,916		20	396	396	396	24
25	A/C Wall Units	2010	3,027		20	169	169	169	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,307,005	\$ 248,639		\$ 154,733	\$ (93,906)	\$ 577,354	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		\$ 4,307,005	\$ 248,639		\$ 154,733	\$ (93,906)	\$ 577,354	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)	\$ 4,307,005	\$ 248,639		\$ 154,733	\$ (93,906)	\$ 577,354	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center

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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		\$ 4,307,005	\$ 248,639		\$ 154,733	\$ (93,906)	\$ 577,354	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)	\$ 4,307,005	\$ 248,639		\$ 154,733	\$ (93,906)	\$ 577,354	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center

0048470

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Ending:

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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	Ridgeview Rehab Relaty, LLC	1975	3,807,152	234,417	30	126,905	(107,512)	508,392	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 3,807,152	\$ 234,417		\$ 126,905	\$ (107,512)	\$ 508,392	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Double You Realty	2003	100,040	2,565	30	2,565		20,414	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Stavcare	2003	4,634		20	232	232	1,751	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)	\$ 104,674	\$ 2,565		\$ 2,797	\$ 232	\$ 22,165	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,305,662	\$ 233	\$ 130,642	\$ 130,409	10	\$ 682,014	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,375				10	1,375	73
74								74
75	TOTALS	\$ 1,307,037	\$ 233	\$ 130,642	\$ 130,409		\$ 683,389	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Staycare	2003	\$ 5,860	\$	\$	\$	5	\$ 5,860	76
77										77
78										78
79										79
80	TOTALS			\$ 5,860	\$	\$	\$		\$ 5,860	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)	\$ 6,230,368	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 248,872	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 285,375	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 36,503	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,266,603	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								5
6								6
7	TOTAL				\$			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: \$ _____ Description: _____
(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	Allocated from Staycare Management		\$	\$ 10,595	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 10,595	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs					\$ 206,411							\$ 206,411	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					9,117							9,117	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs					122,038							122,038	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							146,026					146,026	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>															13
14	TOTAL				\$			\$ 337,566		\$ 146,026				\$	483,592	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 Ridgeview Rehab & Nsg Center# 0048470Report 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	\$ 1,118,409	\$ 1,125,333	1
2	Cash-Patient Deposits	78,796	78,796	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(246,680)	(246,680)	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	107,895	107,895	6
7	Other Prepaid Expenses	1,971	1,971	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	6,291	300,802	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,066,682	\$ 1,368,117	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		600,000	13
14	Buildings, at Historical Cost		3,760,866	14
15	Leasehold Improvements, at Historical Cost	382,586	428,872	15
16	Equipment, at Historical Cost	51,637	1,290,180	16
17	Accumulated Depreciation (book methods)	(119,506)	(1,652,514)	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>	355,556	355,556	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 670,273	\$ 4,782,960	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,736,955	\$ 6,151,077	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 302,528	\$ 302,527	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	78,796	78,796	28
29	Short-Term Notes Payable	157,950		29
30	Accrued Salaries Payable	37,757	37,757	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,105	5,105	31
32	Accrued Real Estate Taxes(Sch.IX-B)		180,000	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>	13,091	13,091	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 595,227	\$ 617,276	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,354,736	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)	\$	\$ 6,354,736	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 595,227	\$ 6,972,012	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,141,728	\$ (820,935)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,736,955	\$ 6,151,077	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,124,815	1
2	Restatements (describe):		2
3	Restatement of Accumulated Depreciation	(30,578)	3
4	Rounding Error	8	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,094,245	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	455,483	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	(408,000)	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)	\$ 47,483	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)	\$ 1,141,728	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeview Rehab & Nsg Center

0048470

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	\$ 7,449,098	1
2	Discounts and Allowances for all Levels	(797,246)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,651,852	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	676,757	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 676,757	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	148,265	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,638	19
20	Radiology and X-Ray		20
21	Other Medical Services	21,459	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 175,362	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	9,858	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,858	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)	\$ 7,513,829	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,037,333	31
32	Health Care	1,917,425	32
33	General Administration	1,343,578	33
B. Capital Expense			
34	Ownership	2,200,048	34
C. Ancillary Expense			
35	Special Cost Centers	485,502	35
36	Provider Participation Fee	74,460	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,058,346	40
41	Income before Income Taxes (line 30 minus line 40)**	455,483	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 455,483	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 Ridgeview Rehab & Nsg Center

0048470

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	2,000	2,080	\$ 86,633	\$ 41.65	1
2	Assistant Director of Nursing	2,004	2,116	60,445	28.57	2
3	Registered Nurses	15,321	15,805	436,733	27.63	3
4	Licensed Practical Nurses	16,395	16,600	387,577	23.35	4
5	CNAs & Orderlies	48,240	52,011	532,482	10.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,543	1,765	26,018	14.74	8
9	Activity Director	1,790	1,907	21,463	11.25	9
10	Activity Assistants	5,079	5,523	57,096	10.34	10
11	Social Service Workers	5,579	5,803	97,683	16.83	11
12	Dietician					12
13	Food Service Supervisor	1,958	2,078	36,625	17.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,134	19,354	178,695	9.23	15
16	Dishwashers					16
17	Maintenance Workers	2,068	2,228	30,375	13.63	17
18	Housekeepers	18,458	19,947	192,712	9.66	18
19	Laundry	5,385	5,965	65,898	11.05	19
20	Administrator	2,360	2,536	96,273	37.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,656	7,000	86,763	12.39	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	1,017	1,105	11,007	9.96	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,854	4,051	134,142	33.11	33
34	TOTAL (lines 1 - 33)	157,841	167,874	\$ 2,538,620 *	\$ 15.12	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	Monthly	\$ 8,902	01-03	35
36	Medical Director	Monthly	9,600	09-03	36
37	Medical Records Consultant	Monthly	4,416	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,673	10-03	39
40	Physical Therapy Consultant	1	32	10a-03	40
41	Occupational Therapy Consultant	1	53	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,640	11-03	44
45	Social Service Consultant	35	1,905	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	37	\$ 31,221		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Lawrence Torf	Administrator	0	\$ 4,509	Workers' Compensation Insurance	\$ 78,938	IDPH License Fee	\$	
David Wengrow (1/5/10 - 5/31/10)	Administrator	0	15,919	Unemployment Compensation Insurance	35,849	Advertising: Employee Recruitment	1,667	
Debra Brown	Administrator	0	75,846	FICA Taxes	188,998	Health Care Worker Background Check	1,630	
				Employee Health Insurance	85,733	(Indicate # of checks performed <u>160</u>)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses/Permits and Fees	1,783	
				Employee Benefits	951	Dues and Subscriptions	8,969	
				Union Pension	20,507			
				401K - Employer	853			
				Chicago Head Tax	4,820	Less: Public Relations Expense	()	
				Christmas Expense	2,625	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 96,273					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 419,274	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,049	
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
Staycare Management Fees			\$ 442,800				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 442,800				Seminar Expense	1,311
							Allocated from Staycare	116
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	()
FR&R	Accounting		\$ 24,673	TOTAL		\$	TOTAL	\$ 1,427
See Attached	Legal		21,945					
Personnel Planners	Unemployment Consulting		1,566					
LTC Solutions	Computer Service		1,644					
KBC Computers	Computer Maintenance		2,892					
Staycare	Consulting Fee		6,500					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 59,220					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeview Rehab & Nsg Center# 0048470Report Period Beginning: 01/01/10Ending: 12/31/10**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC - \$12,648 IAHC - \$1,632
- (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? _____
- (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. \$ 15,205 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 No 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. \$ 74,460
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. \$ _____ Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (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. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.