

Facility Name & ID Number Calvin Johnson Care Center

0023309 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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 _____

	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	132	Skilled (SNF)	132	48,180	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	8,385	575	1,454	10,414		8
9	SNF/PED						9
10	ICF	32,461	1,329		33,790		10
11	ICF/DD						11
12	SC						12
13	DD 16 OR LESS						13
14	TOTALS	40,846	1,904	1,454	44,204		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.28%

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

0 (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 04/01/1977

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 48 and days of care provided 1,454

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	261,198	18,069	8,149	287,416	125	287,541		287,541		1
2	Food Purchase		214,405		214,405	(3,694)	210,711		210,711		2
3	Housekeeping	187,363	35,147		222,510		222,510		222,510		3
4	Laundry	104,135	17,187		121,322		121,322		121,322		4
5	Heat and Other Utilities			216,705	216,705		216,705	1,952	218,657		5
6	Maintenance	115,241	2,871	54,138	172,250		172,250	3,101	175,351		6
7	Other (specify):*										7
8	TOTAL General Services	667,937	287,679	278,992	1,234,608	(3,569)	1,231,039	5,053	1,236,092		8
	B. Health Care and Programs										
9	Medical Director			37,500	37,500		37,500		37,500		9
10	Nursing and Medical Records	2,685,762	431,358	86,688	3,203,808	(148,263)	3,055,545		3,055,545		10
10a	Therapy					56,320	56,320		56,320		10a
11	Activities	61,803	8,631	749	71,183		71,183		71,183		11
12	Social Services	101,129		2,248	103,377		103,377		103,377		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,848,694	439,989	127,185	3,415,868	(91,943)	3,323,925		3,323,925		16
	C. General Administration										
17	Administrative	180,733		79,351	260,084		260,084	(79,351)	180,733		17
18	Directors Fees										18
19	Professional Services			8,844	8,844		8,844	4,326	13,170		19
20	Dues, Fees, Subscriptions & Promotions			24,041	24,041		24,041	(7,938)	16,103		20
21	Clerical & General Office Expenses	318,137	18,043	52,025	388,205	3,275	391,480	12,480	403,960		21
22	Employee Benefits & Payroll Taxes			453,332	453,332	(1,606)	451,726	30,831	482,557		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,189	8,189		8,189	1,264	9,453		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			93,397	93,397		93,397	616	94,013		26
27	Other (specify):*			4,860	4,860		4,860	(4,860)			27
28	TOTAL General Administration	498,870	18,043	724,039	1,240,952	1,669	1,242,621	(42,632)	1,199,989		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,015,501	745,711	1,130,216	5,891,428	(93,843)	5,797,585	(37,579)	5,760,006		29

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

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

Calvin Johnson Care Center

#0023309

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			83,511	83,511		83,511	6,464	89,975			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,039	8,039		8,039	(1,472)	6,567			32
33	Real Estate Taxes			61,359	61,359		61,359		61,359			33
34	Rent-Facility & Grounds			443,565	443,565		443,565	14,880	458,445			34
35	Rent-Equipment & Vehicles			13,461	13,461		13,461		13,461			35
36	Other (specify):*											36
37	TOTAL Ownership			609,935	609,935		609,935	19,872	629,807			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					93,843	93,843		93,843			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		12,310		12,310		12,310		12,310			41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):* Income taxes			75,631	75,631		75,631		75,631			43
44	TOTAL Special Cost Centers		12,310	174,181	186,491	93,843	280,334		280,334			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,015,501	758,021	1,914,332	6,687,854		6,687,854	(17,707)	6,670,147			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,472)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(32)	21		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	(500)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,860)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,392)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (13,256)		\$	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)	735	var	34
35	Other- Attach Schedule	(5,186)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (4,451)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (17,707)		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.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology	X		5,577	39 42
43	Prescription Drugs	X		70,051	39 43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$ 75,628	47

BHF USE ONLY							
48		49		50		51	52

Calvin Johnson Care Center

ID# 0023309

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Cost of Tee shirts sold	\$ (3,186)	22	1
2	Lobbying fees	(2,000)	20	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(5,186)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Calvin Johnson Care Center

0023309

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,952	0	0	0	0	0	0	0	0	1,952	5
6	Maintenance	0	0	3,101	0	0	0	0	0	0	0	0	3,101	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	5,053	0	5,053	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(79,351)	0	0	0	0	0	0	0	0	(79,351)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	4,326	0	0	0	0	0	0	0	0	4,326	19
20	Fees, Subscriptions & Promotions	(8,892)	0	954	0	0	0	0	0	0	0	0	(7,938)	20
21	Clerical & General Office Expenses	(32)	0	12,512	0	0	0	0	0	0	0	0	12,480	21
22	Employee Benefits & Payroll Taxes	(3,186)	0	34,017	0	0	0	0	0	0	0	0	30,831	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,264	0	0	0	0	0	0	0	0	1,264	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	616	0	0	0	0	0	0	0	0	616	26
27	Other (specify):*	(4,860)	0	0	0	0	0	0	0	0	0	0	(4,860)	27
28	TOTAL General Administration	(16,970)	0	(25,662)	0	(42,632)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16,970)	0	(20,609)	0	(37,579)	29							

STATE OF ILLINOIS

Facility Name & ID Number Calvin Johnson Care Center# 0023309

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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	0	0	6,464	0	0	0	0	0	0	0	0	6,464	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,472)	0	0	0	0	0	0	0	0	0	0	(1,472)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	14,880	0	0	0	0	0	0	0	0	14,880	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,472)	0	21,344	0	19,872	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(18,442)	0	735	0	(17,707)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	17-1 Home Office Adm Wages	\$ 86,475	Eldercare Inc	0.00%	\$ 86,475		1	
2	V	21-1 Home Office Wages	164,839	Eldercare Inc	0.00%	164,839		2	
3	V	17-3 Home Office Adm expenses	79,351	Eldercare Inc	0.00%	80,086	735	3	
4	V							4	
5	V							5	
6	V							6	
7	V							7	
8	V							8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 330,665			\$ 331,400	\$ *	735	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 Utilities	\$	Eldercare Inc	0.00%	\$ 1,952	\$ 1,952
16	V	6 Maintenance		Eldercare Inc	0.00%	3,101	3,101
17	V	17 Administrative Wages	86,475	Eldercare Inc	0.00%	86,475	
18	V	19 Professional Services		Eldercare Inc	0.00%	4,326	4,326
19	V	20 Fees,Subscriptions		Eldercare Inc	0.00%	954	954
20	V	21 Clerical and office wages	164,839	Eldercare Inc	0.00%	164,839	
21	V	21 Admin &General Office		Eldercare Inc	0.00%	12,512	12,512
22	V	22 Employee Benefits		Eldercare Inc	0.00%	34,017	34,017
23	V	24 Travel&Seminars		Eldercare Inc	0.00%	1,264	1,264
24	V	26 Ins. Prop		Eldercare Inc	0.00%	616	616
25	V	30 Depreciation		Eldercare Inc	0.00%	6,464	6,464
26	V	34 Rent Facility		Eldercare Inc	0.00%	14,880	14,880
27	V	17 Home Office Admin expenses	79,351	Eldercare Inc	0.00%		(79,351)
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 330,665			\$ 331,400	\$ * 735

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

Facility Name & ID Number

Calvin Johnson Care Center

0023309

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	Steve Wolf	President	Exec Admin	30.00	A 129952	20	40.00	Salary	\$ 86,475	17-1	1
2											2
3											3
4											4
5		A- Columbia Conv Ctr 46963									5
6		B- Eldercare of Alton 82989									6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 86,475		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

Facility Name & ID Number Calvin Johnson Care Center

0023309

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Eldercare Inc
 Street Address 2810 Frank Scott Pkwy West Ste 820
 City / State / Zip Code Belleville, IL 62223
 Phone Number (618-234-2273
 Fax Number (618-234-7777

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Census	86,626	2	\$ 3,826	\$ 44,204	\$ 1,952	1
2	6	Maintenance	Census	86,626	2	6,076	44,204	3,100	2
3	17	Administrative	Census	86,626	2	169,464	169,464	44,204	86,475
4	19	Professional Services	Census	86,626	2	8,477	44,204	4,326	4
5	20	Fees,Subscriptions	Census	86,626	2	1,869	44,204	954	5
6	21	Clerical and office wages	Census	86,626	2	323,033	323,033	44,204	164,839
7	21	Admin &General Office	Census	86,626	2	24,522	44,204	12,513	7
8	22	Employee Benefits	Census	86,626	2	66,662	44,204	34,017	8
9	24	Travel&Seminars	Census	86,626	2	2,477	44,204	1,264	9
10	26	Ins. Prop	Census	86,626	2	1,207	44,204	616	10
11	30	Depreciation	Census	86,626	2	12,667	44,204	6,464	11
12	34	Rent Facility	Census	86,626	2	29,160	44,204	14,880	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					\$ 649,440	\$ 492,497	\$ 331,400	25

Facility Name & ID Number

Calvin Johnson Care Center

0023309

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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		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							
Working Capital																		
6	The Bank of Edwardsville		X	Working Capital	varies/sweep	3/9/09	2,000,000		3/9/10	varies	8,039	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 2,000,000	\$			\$ 8,039	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 2,000,000	\$			\$ 8,039	15						

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

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

** 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

1. Real Estate Tax accrual used on 2008 report.		\$	58,200	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.)		\$	58,599	2
3. Under or (over) accrual (line 2 minus line 1).		\$	399	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	60,960	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.		\$	61,359	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	46,776	8	
	2005	50,327	9	
	2006	53,944	10	
	2007	55,995	11	
	2008	58,599	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

Facility Name & ID Number Calvin Johnson Care Center

0023309

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,326 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column (1-3). Row 1: Land. Row 2: 1. Row 3: 2. Row 4: 3 TOTALS

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Bldg Imp		1982		600		10			600	9
10	1983 Audit		1983		4,085		10				10
11	Bldg Imp		1983		39,106		10			39,106	11
12	Black Top		1983		1,033		12			1,033	12
13	Remodeling		1984		7,160		20			7,160	13
14	Landscaping		1984		3,604		10			3,604	14
15	Windows		1985		1,454		10			1,454	15
16	A/C System		1985		1,983		8			1,983	16
17	Rounding				3						17
18	Sidewalks		1985		7,800		15			7,800	18
19	Driveway Sealer		1985		810		5			810	19
20	Parking Stripes		1986		524		5			524	20
21	Renovate Halls		1988		21,660		10			21,660	21
22	Renovate Baths		1989		14,042		10			14,042	22
23	Roof Remodeling		1990		42,560		10-15y			42,560	23
24	Remodeling (less retirement in 2008 1621)		1991		46,957	506	5-10y	506		46,199	24
25	Remodeling		1992		107,939		5-15y			107,939	25
26	Remodeling (less retirement in 2008 9905)		1993		74,695		5-15y			74,695	26
27	Hall Monitor System		1994		3,208	73	15-20y	73		3,078	27
28	Improvements		1995		24,740	250	5-15y	250		24,615	28
29	Elevator		1996		4,929	329	15	329		4,436	29
30	rounding										30
31	Rooftop		1996		10,643		8			10,643	31
32											32
33	A/C Work & Carpeting		1997		6,164	269	5-15y	269		5,626	33
34	Fence		1998		1,250		8			1,250	34
35	Interior Renovation		1998		11,308	84	5-15y	84		11,058	35
36	Interior Renovation		1999		53,624	2,489	5-15y	2,489		51,929	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

Facility Name & ID Number Calvin Johnson Care Center

0023309

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Cubicle Tracks	2000	\$ 14,481	\$ 965	15	\$ 965	\$	\$ 9,171	37
38	Renovations Interior	2000	12,015	1,202	10	1,202		11,415	38
39	Renovations Interior	2000	4,776		5			4,776	39
40	Landscaping	2000	21,213	2,121	10	2,121		19,622	40
41	Renovations Interior	2001	8,725	1,552	10	1,552		6,396	41
42	Renovations Interior	2001	45,895	3,060	15	3,060		26,772	42
43	Kitchen hood- stainless steel	2002	21,235	1,416	15	1,416		10,264	43
44	Fire alarm control panel	2002	5,857	164	10	164		1,227	44
45	insurance proceeds for control panel	2003	(4,221)						45
46	Fire Alarm panel	2003	1,120	112	10	112		784	46
47	Bldg generator	2003	19,164	958	20	958		6,707	47
48	HVAC units	2003	6,158		10			6,158	48
49	Wiring Hall 400, new door	2004	3,361	168	20	168		1,008	49
50	guardrails, exhaust fan	2004	2,671	178	15	178		979	50
51	Fire alarm pulls, dampers, wiring	2004	4,749	475	10	475		2,849	51
52	Carpeting, vinyl base	2004	4,875	487	5	487		4,875	52
53	Roof, door locks, wall coverings	2005	39,288	3,929	10	3,929		17,680	53
54	Entrance Canopy	2005	10,641	2,338	5	2,338		10,641	54
55	Roof,ductwork, doors, plumbing	2006	57,665	5,766	10	5,766		20,183	55
56	Air conditioning	2006	7,999	1,600	5	1,600		5,599	56
57	lighting, sidewalks, patio	2006	31,149	2,077	15	2,077		7,268	57
58	New decking	2006	37,555	3,756	10	3,756		13,144	58
59	Heating/AC units, new carpeting	2007	13,017	2,603	5	2,603		6,509	59
60	New awnings, canopy, laundry	2007	11,508	1,151	10	1,151		2,877	60
61	Handrails, electrical work	2007	4,203	280	15	280		841	61
62	Boiler, Steel fire doors	2008	9,115	456	20	456		912	62
63	New wood doors and frames	2008	5,045	336	15	336		420	63
64	Windows w/ marble sills, elevator doors, fire alarm	2008	13,720	1,372	10	1,372		2,401	64
65	Carpeting, heating/AC,sewer line	2008	6,384	1,277	5	1,277		1,915	65
66	Landscape paver stones	2008	1,457	146	10	146		291	66
67	New doors	2009	7,357	490	15	490		490	67
68	water lines/new wiring	2009	12,959	648	10	648		648	68
69	Heating/cooling units,covebase	2009	10,562	1,584	5	1,584		1,584	69
70	TOTAL (lines 4 thru 69)		\$ 943,579	\$ 46,667		\$ 46,667	\$	\$ 690,210	70

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

Facility Name & ID Number Calvin Johnson Care Center

0023309

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 341,496	\$ 32,731	\$ 32,731	\$	5-20 yr	\$ 229,068	71
72	Current Year Purchases	45,194	3,891	3,891		3-20 yr	3,891	72
73	Fully Depreciated Assets	253,906					253,906	73
74	Home Office		6,464	6,464				74
75	TOTALS	\$ 640,596	\$ 43,086	\$ 43,086	\$		\$ 486,865	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	Patient Transport	2- 1997 Ford Buses w/ lifts	2004	8,269				3	8,269	77
78	Facility Use	1999 Dodge Caravan	2005	7,214				3	7,214	78
79	Patient Transport	Wheel chair bracing	2009	1,112	222	222		5	222	79
80	TOTALS			\$ 16,595	\$ 222	\$ 222	\$		\$ 15,705	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)	\$ 1,600,770	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 89,975	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 89,975	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,192,780	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			N/A		88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94		N/A	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: National Nursing Homes Inc.

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:	<u>1969</u>	<u>180</u>	<u>4/1/77</u>	\$ <u>443,565</u>	<u>20</u>	<u>15</u>	3
4	Additions							4
5								5
6	Home Office				<u>14,880</u>			6
7	TOTAL		<u>180</u>		\$ <u>458,445</u>			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 13,461 Description: office 218/therapy beds 13243

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning 08/01/2007

Ending 08/01/2012

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

Fiscal Year Ending Annual Rent

12. /2010 \$ varies with net income

13. /2011 \$ varies with net income

14. /2012 \$ varies with net income

* 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.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	L 10A	hrs			297	\$ 20,339					297	\$	20,339		1
2	Licensed Speech and Language Development Therapist	L 10A	hrs			77	5,985					77		5,985		2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	L 10A	hrs			447	29,996					447		29,996		4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	L 39	# of prescrpts								70,051			70,051		9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Lab</u>	L39					4,385							4,385		12
13	Other (specify): <u>X-Ray</u>	L39					1,192									13
14	TOTAL				\$	821	\$ 61,897	\$	70,051	\$	821	\$	130,756			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.

Facility Name & ID Number Calvin Johnson Care Center# 0023309Report Period Beginning: 01/01/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(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	\$ 293,361	\$	1
2	Cash-Patient Deposits	59,616		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,648,241		3
4	Supply Inventory (priced at cost)	84,782		4
5	Short-Term Investments			5
6	Prepaid Insurance	46,544		6
7	Other Prepaid Expenses	33,019		7
8	Accounts Receivable (owners or related parties)	17,304		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,182,867	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable	35,665		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	939,493		15
16	Equipment, at Historical Cost	657,191		16
17	Accumulated Depreciation (book methods)	(1,192,780)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 439,570	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,622,437	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 557,450	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	59,616		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	155,040		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,909		31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,960		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	19,031		35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 863,006	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 863,006	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,759,431	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,622,437	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,509,460	1
2	Restatements (describe):		2
3	Prior period adj- building rent	(18,233)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,491,227	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	268,204	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)	\$ 268,204	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)	\$ 1,759,431	24 *

* This must agree with page 17, line 47.

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	\$ 6,458,690	1
2	Discounts and Allowances for all Levels	(709,888)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,748,802	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	75,096	6
7	Oxygen	166,291	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 241,387	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	17,983	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	129,595	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,084	19
20	Radiology and X-Ray	2,206	20
21	Other Medical Services	699,859	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 857,727	23
D. Non-Operating Revenue			
24	Contributions	1,014	24
25	Interest and Other Investment Income***	1,472	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,486	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Garnish fees 2627/T-shirts 4043/misc 348	7,018	28
28a	<u>Prior Year Income Tax</u>	98,638	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 105,656	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,956,058	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,234,608	31
32	Health Care	3,415,868	32
33	General Administration	1,240,952	33
B. Capital Expense			
34	Ownership	609,935	34
C. Ancillary Expense			
35	Special Cost Centers	87,941	35
36	Provider Participation Fee	98,550	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,687,854	40
41	Income before Income Taxes (line 30 minus line 40)**	268,204	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 268,204	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

return extended

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Calvin Johnson Care Center

0023309

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 56,224	\$ 27.03	1
2	Assistant Director of Nursing	3,488	3,648	91,219	25.01	2
3	Registered Nurses	11,523	12,229	324,577	26.54	3
4	Licensed Practical Nurses	32,752	34,777	772,753	22.22	4
5	CNAs & Orderlies	78,836	89,526	992,847	11.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	778	858	9,290	10.83	8
9	Activity Director	2,000	2,080	27,596	13.27	9
10	Activity Assistants	3,971	4,131	34,207	8.28	10
11	Social Service Workers	7,016	7,336	101,129	13.79	11
12	Dietician					12
13	Food Service Supervisor	2,916	3,036	51,648	17.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,052	23,492	209,550	8.92	15
16	Dishwashers					16
17	Maintenance Workers	7,814	8,214	115,241	14.03	17
18	Housekeepers	19,312	20,657	187,363	9.07	18
19	Laundry	10,379	11,494	104,135	9.06	19
20	Administrator	2,000	2,080	94,258	45.32	20
21	Assistant Administrator					21
22	Other Administrative	1,000	1,040	86,475	83.15	22
23	Office Manager					23
24	Clerical	15,312	16,526	318,137	19.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>Respiratory</u>	16,138	16,693	384,113	23.01	32
33	Other(specify) <u>Inservice</u>		2,460	54,739	22.25	33
34	TOTAL (lines 1 - 33)	239,287	262,357	\$ 4,015,501 *	\$ 15.31	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	183	\$ 8,149	1-3	35
36	Medical Director	monthly	37,500	9-3	36
37	Medical Records Consultant	42	1,638	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant			10-3	39
40	Physical Therapy Consultant	37	1,977	10-3	40
41	Occupational Therapy Consultant	38	1,790	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	5	319	10-3	43
44	Activity Consultant	20	749	11-3	44
45	Social Service Consultant	72	2,248	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	397	\$ 54,370		49

C. CONTRACT NURSES

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

Facility Name & ID Number Calvin Johnson Care Center

0023309

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ n/a Line _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 98,550
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. \$ 3,694 Has any meal income been offset against related costs? no Indicate the amount. \$ n/a
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
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: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.