

		FOR BHF USE					

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**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0032862</u></p> <p>Facility Name: <u>Danville Care Center</u></p> <p>Address: <u>1701 North Bowman Ave.</u> <u>Danville</u> <u>61832</u> Number City Zip Code</p> <p>County: <u>Vermilion</u></p> <p>Telephone Number: <u>(217) 443-2955</u> Fax # <u>(217) 443-0315</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/01/87</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) _____ (Date) _____</td> </tr> <tr> <td rowspan="4" style="width: 20%; vertical-align: top;">Paid Preparer</td> <td>(Title) _____</td> </tr> <tr> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> <tr> <td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____ (Date) _____	Paid Preparer	(Title) _____	(Signed) _____	(Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>		(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center

0032862 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	43,070	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	29,930	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			3,806	3,806	8
9	SNF/PED					9
10	ICF	31,772	2,063	1,587	35,422	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,772	2,063	5,393	39,228	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.74%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 118 and days of care provided 3,780

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: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	240,903	23,200	11,139	275,242		275,242		275,242		1
2	Food Purchase		279,801		279,801		279,801	(147)	279,654		2
3	Housekeeping	211,966	47,035		259,001		259,001		259,001		3
4	Laundry	38,012	27,247		65,259		65,259		65,259		4
5	Heat and Other Utilities			216,056	216,056		216,056	1,512	217,568		5
6	Maintenance	73,372	51,156	44,190	168,718		168,718	(8,234)	160,484		6
7	Other (specify):*										7
8	TOTAL General Services	564,253	428,439	271,385	1,264,077		1,264,077	(6,870)	1,257,207		8
	B. Health Care and Programs										
9	Medical Director			10,000	10,000		10,000		10,000		9
10	Nursing and Medical Records	1,703,605	83,076	160,022	1,946,703		1,946,703	5,665	1,952,368		10
10a	Therapy	42,054	1,937	217	44,208		44,208		44,208		10a
11	Activities	157,655	4,344		161,999		161,999		161,999		11
12	Social Services	54,273		11,830	66,103		66,103		66,103		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*	42,148			42,148		42,148	5,399	47,547		15
16	TOTAL Health Care and Programs	1,999,735	89,357	182,069	2,271,161		2,271,161	11,064	2,282,225		16
	C. General Administration										
17	Administrative	128,264		54,000	182,264		182,264	13,200	195,464		17
18	Directors Fees										18
19	Professional Services			294,289	294,289		294,289	(245,388)	48,901		19
20	Dues, Fees, Subscriptions & Promotions			42,657	42,657		42,657	(13,586)	29,071		20
21	Clerical & General Office Expenses	127,898	8,840	138,113	274,851		274,851	31,352	306,203		21
22	Employee Benefits & Payroll Taxes			479,466	479,466		479,466		479,466		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,962	2,962		2,962	272	3,234		24
25	Other Admin. Staff Transportation			15,542	15,542		15,542	2,808	18,350		25
26	Insurance-Prop.Liab.Malpractice			118,825	118,825		118,825	3,992	122,817		26
27	Other (specify):*							34,699	34,699		27
28	TOTAL General Administration	256,162	8,840	1,145,854	1,410,856		1,410,856	(172,651)	1,238,205		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,820,150	526,636	1,599,308	4,946,094		4,946,094	(168,457)	4,777,637		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Danville Care Center

#0032862

Report Period Beginning:

01/01/11

Ending:

12/31/11

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			118,640	118,640		118,640	117,429	236,069			30
31	Amortization of Pre-Op. & Org.							(0)	(0)			31
32	Interest			41,671	41,671		41,671	402,542	444,213			32
33	Real Estate Taxes			66,990	66,990		66,990		66,990			33
34	Rent-Facility & Grounds			618,899	618,899		618,899	(609,547)	9,352			34
35	Rent-Equipment & Vehicles			8,739	8,739		8,739	7,662	16,401			35
36	Other (specify):*											36
37	TOTAL Ownership			854,939	854,939		854,939	(81,914)	773,025			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		306,367	412,292	718,659		718,659		718,659			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):*	47,495			47,495		47,495	(47,495)	(0)			43
44	TOTAL Special Cost Centers	47,495	306,367	521,792	875,654		875,654	(47,495)	828,159			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,867,645	833,003	2,976,039	6,676,687		6,676,687	(297,866)	6,378,821			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center

0032862

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	(8,842)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(145,369)	30		9
10	Interest and Other Investment Income	(190)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(147)	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	(7,763)	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	(80,482)	21		24
25	Fund Raising, Advertising and Promotional	(9,943)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,900)	20		28
29	Other-Attach Schedule	(346,232)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (602,868)		\$	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)	305,002		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 305,002		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (297,866)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

BHF USE ONLY							
48		49		50		51	52

Danville Care CenterID# 0032862Report Period Beginning: 01/01/11Ending: 12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Purchased Services - Veterans	\$ (24,021)	10	1
2	Marketing	(47,495)	43	2
3	Bank Charges	(4,851)	21	3
4	Theft & Damage Loss	(428)	21	4
5	Non-Allowable Interest Expense	(7,000)	32	5
6	Building Co. - Accounting Fees	(1,440)	19	6
7	Building Co. - Amortization	(26,623)	31	7
8	Building Co. - Bank Charges	(49)	21	8
9	Building Co. - Licenses & Permits	(309)	20	9
10	Building Co. - Prepayment Penalties	(188,071)	21	10
11	Building Co. - Titles Fees	(800)	20	11
12	Building Co. - Amortization of Loan Fees	(4,557)	31	12
13	Building Co. - Office Expenses	(54)	21	13
14	Additional R&M	7,303	06	14
15	PPA - Office Expense	(6,715)	21	15
16	Non-Allowable Legal Fees	(24,415)	19	16
17	Non-Allowable Marketing Travel	(4,547)	25	17
18	Capitalized R&M	(6,731)	06	18
19	Non-Allowable Expense	(5,429)	21	19
20				20
21				21
22				22
23				23
24				24
25				25
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44				44
45				45
46				46
47				47
48				48
49	Total	(346,232)		49

Danville Care Center

ID# 0032862

Report Period Beginning: 01/01/11

Ending: 12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number Danville Care Center# 0032862

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	(147)											(147)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,512									1,512	5
6	Maintenance	(8,270)		36									(8,234)	6
7	Other (specify):*													7
8	TOTAL General Services	(8,417)		1,547									(6,870)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(24,021)		29,686									5,665	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			5,399									5,399	15
16	TOTAL Health Care and Programs	(24,021)		35,085									11,064	16
	C. General Administration													
17	Administrative			13,200									13,200	17
18	Directors Fees													18
19	Professional Services	(25,855)	1,440	(220,973)									(245,388)	19
20	Fees, Subscriptions & Promotions	(14,952)	1,109	257									(13,586)	20
21	Clerical & General Office Expenses	(293,842)	188,174	137,020									31,352	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			272									272	24
25	Other Admin. Staff Transportation	(4,547)		7,355									2,808	25
26	Insurance-Prop.Liab.Malpractice			3,992									3,992	26
27	Other (specify):*			34,699									34,699	27
28	TOTAL General Administration	(339,195)	190,723	(24,178)									(172,651)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(371,634)	190,723	12,454									(168,457)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Danville Care Center# 0032862

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	(145,369)	261,597	1,201									117,429	30
31	Amortization of Pre-Op. & Org.	(31,180)	31,180										(0)	31
32	Interest	(7,190)	409,732										402,542	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(618,899)	9,352									(609,547)	34
35	Rent-Equipment & Vehicles			7,662									7,662	35
36	Other (specify):*													36
37	TOTAL Ownership	(183,740)	83,610	18,215									(81,914)	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):*	(47,495)											(47,495)	43
44	TOTAL Special Cost Centers	(47,495)											(47,495)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(602,868)	274,333	30,669									(297,866)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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 Rental Income	\$ 618,899	Danville Care Center, LLC		\$	\$ (618,899)	1
2	V	32 Interest Income	15	Danville Care Center, LLC			(15)	2
3	V	19 Accounting Fees		Danville Care Center, LLC		1,440	1,440	3
4	V	31 Amortization		Danville Care Center, LLC		26,623	26,623	4
5	V	21 Bank Charges & Prepayment Penalties		Danville Care Center, LLC		188,120	188,120	5
6	V	30 Depreciation		Danville Care Center, LLC		261,597	261,597	6
7	V	31 Amortization of Loan Fees		Danville Care Center, LLC		4,557	4,557	7
8	V	32 Interest Expense		Danville Care Center, LLC		409,747	409,747	8
9	V	20 Licenses, Permits, & Title Fees		Danville Care Center, LLC		1,109	1,109	9
10	V	21 Office Expenses		Danville Care Center, LLC		54	54	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 618,914			\$ 893,247	\$ * 274,333	14

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

Facility Name & ID Number Danville Care Center# 0032862Report Period Beginning: 01/01/11 Ending: 12/31/11

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	\$	CERTIFIED HEALTH MANAGEMENT	100.00%	\$ 1,512	\$	1,512	15
16	V	6 AUTO REPAIRS		CERTIFIED HEALTH MANAGEMENT	100.00%	36		36	16
17	V	10 NURSING		CERTIFIED HEALTH MANAGEMENT	100.00%	29,686		29,686	17
18	V	15 EMP. BEN. HEALTHCARE		CERTIFIED HEALTH MANAGEMENT	100.00%	5,399		5,399	18
19	V	19 PROFESSIONAL FEES		CERTIFIED HEALTH MANAGEMENT	100.00%	4,243		4,243	19
20	V	20 DUES, FEES, SUBSCRIPTIONS		CERTIFIED HEALTH MANAGEMENT	100.00%	257		257	20
21	V	21 SALARIES - CLERICAL		CERTIFIED HEALTH MANAGEMENT	100.00%	120,880		120,880	21
22	V	21 OFFICE EXPENSES		CERTIFIED HEALTH MANAGEMENT	100.00%	16,140		16,140	22
23	V	24 SEMINAR EXPENSE		CERTIFIED HEALTH MANAGEMENT	100.00%	272		272	23
24	V	25 AUTO & TRAVEL EXPENSE		CERTIFIED HEALTH MANAGEMENT	100.00%	7,355		7,355	24
25	V	26 INSURANCE		CERTIFIED HEALTH MANAGEMENT	100.00%	3,992		3,992	25
26	V	27 EMP. BEN. GEN. ADMIN.		CERTIFIED HEALTH MANAGEMENT	100.00%	22,943		22,943	26
27	V	30 DEPRECIATION		CERTIFIED HEALTH MANAGEMENT	100.00%	1,201		1,201	27
28	V	34 RENT		CERTIFIED HEALTH MANAGEMENT	100.00%	9,352		9,352	28
29	V	35 AUTO LEASE		CERTIFIED HEALTH MANAGEMENT	100.00%	7,662		7,662	29
30	V								30
31	V	17 ADMIN COMP - B. ALTER		CERTIFIED HEALTH MANAGEMENT	100.00%	60,000		60,000	31
32	V	17 ADMIN COMP - H. GELLER		CERTIFIED HEALTH MANAGEMENT	100.00%	7,200		7,200	32
33	V	27 EMP. BEN. - B. ALTER		CERTIFIED HEALTH MANAGEMENT	100.00%	11,137		11,137	33
34	V	27 EMP. BEN. - H. GELLER		CERTIFIED HEALTH MANAGEMENT	100.00%	620		620	34
35	V								35
36	V	17 MANAGEMENT FEES	54,000	CERTIFIED HEALTH MANAGEMENT	100.00%			(54,000)	36
37	V	19 BOOKEEPING FEES	206,016	CERTIFIED HEALTH MANAGEMENT	100.00%			(206,016)	37
38	V	19 ADMIN.-CONSULT FEES	19,200	CERTIFIED HEALTH MANAGEMENT	100.00%			(19,200)	38
39	Total		\$ 279,216			\$ 309,885	\$ *	30,669	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Danville Care Center

0032862

Report Period Beginning:

01/01/11

Ending:

12/31/11

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BRADLEY M. ALTER	22.826%	GLENWOOD HEALTHCARE & REHAB, INC.	GLENWOOD	DANVILLE CARE CTR.	SKOKIE	BUILDING CO.	1
2	ESBT JENNIFER T. W. CHOW	19.565%	PRAIRIE VIEW CARE CENTER OF LEWISTOWN, INC.	LEWISTOWN	CERTIFIED HEALTH MGMT.	SKOKIE, ILLINOIS	MANAGEMENT	2
3	ESBT JULIE BRUM	19.565%	RENAISSANCE CARE CENTER, INC.	CANTON				3
4	RITA L. GELLER	38.044%						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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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

Facility Name & ID Number Danville Care Center # 0032862 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bradley Alter	Owner	Administration	22.83%	See Attached	15	30.00%	Alloc. Sal.	\$ 60,000	17-7	1
2	Howard Geller	Relative	Administration	0.00%	See Attached	3	12.00%	Mgmt. Fees	7,200	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10	Where applicable, the amounts reported on this page have been adjusted from the actual costs										10
11	to reflect only amount anticipated to be considered allowable by the IL. Dept of HFS										11
12											12
13								TOTAL	\$ 67,200		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center

0032862

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center

0032862

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	150,902	4	\$ 5,818	\$ 39,202	\$ 1,512	1
2	6	AUTO REPAIRS	PATIENT DAYS	150,902	4	137	39,202	36	2
3	10	NURSING	PATIENT DAYS	150,902	4	114,272	114,272	29,686	3
4	15	EMP. BEN. HEALTHCARE	PATIENT DAYS	150,902	4	20,782	39,202	5,399	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	150,902	4	16,333	39,202	4,243	5
6	20	DUES, FEES, SUBSCRIPTIONS	PATIENT DAYS	150,902	4	988	39,202	257	6
7	21	SALARIES - CLERICAL	PATIENT DAYS	150,902	4	465,308	465,308	120,880	7
8	21	OFFICE EXPENSES	PATIENT DAYS	150,902	4	62,130	39,202	16,140	8
9	24	SEMINAR EXPENSE	PATIENT DAYS	150,902	4	1,045	39,202	272	9
10	25	AUTO & TRAVEL EXPENSE	PATIENT DAYS	150,902	4	28,312	39,202	7,355	10
11	26	INSURANCE	PATIENT DAYS	150,902	4	15,366	39,202	3,992	11
12	27	EMP. BEN. GEN. ADMIN.	PATIENT DAYS	150,902	4	88,314	39,202	22,943	12
13	30	DEPRECIATION	PATIENT DAYS	150,902	4	4,624	39,202	1,201	13
14	34	RENT	PATIENT DAYS	150,902	4	36,000	39,202	9,352	14
15	35	AUTO LEASE	PATIENT DAYS	150,902	4	29,493	39,202	7,662	15
16									16
17	17	ADMIN COMP - B. ALTER	AVG HOURS WORKED	50	4	200,000	200,000	60,000	17
18	17	ADMIN COMP - H. GELLER	AVG HOURS WORKED	25	4	60,000	60,000	7,200	18
19	27	EMP. BEN. - B. ALTER	AVG HOURS WORKED	50	4	37,124	15	11,137	19
20	27	EMP. BEN. - H. GELLER	AVG HOURS WORKED	25	4	5,164	3	620	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,191,210	\$ 839,580	\$ 309,885	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center

0032862

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center

0032862 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center

0032862

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center

0032862 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center

0032862

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center

0032862

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center

0032862 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (____) _____
 Fax Number (____) _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center

0032862

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Danville Care Center

0032862

Report Period Beginning:

01/01/11

Ending:

12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Enloe		X	Notes Payable			\$	\$ 236,712		\$ 11,051	1								
2	Rehab Care		X	Notes Payable						2,108	2								
3	Cole Taylor		X	Mortgage Payable				3,500,000		43,130	3								
4	Barry Kirschenbaum		X	Mortgage Payable						366,617	4								
5	See Supplemental Schedule										5								
Working Capital																			
6	Bank Financial		X	Line of Credit				897,504		19,338	6								
7	Insurance Financing		X							2,174	7								
8	See Supplemental Schedule										8								
9	TOTAL Facility Related						\$	\$ 4,634,216		\$ 444,419	9								
B. Non-Facility Related*																			
10	Interest Income		X							(190)	10								
11	Interest Income - Bldg Co		X							(15)	11								
12											12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related						\$	\$		\$ (205)	14								
15	TOTALS (line 9+line14)						\$	\$ 4,634,216		\$ 444,214	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

Danville Care Center

0032862

Report Period Beginning:

01/01/11

Ending:

12/31/11

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 2010 report.		\$	71,270		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.)		\$	68,442		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,828)		3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	69,811		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.		\$	66,983		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	71,929	8	FOR BHF USE ONLY	
	2007	72,234	9	13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
	2008	75,144	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2009	69,871	11	15	LESS REFUND FROM LINE 6 \$ 15
	2010	68,442	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
2011 Accrual = \$68,442 x 1.02 = \$69,811					

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Danville Care Center COUNTY Vermilion

FACILITY IDPH LICENSE NUMBER 0032862

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Danville Care Center

0032862

Report Period Beginning:

01/01/11

Ending:

12/31/11

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	200		1974	\$ 2,954,225	\$ 261,597		\$ 152,666	\$ (108,931)	\$ 2,137,330	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1989	34,167		20			34,167	9
10	Various		1990	17,344		20			17,344	10
11	Various		1991	45,376		20	1,134	1,134	45,376	11
12	Various		1992	12,043		20	602	602	11,792	12
13	Various		1993	9,213		20	461	461	8,522	13
14	Various		1994	8,304		20	415	415	7,266	14
15	Various		1995	39,047		20	1,952	1,952	31,888	15
16	Various		1996	44,007		20	2,200	2,200	33,919	16
17	Various		1997	28,811		20	1,441	1,441	20,888	17
18	Various		1998	394,658		20	19,733	19,733	276,261	18
19	Various		1999	42,329		20	2,116	2,116	26,456	19
20	Various		2000	51,980		20	2,599	2,599	30,050	20
21	Various		2001	1,377		20	69	69	723	21
22	Various		2002	11,592		20	580	580	5,289	22
23	Various		2003	122,592		20	6,130	6,130	52,115	23
24	Various		2004	68,558		20	3,428	3,428	25,232	24
25	Various		2005	83,307		20	4,165	4,165	27,294	25
26	Various		2006	46,793		20	2,340	2,340	13,007	26
27	Various		2007	6,180		20	309	309	1,545	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)	108,929			5,446	5,446	5,446	67
68	Related Party Allocations (Pages 12H & 12I)	24,478	628		1,224	596	18,358	68
69	Financial Statement Depreciation		118,640			(118,640)		69
70	TOTAL (lines 4 thru 69)	\$ 4,155,310	\$ 380,865		\$ 209,010	\$ (171,855)	\$ 2,830,267	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Danville Care Center

0032862

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 4,155,310	\$ 380,865		\$ 209,010	\$ (171,855)	\$ 2,830,267	1
2	Water Heater	2008	5,520		20	276	276	1,058	2
3	Glass Replacement In Doors	2008	938		20	47	47	172	3
4	Blower Motor, Capacitor, Circuit Board	2008	668		20	33	33	117	4
5	Vinyl Fence And Materials	2008	5,398		20	270	270	922	5
6	Water Guages/Sprinkler Heads	2008	641		20	32	32	110	6
7	Compressor For Cooler	2008	675		20	135	135	495	7
8	2 Hollow Metal Doors	2008	1,155		20	58	58	197	8
9	1 Kitchen Hood	2009	10,500		20	525	525	1,575	9
10	Roof Repairs	2009	24,407		20	1,220	1,220	3,356	10
11	Refrigeration & Heating -Hood & Exhaust Fan	2009	10,500		20	2,100	2,100	5,600	11
12	Security Cameras	2009	11,025		20	551	551	1,286	12
13	Phone System	2009	3,115		20	312	312	779	13
14	Fence	2009	6,480		20	432	432	1,044	14
15	Concrete Work	2009	2,600		20	173	173	462	15
16	Freezer	2011	5,400		20	990	990	990	16
17	Thru Wall A/C Units	2011	4,255		20	496	496	496	17
18	Phone System	2011	9,598		20	960	960	960	18
19	Thru Wall A/C Units	2011	3,564		20	297	297	297	19
20	Lock Replacement/Repairs	2011	3,575		20	179	179	179	20
21	Paint	2011	3,156		20	158	158	158	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)		\$ 4,268,480	\$ 380,865		\$ 218,255	\$ (162,610)	\$ 2,850,520	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 and Improvement Costs-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		\$ 4,268,480	\$ 380,865		\$ 218,255	\$ (162,610)	\$ 2,850,520	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		\$ 4,268,480	\$ 380,865		\$ 218,255	\$ (162,610)	\$ 2,850,520	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 and Improvement Costs-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		\$ 4,268,480	\$ 380,865		\$ 218,255	\$ (162,610)	\$ 2,850,520	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)	\$ 4,268,480	\$ 380,865		\$ 218,255	\$ (162,610)	\$ 2,850,520	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 and Improvement Costs-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		\$ 4,268,480	\$ 380,865		\$ 218,255	\$ (162,610)	\$ 2,850,520	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		\$ 4,268,480	\$ 380,865		\$ 218,255	\$ (162,610)	\$ 2,850,520	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Parking Lot Paving - Asphalt	2011	108,929		20	5,446	5,446	5,446	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 and Improvement Costs-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)	\$ 108,929	\$		\$ 5,446	\$ 5,446	\$ 5,446	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Certified Health Management	1997	24,478	628	20	1,224	596	18,358	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 and Improvement Costs-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)		\$ 24,478	\$ 628		\$ 1,224	\$ 596	\$ 18,358	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Danville Care Center

0032862

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 123,030	\$ 29	\$ 11,478	\$ 11,449	10	\$ 82,911	71
72	Current Year Purchases	43,456	545	4,605	4,060	10	4,605	72
73	Fully Depreciated Assets	886,070		66	66	10	886,070	73
74								74
75	TOTALS	\$ 1,052,556	\$ 574	\$ 16,148	\$ 15,574		\$ 973,586	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		FORD VAN	1994	\$ 19,594	\$	\$	\$	5	\$ 19,594	76
77		LIFT/TIE DOWNS	2007	8,783		1,463	1,463	5	8,051	77
78		VEHICLE	2000	21,907				5	21,907	78
79		2006 FORD F-350	2011	17,072		203	203	5	203	79
80	TOTALS			\$ 67,356	\$	\$ 1,666	\$ 1,666		\$ 49,756	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,388,392	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 381,439	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 236,070	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (145,369)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,873,862	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5	<u>Allocated from Certified Health Management</u>			<u>9,352</u>			5
6							6
7	TOTAL			\$ 9,352			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: \$ 8,739 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	<u>Allocated from Certified Health Management</u>			<u>7,662</u>	18
19					19
20					20
21	TOTAL		\$	\$ 7,662	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. _____/2012 \$ _____

13. _____/2013 \$ _____

14. _____/2014 \$ _____

* 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		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	\$				\$ 160,488	\$		\$ 160,488	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					46,167			46,167	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	39 - 03	hrs					205,637			205,637	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						139,477		139,477	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>								166,890		166,890	13	
14	TOTAL			\$				\$ 412,292	\$ 306,367		\$ 718,659	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center# 0032862Report Period Beginning: 01/01/11

Ending:

12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 36,104	\$ 408,055	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,393,074	2,393,074	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	100,924	100,924	6
7	Other Prepaid Expenses	22,460	22,460	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	232,228	655,612	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,784,790	\$ 3,580,125	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		350,000	13
14	Buildings, at Historical Cost		5,954,225	14
15	Leasehold Improvements, at Historical Cost	1,193,441	1,302,370	15
16	Equipment, at Historical Cost	787,008	1,087,008	16
17	Accumulated Depreciation (book methods)	(1,234,239)	(3,780,530)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(373,333)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>		50,131	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 746,210	\$ 4,589,871	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,531,000	\$ 8,169,996	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 626,538	\$ 626,538	26
27	Officer's Accounts Payable	348,180	348,180	27
28	Accounts Payable-Patient Deposits	64,669	64,669	28
29	Short-Term Notes Payable	1,134,216	1,134,216	29
30	Accrued Salaries Payable	126,569	126,569	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,080	16,080	31
32	Accrued Real Estate Taxes(Sch.IX-B)	69,811	69,811	32
33	Accrued Interest Payable	14,134	26,250	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	2,589,291	3,642,287	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,989,488	\$ 6,054,600	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,500,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>		139,075	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,639,075	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,989,488	\$ 9,693,675	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,458,488)	\$ (1,523,679)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,531,000	\$ 8,169,996	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,551,264)	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,551,265)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	92,777	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 92,777	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)	\$ (1,458,488)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Danville Care Center# 0032862Report Period Beginning: 01/01/11Ending: 12/31/11

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	\$ 6,572,778	1
2	Discounts and Allowances for all Levels	(776,519)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,796,259	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	551,791	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 551,791	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	144,341	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,255	19
20	Radiology and X-Ray		20
21	Other Medical Services	262,628	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 421,224	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	190	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 190	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,769,464	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,264,077	31
32	Health Care	2,271,161	32
33	General Administration	1,410,856	33
B. Capital Expense			
34	Ownership	854,939	34
C. Ancillary Expense			
35	Special Cost Centers	766,154	35
36	Provider Participation Fee	109,500	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,676,687	40
41	Income before Income Taxes (line 30 minus line 40)**	92,777	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 92,777	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 **Danville Care Center**

0032862

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	1,004	1,038	\$ 31,361	\$ 30.21	1
2	Assistant Director of Nursing	2,389	2,999	83,623	27.88	2
3	Registered Nurses	13,206	13,809	397,192	28.76	3
4	Licensed Practical Nurses	23,572	24,221	487,045	20.11	4
5	CNAs & Orderlies	63,459	66,950	675,965	10.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,942	4,129	42,054	10.19	8
9	Activity Director	2,343	2,600	35,826	13.78	9
10	Activity Assistants	3,520	3,597	28,559	7.94	10
11	Social Service Workers	3,916	4,338	54,273	12.51	11
12	Dietician					12
13	Food Service Supervisor	1,921	2,080	36,362	17.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,603	11,281	111,840	9.91	15
16	Dishwashers	10,439	10,718	92,701	8.65	16
17	Maintenance Workers	3,797	4,241	73,372	17.30	17
18	Housekeepers	22,396	23,535	211,966	9.01	18
19	Laundry	3,966	4,250	38,012	8.94	19
20	Administrator	1,744	1,760	71,216	40.46	20
21	Assistant Administrator	1,944	2,080	57,048	27.43	21
22	Other Administrative					22
23	Office Manager	1,798	1,920	32,075	16.71	23
24	Clerical	8,334	8,798	95,823	10.89	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,952	4,399	93,270	21.20	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,965	2,156	28,419	13.18	31
32	Other Health Care Plan Coord	1,979	2,167	42,148	19.45	32
33	Other(specify) <u>See Supplemental</u>	2,337	2,406	47,495	19.74	33
34	TOTAL (lines 1 - 33)	194,526	205,472	\$ 2,867,645 *	\$ 13.96	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	279	\$ 11,139	01-03	35
36	Medical Director	Monthly	10,000	09-03	36
37	Medical Records Consultant	56	2,075	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,541	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	5	217	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	338	11,830	12-03	45
46	Other(specify)				46
47	<u>Psychiatric Consultant</u>	Monthly	13,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	678	\$ 55,802		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	180	\$ 9,603	10-03	50
51	Licensed Practical Nurses	30,474	127,803	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	30,654	\$ 137,406		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	
Deb Porter	Administrator	0	\$ 59,706	Workers' Compensation Insurance	\$ 116,893	IDPH License Fee	\$	
Tracie O'Neil	Administrator	0	5,298	Unemployment Compensation Insurance	50,142	Advertising: Employee Recruitment	19,829	
Mary Stanley	Administrator	0	6,212	FICA Taxes	207,829	Health Care Worker Background Check	2,750	
Angela Pankey	Asst. Admin.	0	57,048	Employee Health Insurance	101,239	(Indicate # of checks performed <u>275</u>)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	1,938	
				Pension Plan Contributions	2,760	Licenses & Permits	4,297	
				Employee Benefits - Other	603	Advertising	9,942	
						Yellow Page Advertising	3,900	
						See Supplemental Schedule	257	
						Less: Public Relations Expense (
						Non-allowable advertising	(9,942)	
						Yellow page advertising	(3,900)	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)			\$ 128,264			\$ 29,071		
B. Administrative - Other								
Description			Amount					
Management Fees - Certified Health Management			\$ 54,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 54,000					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Frost, Ruttenberg & Rothblatt	Accounting		\$ 12,450				Out-of-State Travel	\$
Richard Peelo	Accounting		3,750					
Personnel Planners	Unemployment Consulting		6,640					
E-Health Data Solutions	MDS Consulting		4,339				In-State Travel	
MPRO	Survey Finding Arbitration		3,020					
Pioneer Environmental	Environmental Survey		2,300					
Certified Health Management	Admin Consulting		19,200					
Certified Health Management	Clerical Service		206,016				Seminar Expense	2,962
Paychex	Payroll Processing		12,158				Allocated from Certified Health Mgmt	272
Legal Fees	Adj on Pg 5A		24,415					
							Entertainment Expense (
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 3,234
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 294,289					

* 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 Danville Care Center# 0032862

Report Period Beginning:

01/01/11

Ending:

12/31/11**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? None
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 956 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. \$ 109,500
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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln14
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT