

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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>0048355</u></p> <p>Facility Name: <u>COMMUNITY CARE</u></p> <p>Address: <u>4314 SOUTH WABASH AVENUE</u> <u>CHICAGO</u> <u>60653</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(847) 674-5795</u> Fax # <u>(847) 674-5794</u></p> <p>HFS ID Number: <u>300383293-0001</u></p> <p>Date of Initial License for Current Owners: <u>11/1/06</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <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 type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" 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>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: <u>kvanstockum@kbbcpa.com</u></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 type="checkbox"/> "Sub-S" Corp.			<input checked="" 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>01/01/2009</u> to <u>12/31/2009</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 style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>AVRUM WEINFELD</u> (Title) <u>CEO</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="center">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>AVRUM WEINFELD</u> (Title) <u>CEO</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number COMMUNITY CARE

0048355 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	145	Skilled (SNF)	145	52,925	1
2		Skilled Pediatric (SNF/PED)			2
3	59	Intermediate (ICF)	59	21,535	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,460	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,112		4,126	10,238	8
9	SNF/PED					9
10	ICF	57,597	191	31	57,819	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	63,709	191	4,157	68,057	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.40%

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 11/01/06

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

YES Date 11/01/06 NO

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

YES NO If YES, enter number

of beds certified 30 and days of care provided 4,126

Medicare Intermediary ADMINISTAR OF ILLINOIS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number

COMMUNITY CARE

0048355

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	346,690	38,284	19,800	404,774		404,774		404,774		1
2	Food Purchase		321,112		321,112		321,112	(585)	320,527		2
3	Housekeeping	246,986	35,093		282,079		282,079	5,939	288,018		3
4	Laundry	131,290	20,889	7,129	159,308		159,308		159,308		4
5	Heat and Other Utilities			155,075	155,075		155,075	519	155,594		5
6	Maintenance	77,365	26,851	66,302	170,518		170,518	8,562	179,080		6
7	Other (specify):* SECURITY	71,694		14,115	85,809		85,809	94	85,903		7
8	TOTAL General Services	874,025	442,229	262,421	1,578,675		1,578,675	14,529	1,593,204		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,298,708	89,194	15,426	2,403,328		2,403,328		2,403,328		10
10a	Therapy	15,749		191	15,940		15,940		15,940		10a
11	Activities	51,439	3,003		54,442		54,442		54,442		11
12	Social Services	228,869		2,645	231,514		231,514		231,514		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,594,765	92,197	30,262	2,717,224		2,717,224		2,717,224		16
	C. General Administration										
17	Administrative	73,800		130,267	204,067		204,067	(20,636)	183,431		17
18	Directors Fees										18
19	Professional Services			61,994	61,994		61,994	7,701	69,695		19
20	Dues, Fees, Subscriptions & Promotions			46,352	46,352		46,352	(20,603)	25,749		20
21	Clerical & General Office Expenses	136,877	26,285	62,849	226,011		226,011	(13,563)	212,448		21
22	Employee Benefits & Payroll Taxes			465,467	465,467		465,467		465,467		22
23	Inservice Training & Education							15	15		23
24	Travel and Seminar			257	257		257		257		24
25	Other Admin. Staff Transportation			10,180	10,180		10,180	841	11,021		25
26	Insurance-Prop.Liab.Malpractice			106,157	106,157		106,157	1,363	107,520		26
27	Other (specify):*			436,725	436,725		436,725	(423,094)	13,631		27
28	TOTAL General Administration	210,677	26,285	1,320,248	1,557,210		1,557,210	(467,976)	1,089,234		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,679,467	560,711	1,612,931	5,853,109		5,853,109	(453,447)	5,399,662		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	19,800
	REPAIRS & MAINTENANCE	0
		0
		19,800
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	7,129
		0
		7,129
5	HEAT & OTHER UTILITIES	
	GAS HEAT	50,952
	ELECTRICITY	65,059
	WATER	35,778
	CABLE TV - LOBBY	3,286
		0
		155,075
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,670
	PAINTING & DECORATING	0
	BUILDING REPAIRS	14,014
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	32,075
	ELEVATOR MAINTENANCE & REPAIR	3,834
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,637
	FIRE SERVICE	6,416
	PAINTING & DECORATING	2,656
		0
		0
		0
		66,302
7	OTHER	
	SCAVENGER	14,115
	SECURITY SERVICE	0
		0
		0
		14,115
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,000
		12,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	600
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,179
	PHARMACY CONSULTANT XVIII B 39-2	10,047
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL CONSULTANT	3,600
		0
		15,426
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	191
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		191
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	2,645
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,645
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	130,267
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	22,433
	ADMINISTRATIVE CONSULTANTS XIX C	2,686
	PROFESSIONAL FEES XIX C	36,875
		0
		61,994
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	3,554
	EMPLOYEE WANT ADS XIX F	304
	CONTRIBUTIONS VI 20 XIX F	500
	DUES & SUBSCRIPTIONS XIX F	16,096
	LICENSES & PERMITS XIX F	4,085
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	594
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	890
	PATIENT BACKGROUND CHECKS XIX F	915
	Staff Development	19414
		46,352
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,388
	EQUIPMENT REPAIR & MAINTENANCE	5,498
	OUTSIDE CLERICAL SERVICES	30,000
	PENALTIES / OVERDRAFT CHARGES VI 18	100
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	5,926
	TELEPHONE	19,937
	MESSENGER SERVICE	0
		0
		62,849

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	278,283
	UNEMPLOYMENT COMPENSATION XIX D	41,526
	WORKERS COMPENSATION INSURANCE XIX D	82,216
	HOSPITALIZATION INSURANCE XIX D	34,871
	EMPLOYEE BENEFITS - OTHER XIX D	9,609
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	11,198
	CHICAGO HEAD TAX XIX D	7,764
		0
		465,467
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	257
	TRAVEL XIX G	0
		257
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	10,180
		10,180
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	106,157
		106,157
27	OTHER	
	BAD DEBTS VI 24	436,725
		436,725

GRAND TOTAL COLUMN 3 OTHER

1,612,931

COMMUNITY CARE
SCHEDULES
12/31/2009

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	321,112
LESS SALES TAX	<u>(585)</u>
NET FOOD	320,527

TOTAL PATIENT CENSUS	68,057
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	204,171

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	204,171
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	204,171

NET FOOD	320,527
DIVIDE TOTAL MEALS/YEAR	<u>204,171</u>

COST PER MEAL	1.57
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0
	=====

Facility Name & ID Number

COMMUNITY CARE

#0048355

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			16,251	16,251		16,251	(4,982)	11,269			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,044	25,044		25,044	(36,310)	(11,266)			32
33	Real Estate Taxes			247,973	247,973		247,973	2,034	250,007			33
34	Rent-Facility & Grounds			1,533,678	1,533,678		1,533,678		1,533,678			34
35	Rent-Equipment & Vehicles			44,420	44,420		44,420	(7,890)	36,530			35
36	Other (specify):* IME			15,912	15,912		15,912	(15,912)				36
37	TOTAL Ownership			1,883,278	1,883,278		1,883,278	(63,060)	1,820,218			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		121,869	288,013	409,882		409,882		409,882			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,690	111,690		111,690		111,690			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		121,869	399,703	521,572		521,572		521,572			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,679,467	682,580	3,895,912	8,257,959		8,257,959	(516,507)	7,741,452			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	(6,660)	30		9
10	Interest and Other Investment Income	(38,930)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(585)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(100)	21		18
19	Entertainment		20		19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(436,725)	27		24
25	Fund Raising, Advertising and Promotional	(3,554)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(594)	20		28
29	Other-Attach Schedule	(47,267)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (534,915)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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)	18,408		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 18,408		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (516,507)		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			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

COMMUNITY CARE

ID# 0048355

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount Reference

1	DEFERRED MAINTENANCE	\$ 1023	6	1
2	MARKETING SALARIES	(15,750)	21	2
3	BANK CHARGES	(1,388)	21	3
4	STAFF DEVELOPMENT	(19,414)	20	4
5	MARKETING AUTO LEASE	(11,738)	35	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	(47,267)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COMMUNITY CARE# 0048355

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	(585)	0	0	0	0	0	0	0	0	0	0	(585)	2
3	Housekeeping	0	0	5,939	0	0	0	0	0	0	0	0	5,939	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	519	0	0	0	0	0	0	519	5
6	Maintenance	1,023	0	2,085	3,058	2,396	0	0	0	0	0	0	8,562	6
7	Other (specify):*	0	0	68	0	26	0	0	0	0	0	0	94	7
8	TOTAL General Services	438	0	8,092	3,058	2,941	0	0	0	0	0	0	14,529	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	(2,550)	9,237	(27,323)	0	0	0	0	0	0	0	(20,636)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	88	6,987	550	76	0	0	0	0	0	0	7,701	19
20	Fees, Subscriptions & Promotions	(24,062)	0	3,419	0	40	0	0	0	0	0	0	(20,603)	20
21	Clerical & General Office Expenses	(17,238)	0	(3,915)	7,578	12	0	0	0	0	0	0	(13,563)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	15	0	0	0	0	0	0	0	0	15	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	578	263	0	0	0	0	0	0	0	841	25
26	Insurance-Prop.Liab.Malpractice	0	0	231	994	138	0	0	0	0	0	0	1,363	26
27	Other (specify):*	(436,725)	0	4,984	8,647	0	0	0	0	0	0	0	(423,094)	27
28	TOTAL General Administration	(478,025)	(2,462)	21,536	(9,291)	266	0	0	0	0	0	0	(467,976)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(477,587)	(2,462)	29,628	(6,233)	3,207	0	0	0	0	0	0	(453,447)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COMMUNITY CARE# 0048355

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

	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	(6,660)	0	142	61	1,475	0	0	0	0	0	0	(4,982)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(38,930)	0	0	0	2,620	0	0	0	0	0	0	(36,310)	32
33	Real Estate Taxes	0	0	0	0	2,034	0	0	0	0	0	0	2,034	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(11,738)	0	2,697	502	649	0	0	0	0	0	0	(7,890)	35
36	Other (specify):*	0	0	0	0	(15,912)	0	0	0	0	0	0	(15,912)	36
37	TOTAL Ownership	(57,328)	0	2,839	563	(9,134)	0	0	0	0	0	0	(63,060)	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
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(534,915)	(2,462)	32,467	(5,670)	(5,927)	0	0	0	0	0	0	(516,507)	45

Facility Name & ID Number COMMUNITY CARE

0048355

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

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
PHILIP ESFORMES	48			6865 FINANCIAL INC	LINCOLNWOOD	MANAGEMENT
AVRUM WEINFELD	2					
RIVKIE LAFER	1			EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
RACHEL ESFORMES	1	SEE ATTACHED SCHEDULE		EMI ENTERPRISES	LINCOLNWOOD	MANAGEMENT
MORRIS ESFORMES	48			IME REALTY	LINCOLNWOOD	HOME OFFICE

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	17 MANAGEMENT FEES	\$ 130,267	6865 FINANCIAL INC		\$	(130,267)	1
2	V	17 EM ENTERPRISES				50,020	50,020	2
3	V	17 PHILIP ESFORMES INC				59,115	59,115	3
4	V	17 DANIEL WEISS				3,789	3,789	4
5	V	17 AVRUM WEINFELD				14,793	14,793	5
6	V	19 ACCOUNTING FEES				88	88	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 130,267			\$ 127,805	\$ * (2,462)	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	21	OUTSIDE CLERICAL	\$ 30,000	EKS MANAGEMENT		\$ (30,000)
16	V	3	HOUSEKEEPING SALARIES			5,939	5,939
17	V	6	PAINTER SALARIES			2,085	2,085
18	V	7	SCAVENGER			68	68
19	V	17	CFO SALARY - A. WEINFELD			9,237	9,237
20	V	19	PROFESSIONAL FEES			6,987	6,987
21	V	20	WANT ADS/BACKGR CKS			3,419	3,419
22	V	21	OFFICE			26,085	26,085
23	V	23	SEMINARS			15	15
24	V	25	TRANSPORTATION			578	578
25	V	26	INSURANCE			231	231
26	V	27	EMPLOYEE BENEFITS			4,984	4,984
27	V	30	DEPRECIATION (SL)			142	142
28	V	35	EQUIPMENT RENT			2,697	2,697
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 30,000			\$ 62,467	\$ * 32,467

* 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	17 MANAGEMENT FEES	\$ 50,020	EMI MANAGEMENT		\$	\$ (50,020)
16	V	6 DRIVERS' SALARY				3,058	3,058
17	V	17 OFFICER SALARY				15,667	15,667
18	V	17 REGIONAL DIRECTOR				7,030	7,030
19	V	19 ACCOUNTING FEES				550	550
20	V	21 OFFICE				7,578	7,578
21	V	25 TRANSPORTATION				263	263
22	V	26 INSURANCE				994	994
23	V	27 EMPLOYEE BENEFITS				8,647	8,647
24	V	30 DEPRECIATION S/L				61	61
25	V	35 AUTO LEASE				502	502
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 50,020			\$ 44,350	\$ * (5,670)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	36 OFFICE RENT	\$ 15,912	IME REALTY		\$	\$ (15,912)
16	V	5 UTILITIES				519	519
17	V	6 PAINTERS FEES				1,047	1,047
18	V	6 REPAIRS / MAINT				1,349	1,349
19	V	7 ALARM SERVICE				26	26
20	V	19 PROFESSIONAL FEES				76	76
21	V	21 OFFICE EXPENSE				12	12
22	V	26 INSURANCE				138	138
23	V	30 DEPRECIATION				1,475	1,475
24	V	32 INTEREST				2,620	2,620
25	V	33 R/E TAX				2,034	2,034
26	V	35 STORAGE FEES				649	649
27	V	20 LICENSES & PERMITS				40	40
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 15,912			\$ 9,985	\$ * (5,927)

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

Facility Name & ID Number

COMMUNITY CARE

#

0048355

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	MORRIS ESFORMES		Administrative	48.00		List		Comp fr EMI	\$ 15,667	17-7	1
2						Attached		ADM CONS		19-3	2
3											3
4	PHILIP ESFORMES		Administrative	48.00		List		Comp fr 6865	59,115	17-7	4
5						Attached					5
6											6
7	DANIEL WEISS		Administrative			List		Comp fr 6865	3,789	17-7	7
8						Attached					8
9											9
10	AVRUM WEINFELD		Administrative	2.00		List		Comp fr 6865	14,793	17-7	10
11						Attached		Comp fr EKS	9,237	17-7	11
12	FLORA WEISS		CLERICAL					Comp fr EKS	1,343	21-7	12
13								TOTAL	\$ 103,944		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 COMMUNITY CARE

0048355

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 6865 FINANCIAL INC
 Street Address 6865 N. LINCOLN AVE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-5795
 Fax Number (847) 674-5794

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	17	EMI ENTERPRISES	PATIENT DAYS	538,796	10	\$ 396,000	\$ 68,057	\$ 50,020	1	
2	17	PHILIP ESFORMES	PATIENT DAYS	538,796	10	468,000	468,000	68,057	59,115	2
3	17	DANIEL WEISS	PATIENT DAYS	538,796	10	30,000	30,000	68,057	3,789	3
4	17	AVRUM WEINFELD	PATIENT DAYS	538,796	10	117,111	117,111	68,057	14,793	4
5	19	ACCOUNTING FEES	PATIENT DAYS	538,796	10	700	68,057	88	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					\$ 1,011,811	\$ 615,111	\$ 127,805	25	

Facility Name & ID Number COMMUNITY CARE

0048355

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 EKS MANAGEMENT
 Street Address 6865 N. LINCOLN AVE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-1946
 Fax Number (847) 674-1962

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	3	HOUSEKEEPING SALARIES	PATIENT DAYS	847,051	14	\$ 73,923	\$ 73,923	68,057	\$ 5,939	1
2	6	PAINTERS' SALARIES	PATIENT DAYS	847,051	14	25,953	25,953	68,057	2,085	2
3	7	SCAVENGER	PATIENT DAYS	847,051	14	842		68,057	68	3
4	17	CFO SALARY - A. WEINFELD	PATIENT DAYS	847,051	14	114,971	114,971	68,057	9,237	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	847,051	14	86,967	74,170	68,057	6,987	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	847,051	14	42,556		68,057	3,419	6
7	21	OFFICE EXPENSE	PATIENT DAYS	847,051	14	324,660	246,961	68,057	26,085	7
8	23	SEMINAR	PATIENT DAYS	847,051	14	190		68,057	15	8
9	25	TRANSPORTATION	PATIENT DAYS	847,051	14	7,194		68,057	578	9
10	26	INSURANCE	PATIENT DAYS	847,051	14	2,872		68,057	231	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	62,031		68,057	4,984	11
12	30	DEPRECIATION S.L	PATIENT DAYS	847,051	14	1,757		68,057	142	12
13	35	EQUIPMENT RENT	PATIENT DAYS	847,051	14	33,562		68,057	2,697	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					\$ 777,478	\$ 535,978		\$ 62,467	25

Facility Name & ID Number COMMUNITY CARE

0048355

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 EMI MANAGEMENT
 Street Address 6865 N. LINCOLN AVE
 City / State / Zip Code LINCOLNWOOD , IL. 60712
 Phone Number (847) 674-5795
 Fax Number (847) 674-5794

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	DRIVERS' SALARY	PATIENT DAYS	847,051	14	\$ 38,060	\$ 68,057	\$ 3,058	1
2	17	OFFICER SALARY	PATIENT DAYS	847,051	14	195,000	68,057	15,667	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	847,051	14	87,500	68,057	7,030	3
4	19	ACCOUNTING FEES	PATIENT DAYS	847,051	14	6,850	68,057	550	4
5	21	OFFICE	PATIENT DAYS	847,051	14	94,319	68,057	7,578	5
6	25	TRANSPORTATION	PATIENT DAYS	847,051	14	3,276	68,057	263	6
7	26	INSURANCE	PATIENT DAYS	847,051	14	12,367	68,057	994	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	107,628	68,057	8,647	8
9	30	DEPRECIATION S/L	PATIENT DAYS	847,051	14	765	68,057	61	9
10	35	AUTO LEASE	PATIENT DAYS	847,051	14	6,253	68,057	502	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					\$ 552,018	\$ 378,811	\$ 44,350	25

Facility Name & ID Number COMMUNITY CARE

0048355

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 IME REALTY CORP
 Street Address 6865 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL 607712
 Phone Number (847) 674-5795
 Fax Number (847) 675-5794

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	INCOME	187,059	14	\$ 6,106	\$ 15,912	\$ 519	1
2	6	PAINTERS FEES	INCOME	187,059	14	12,303	15,912	1,047	2
3	6	REPAIRS / MAINT	INCOME	187,059	14	15,863	15,912	1,349	3
4	7	ALARM SERVICE	INCOME	187,059	14	301	15,912	26	4
5	19	PROFESSIONAL FEES	INCOME	187,059	14	897	15,912	76	5
6	21	OFFICE EXPENSE	INCOME	187,059	14	136	15,912	12	6
7	26	INSURANCE	INCOME	187,059	14	1,627	15,912	138	7
8	30	DEPRECIATION	INCOME	187,059	14	17,336	15,912	1,475	8
9	32	INTEREST	INCOME	187,059	14	30,806	15,912	2,620	9
10	33	R/E TAX	INCOME	187,059	14	23,914	15,912	2,034	10
11	35	STORAGE FEES	INCOME	187,059	14	7,635	15,912	649	11
12	20	LICENSES & PERMITS	INCOME	187,059	14	468	15,912	40	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					\$ 117,392	\$	\$ 9,985	25

Facility Name & ID Number COMMUNITY CARE

0048355

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	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																			
2																			
3																			
4									2,620										
5																			
Working Capital																			
6		X	WORKINT CAPITAL	INTEREST	REVOLV		57,000	REVOLV	PRIME +	25,044									
7																			
8																			
9							57,000			27,664									
B. Non-Facility Related*																			
10		X	LATE FEES																
11																			
12																			
13																			
14																			
15							57,000			27,664									

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

1. Real Estate Tax accrual used on 2008 report.		\$	243,095	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.)		\$	245,534	2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,439	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	245,534	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.		\$	247,973	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004		8
	2005	288,520	9
	2006	245,718	10
	2007	243,095	11
	2008	245,534	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COMMUNITY CARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0048355

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2008 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 2008.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>20-03-300-026-0000</u>	<u>NURSING HOME</u>	\$ <u>5,469.29</u>	\$ <u>5,469.29</u>
2. <u>20-03-300-025-0000</u>	<u>NURSING HOME</u>	\$ <u>57,837.51</u>	\$ <u>57,837.51</u>
3. <u>20-03-300-024-0000</u>	<u>NURSING HOME</u>	\$ <u>58,779.38</u>	\$ <u>58,779.38</u>
4. <u>20-03-300-023-0000</u>	<u>NURSING HOME</u>	\$ <u>59,474.13</u>	\$ <u>59,474.13</u>
5. <u>20-03-300-022-0000</u>	<u>NURSING HOME</u>	\$ <u>58,526.34</u>	\$ <u>58,526.34</u>
6. <u>20-03-300-021-0000</u>	<u>NURSING HOME</u>	\$ <u>5,447.47</u>	\$ <u>5,447.47</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>245,534.12</u>	\$ <u>245,534.12</u>

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 X NO

If YES, attach an explanation and 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 original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies of their originalsecond installment tax bill.

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:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7		RELATED PARTY			46,940	1,417	39	1,417			7
8		HOME OFFICE									8
		Improvement Type**									
9		WATER BOILER		2007	91,500	3,327	27.5	3,327		7,624	9
10		GENERATOR		2007	17,887	650	27.5	650		1,327	10
11		ROOF REPAIRS		2008	12,500	455	27.5	455		701	11
12		PUMPS		2008	14,870	540	27.5	540		833	12
13		A/C COMPRESSOR		2008	9,904	360	27.5	360		555	13
14		FENCE		2008	3,186	212	15	212		318	14
15		FIREALARM		2009	3,000	50	27.5	50		50	15
16		COOLING COIL		2009	5,694	78	27.5	78		78	16
17		ELEVATOR		2009	111,000	841	27.5	841		841	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **COMMUNITY CARE**

0048355

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	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								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	316,481	\$	7,930	\$	7,930	\$	12,327	70

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

Facility Name & ID Number COMMUNITY CARE

0048355

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	\$ 26,961	\$ 5,158	\$ 2,696	\$ (2,462)		\$ 5,801	71
72	Current Year Purchases	7,633	4,580	382	(4,198)		382	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		261	261				74
75	TOTALS	\$ 34,594	\$ 9,999	\$ 3,339	\$ (6,660)		\$ 6,183	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										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 351,075	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 17,929	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 11,269	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,660)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 18,510	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.

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?</p> <p><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><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			
		1	2	3	4
		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 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 114,987	\$		\$ 114,987	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			163			163	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			172,863			172,863	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				98,578		98,578	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>supplies,lab,rentals</u>	39-2					23,291		23,291	13
14	TOTAL			\$		\$ 288,013	\$ 121,869		\$ 409,882	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 COMMUNITY CARE

0048355

Report Period Beginning: 01/01/2009

Ending:

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	\$ 41,477	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (150,000))	2,846,421		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	132,100		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Real Estate & Ins Escrow</u>	144,773		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,164,771	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	269,541		15
16	Equipment, at Historical Cost	34,594		16
17	Accumulated Depreciation (book methods)	(36,106)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	113,713		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 381,742	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,546,513	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,421,402	\$	26
27	Officer's Accounts Payable	45,544		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	57,000		29
30	Accrued Salaries Payable	124,444		30
31	Accrued Taxes Payable (excluding real estate taxes)	48,085		31
32	Accrued Real Estate Taxes(Sch.IX-B)	245,534		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,942,009	\$	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)	\$ 1,942,009	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,604,504	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,546,513	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,727,024	1
2	Restatements (describe):		2
3		1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,727,025	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	270,021	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	(392,542)	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)	\$ (122,521)	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)	\$ 1,604,504	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	\$ 8,170,881	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,170,881	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	318,169	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 318,169	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	38,930	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 38,930	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			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)	\$ 8,527,980	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,578,675	31
32	Health Care	2,717,224	32
33	General Administration	1,557,210	33
B. Capital Expense			
34	Ownership	1,883,278	34
C. Ancillary Expense			
35	Special Cost Centers	409,882	35
36	Provider Participation Fee	111,690	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,257,959	40
41	Income before Income Taxes (line 30 minus line 40)**	270,021	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 270,021	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.
TAX RETURN PREPARED ON CASH BASIS

*** 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 **COMMUNITY CARE**

0048355

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			\$	\$	1
2					2
3	5,352	5,539	244,269	44.10	3
4	26,585	27,845	936,776	33.64	4
5	101,394	112,048	1,049,503	9.37	5
6					6
7					7
8	1,093	1,258	15,749	12.52	8
9					9
10	4,313	4,390	51,439	11.72	10
11	16,031	18,413	228,869	12.43	11
12					12
13					13
14					14
15	32,555	35,798	346,690	9.68	15
16					16
17	6,166	6,476	77,365	11.95	17
18	27,196	29,851	246,986	8.27	18
19	10,811	12,849	131,290	10.22	19
20	2,080	2,080	73,800	35.48	20
21					21
22					22
23					23
24	13,290	13,811	136,877	9.91	24
25					25
26					26
27					27
28					28
29					29
30					30
31	1,309	1,406	16,248	11.56	31
32	2,080	2,080	51,912	24.96	32
33	7,613	8,072	71,694	8.88	33
34	257,868	281,916	\$ 3,679,467 *	\$ 13.05	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	M	\$ 19,800	1-3	35
36	O	12,000	9-3	36
37	N	1,179	10-3	37
38	T	0	10-3	38
39	H	10,047	10-3	39
40	L	191	10a-3	40
41	Y	0	10a-3	41
42		0	10a-3	42
43	F	0	10a-3	43
44	E	0	11-3	44
45	E	2,645	12-3	45
46	S	3,600	10-3	46
47				47
48				48
49		\$ 49,462		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50		\$		50
51				51
52				52
53		\$		53

Facility Name & ID Number COMMUNITY CARE

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

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

1	2	3	4	5	6	7	8	9	10	11	12	13												
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year							
																	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	PAINT/DECORATING	2005	\$ 1,751	3 YRS	\$ 585	\$ 585	\$ 290	\$	\$	\$	\$	\$												
2	PAINT/DECORATING	2006	6,143	3 YRS	1,024	2,048	2,048	1,023																
3																								
4																								
5																								
6																								
7																								
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9																								
10																								
11																								
12																								
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14																								
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16																								
17																								
18																								
19																								
20	TOTALS		\$ 7,894		\$ 1,609	\$ 2,633	\$ 2,338	\$ 1,023	\$	\$	\$	\$												

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$16,096
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (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? YES
If YES, give effective date of lease. 11/1/06
- (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 X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
COMMUNITY CARE CENTER, INC 0029132 11/1/06
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 111,690
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. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
 - 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? YES
 - 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.