



Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center

# 0039651 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	4,927		1,399	6,326	8
9	SNF/PED					9
10	ICF	28,416		30	28,446	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,343		1,429	34,772	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.51%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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 06/01/94

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

YES  Date 06/01/94 NO

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

YES  NO  If YES, enter number of beds certified 27 and days of care provided 1,399

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Cent # 0039651 Report Period Beginning: 01/01/09 Ending: 12/31/09

**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
	<b>A. General Services</b>										
1	Dietary	219,859	14,861	4,036	238,756		238,756		238,756		1
2	Food Purchase		185,332		185,332		185,332	(5,846)	179,486		2
3	Housekeeping	165,964	42,434		208,398		208,398	250	208,648		3
4	Laundry	40,171	6,070		46,241		46,241		46,241		4
5	Heat and Other Utilities			112,944	112,944		112,944	1,456	114,400		5
6	Maintenance	79,633	40,157	12,644	132,434		132,434	724	133,158		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	505,627	288,854	129,624	924,105		924,105	(3,416)	920,689		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	1,311,699	27,987	7,763	1,347,449		1,347,449	513	1,347,962		10
10a	Therapy			314,224	314,224		314,224		314,224		10a
11	Activities	55,097	2,144	165	57,406		57,406		57,406		11
12	Social Services	58,735			58,735		58,735		58,735		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,425,531	30,131	325,152	1,780,814		1,780,814	513	1,781,327		16
	<b>C. General Administration</b>										
17	Administrative	69,707		253,158	322,865		322,865	(186,238)	136,627		17
18	Directors Fees										18
19	Professional Services			98,797	98,797		98,797	25,708	124,505		19
20	Dues, Fees, Subscriptions & Promotions			18,527	18,527		18,527	635	19,162		20
21	Clerical & General Office Expenses	214,415		26,919	241,334		241,334	46,022	287,356		21
22	Employee Benefits & Payroll Taxes			280,353	280,353		280,353	3,438	283,791		22
23	Inservice Training & Education										23
24	Travel and Seminar			360	360		360	15	375		24
25	Other Admin. Staff Transportation			1,929	1,929		1,929	1,224	3,153		25
26	Insurance-Prop.Liab.Malpractice			28,094	28,094		28,094	1,251	29,345		26
27	Other (specify):* <b>Mgmt Alloc of Benefit</b>							15,231	15,231		27
28	<b>TOTAL General Administration</b>	284,122		708,137	992,259		992,259	(92,714)	899,545		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,215,280	318,985	1,162,913	3,697,178		3,697,178	(95,617)	3,601,561		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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	
	<b>D. Ownership</b>											
30	Depreciation			22,835	22,835		22,835	149,973	172,808			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,660	52,660		52,660	306,382	359,042			32
33	Real Estate Taxes							98,410	98,410			33
34	Rent-Facility & Grounds			660,000	660,000		660,000	(660,000)				34
35	Rent-Equipment & Vehicles							1,045	1,045			35
36	Other (specify):* <b>Mortgage Insurance</b>							28,188	28,188			36
37	<b>TOTAL Ownership</b>			735,495	735,495		735,495	(76,002)	659,493			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		48,011		48,011		48,011		48,011			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):* <b>Non-allowable cost</b>			14,123	14,123		14,123	(14,123)				43
44	<b>TOTAL Special Cost Centers</b>		48,011	96,248	144,259		144,259	(14,123)	130,136			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,215,280	366,996	1,994,656	4,576,932		4,576,932	(185,742)	4,391,190			45

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

\*\* See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	20,760	30		9
10	Interest and Other Investment Income	(52,599)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(252)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(400)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,658)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,710)	43		24
25	Fund Raising, Advertising and Promotional	(186)	43		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 See PG5A	14			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (43,031)		\$	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)	(142,711)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (142,711)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (185,742)		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		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Virgil Calvert Nursing & Rehabilitation Center

ID# 0039651

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Lab Expense Med A	\$ (3,682)	43	1
2	X Ray Expense Med A	(3,893)	43	2
3	Offset Interest Income against Interest Expense	(1,210)	21	3
4	Real Estate Taxes	8,799	33	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	<b>Total</b>	14		49

**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 Schedule 6A		See Schedule 6B		See Schedule 6B		

**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	19 Professional Services	\$	Virgil Calvert Property LLC	100.00%	\$ 26,256	\$ 26,256	1
2	V	21 Office Expense		Virgil Calvert Property LLC	100.00%	6,826	6,826	2
3	V	30 Depreciation		Virgil Calvert Property LLC	100.00%	126,658	126,658	3
4	V	32 Interest Income	61	Virgil Calvert Property LLC	100.00%		(61)	4
5	V	32 Interest		Virgil Calvert Property LLC	100.00%	354,372	354,372	5
6	V	33 Real Estate Taxes		Virgil Calvert Property LLC	100.00%	86,102	86,102	6
7	V	34 Rent-Facility & Grounds	660,000	Virgil Calvert Property LLC	100.00%		(660,000)	7
8	V	36 Mortgage Insurance		Virgil Calvert Property LLC	100.00%	28,188	28,188	8
9	V	20 Dues Fees Subscriptions		Virgil Calvert Property LLC	100.00%	500	500	9
10	V	26 Insurance		Virgil Calvert Property LLC	100.00%	752	752	10
11	V	32 Amortization		Virgil Calvert Property LLC	100.00%	4,670	4,670	11
12	V							12
13	V							13
14	Total		\$ 660,061			\$ 634,324	\$ * (25,737)	14

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

**Virgil Calvert Nursing & Rehabilitation Center**  
**Provider #: 0039651**  
**12/31/2009**

**VII Related Parties - Page 6**

**Schedule 6A**

<b>Share Number</b>	<b>Shareholder Name</b>	<b>Beginning Shares</b>	<b>Ownership Percentage</b>
1	Abraham J Stern	70	4.67
2	Albert Milstein	390	26
3	Sheldon Wolfe	355	23.67
4	Ronnie Klein as Trustee	82	5.5
5	Maurice Aaron	70	4.67
6	Michael Klein Revocable Trust	20	1.33
7	Wanda Bowling	10	0.67
8	Michael Klein Revocable Trust	100	6.67
9	Michael Klein Revocable Trust	100	6.67
10	Kenneth Klein	82	5.5
11	Susan Stern	70	4.67
12	Jonathan B Stern 2001 Trust	23.33	1.56
13	Todd A. Stern 2001 Trust	23.33	1.56
14	Evan M. Stern	23.33	1.56
15	Ora Aaron	70	4.67
16	Moshe Herman	10	0.67

**SEE ACCOUNTANTS' COMPILATION REPORT**

Virgil Calvert Nursing & Rehabilitation Center, Inc.

Provider #: 0039651

12/31/2009

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Cahokia Nursing and Rehab	Cahokia
Caseyville Nursing and Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing and Rehab	East St. Louis

Out-of-State:

Beauvais Manor Healthcare & Rehab	St. Louis, MO
Hillside Manor Healthcare and Rehab	St. Louis, MO
Rancho Manor Healthcare and Rehab	Florissant, MO

Other Related Business Entities

Shabbona Supportive Living Center, LLC	Shabbona	Supportive Living Facility
S.W. Management Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply Co.	Skokie	Medical Supplies
* SFO Associates	Skokie	Finance Company
** Unity Hospice	Skokie	Hospice Services

\* This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center, and Oregon Healthcare Center.

\*\* Pages 6 and 8 are not required for this entity since there was no payment from the nursing homes to the related entity.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 Food	\$	SW Management Co.	100.00%	\$ 15	\$	15
16	V	3 Housekeeping		SW Management Co.	100.00%	250		250
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	1,456		1,456
18	V	6 Maintenance		SW Management Co.	100.00%	724		724
19	V	17 Administrative	253,158	SW Management Co.	100.00%	66,920		(186,238)
20	V	19 Professional Services		SW Management Co.	100.00%	4,110		4,110
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	135		135
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	40,406		40,406
23	V	24 Travel & Seminar		SW Management Co.	100.00%	15		15
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	1,224		1,224
25	V	26 Insurance-Prop Liab. Malpractice		SW Management Co.	100.00%	499		499
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	15,231		15,231
27	V	30 Depreciation		SW Management Co.	100.00%	2,555		2,555
28	V	33 Real Estate Taxes		SW Management Co.	100.00%	3,509		3,509
29	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	1,045		1,045
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 253,158			\$ 138,094	\$ *	(115,064)

\* 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	2 Food	\$ 13,711	S & E Medical Supply Co.	100.00%	\$ 11,288	\$ (2,423)
16	V	3 Housekeeping	64	S & E Medical Supply Co.	100.00%	64	
17	V	10 Medical Supplies	3,982	S & E Medical Supply Co.	100.00%	4,495	513
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 17,757			\$ 15,847	\$ * (1,910)

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

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Cen # 0039651 Report Period Beginning: 01/01/09 Ending: 12/31/09

## 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	Sheldon Wolfe	President	Administrative	23.67	See Schedule 7A	5	12.50	Salary	\$ 23,900	L17,C7	1
2	Ronnie Klein	COO	Administrative	5.50	See Schedule 7B	5	10.00	Salary & Fees	19,120	L17,3 & 21,7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	5	12.50	Salary	23,900	L17,C7	3
4											4
5											5
6											6
7			Note: All individuals work in excess of 40 hours per week.								7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 66,920		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center # 0039651 Report Period Beginning: 01/01/09 Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization SW Management Co.  
 Street Address 7434 N. Skokie Blvd.  
 City / State / Zip Code Skokie, IL 60077  
 Phone Number (847) 982-2300  
 Fax Number (847) 982-2304

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	2	Food	Bed Days Available	657,730	11	\$ 177	\$ 54,750	\$ 15	1	
2	3	Housekeeping	Bed Days Available	657,730	11	3,004	54,750	250	2	
3	5	Heat and Other Utilities	Bed Days Available	657,730	11	17,488	54,750	1,456	3	
4	6	Maintenace	Bed Days Available	657,730	11	8,697	54,750	724	4	
5	19	Professional Services	Bed Days Available	657,730	11	49,378	54,750	4,110	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	657,730	11	1,616	54,750	135	6	
7	21	Clerical & General Office Exp	Bed Days Available	657,730	11	485,405	432,056	54,750	40,406	7
8	24	Travel & Seminar	Bed Days Available	657,730	11	186	54,750	15	8	
9	25	Other Admin. Staff Transport	Bed Days Available	657,730	11	14,707	54,750	1,224	9	
10	26	Insurance-Prop., Liab. & Malp.	Bed Days Available	657,730	11	5,991	54,750	499	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	657,730	11	182,974	54,750	15,231	11	
12	33	Real Estate Taxes	Bed Days Available	657,730	11	42,159	54,750	3,509	12	
13	35	Rent-Equipment & Vehicles	Bed Days Available	657,730	11	12,559	54,750	1,045	13	
14									14	
15									15	
16	17	Administrative	Average Hrs Worked	40	11	382,400	382,400	5	47,800	16
17	17	Administrative	Average Hrs Worked	50	6	191,200	191,200	5	19,120	17
18									18	
19	30	Depreciation	Direct Cost						2,555	19
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,397,941	\$ 1,005,656	\$ 138,094	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center # 0039651 Report Period Beginning: 01/01/09 Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization S & E Medical Supply Co.  
 Street Address 3100 Commercial Ave.  
 City / State / Zip Code Northbrook, IL 60062  
 Phone Number (847) 982-9300  
 Fax Number ( )

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	2	Food	Direct Cost		\$	\$		\$ 11,288	1
2	3	Housekeeping	Direct Cost					64	2
3	10	Medical Supplies	Direct Cost					4,495	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 15,847	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Cent # 0039651 Report Period Beginning: 01/01/09 Ending: 12/31/09

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Heartland Bank		X	Mortgage	\$23,524.00	11/27/01	\$ 6,359,200	\$ 5,602,269	12/1/36	0.0635	\$ 354,372	1								
2							Amortization of Mortgage Costs				4,670	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	N/P Stockholder	X		Working Capital				500,000	Demand	Variable	23,239	6								
7	Intercompany Loan	X		Working Capital				769,811	Demand	0.0400	29,421	7								
8												8								
9	<b>TOTAL Facility Related</b>				\$23,524.00		\$ 6,359,200	\$ 6,872,080			\$ 411,702	9								
<b>B. Non-Facility Related*</b>																				
10							Related Party Interest Net of Interest Income				(52,599)	10								
11							Real Estate Entity Interest Income Offset				(61)	11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (52,660)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 6,359,200	\$ 6,872,080			\$ 359,042	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 28,188 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)





Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center

# 0039651

Report Period Beginning:

01/01/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,932 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>		<u>2001</u>	<u>\$ 400,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			<u>\$ 400,000</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Virgil Calvert Nursing &amp; Rehabilitation Center

# 0039651

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	150	2001		\$ 4,801,297	\$	15-40	\$ 132,029	\$ 132,029	\$ 1,067,234	4
5										5
6	Mgmt. Co.	1995		36,032		39	1,029	1,029	15,086	6
7										7
8										8
	Improvement Type**									
9	Various		1994	30,237	676	20	1,512	836	22,968	9
10	Various		1995	25,180	459	20	1,259	800	18,713	10
11	Various		1996	5,688	244	20	284	40	3,884	11
12	Various		1997	4,115	106	20	206	100	2,608	12
13	Various		1998	4,092		20	205	205	2,626	13
14	Various		1999	27,640		20	1,375	1,375	14,741	14
15	Concrete Work		2000	3,181	82	20	159	77	1,511	15
16	Concrete Work		2000	5,030	129	20	252	123	2,390	16
17	Concrete Work		2000	5,195	133	20	260	127	2,469	17
18	Exhaust Fan		2000	3,820		20	191	191	2,069	18
19	Water Heater		2000	5,300		20	265	265	2,827	19
20	Carpeting		2000	5,400		20	270	270	2,790	20
21	Mechanical Room Volv		2000	1,315		20	66	66	593	21
22	Check Valve		2000	877		20	44	44	395	22
23	Plumbing		2000	1,024		20	51	51	460	23
24	100 Gal. Waterheater		2001	4,642		20	232	232	3,160	24
25	Steamer		2001	2,545		20	127	127	1,732	25
26	Concentrator		2001	2,703		7			2,703	26
27	Air Conditioner		2001	1,895		20	95	95	1,290	27
28	Fire Protection		2001	6,752		20	338	338	4,596	28
29	Air Conditioner		2001	8,313		20	416	416	5,658	29
30	Sprinkler Heads		2001	3,273		20	164	164	2,228	30
31	Blinds		2001	1,212		20	61	61	826	31
32	Sprinkler System Rep		2001	1,827		20	91	91	761	32
33	Heating Systems Repr		2001	1,269		20	63	63	513	33
34	Dining Room Wall		2002	11,663	209	10	1,166	957	8,942	34
35	Dining Room Wall		2002	8,020	144	10	802	658	6,149	35
36	Air Conditioners		2002	1,659		7	99	99	1,659	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Virgil Calvert Nursing &amp; Rehabilitation Center

# 0039651

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	Air Conditioners	2002	\$ 2,185	\$	7	\$ 130	\$ 130	\$ 2,185	37
38	Front Door	2003	9,860	253	20	493	240	3,451	38
39	Roof	2003	72,800	1,867	20	3,640	1,773	24,873	39
40	Gutters And Soffits	2003	24,221	621	20	1,211	590	8,073	40
41	Nursing Station	2003	2,901		20	145	145	979	41
42	Nursing Station	2003	13,285		20	664	664	4,484	42
43	Nursing Station	2003	12,188		20	609	609	3,910	43
44	Fire Sprinkler System	2003	2,075		20	104	104	684	44
45	Fire Suppression System	2003	2,030		20	102	102	660	45
46	100 Gl. Water Heater	2003	3,085		20	154	154	1,080	46
47	Resident Room Casework/counters	2003	7,259		20	363	363	2,420	47
48	Pipe/Dry system	2004	2,472	90	20	124	34	680	48
49	Air Compressor	2004	2,766	66	20	138	72	761	49
50	Condensing unit and evaporator	2004	2,230	90	20	112	22	613	50
51	Concrete removal/new pipe	2004	6,111	248	20	306	58	1,681	51
52	A/C unit in Laundry System	2004	3,329	121	20	166	45	915	52
53	Sprinkler System	2004	2,056	75	20	103	28	565	53
54	Duct Heater	2005	1,381	50	20	69	19	311	54
55	Freezer Door	2005	2,100	242	20	105	(137)	473	55
56	Wallpaper	2005	14,510	1,672	20	726	(947)	3,265	56
57	Water Heaters	2005	5,724	208	20	286	78	1,288	57
58	Security System	2005	25,534	929	20	1,277	348	5,745	58
59	Compressor	2005	1,090	40	20	55	15	245	59
60	Water Heater	2005	1,490	54	20	75	21	335	60
61	Painting & Wallcovering	2005	38,792	4,469	20	1,940	(2,529)	8,728	61
62	Carpet	2005	3,164	516	20	158	(358)	712	62
63	Vinyl floor	2005	6,327	182	20	316	134	1,424	63
64	Doors	2005	1,925	70	20	96	26	433	64
65	Asphalt-parking lot	2005	8,500	589	20	425	(164)	1,913	65
66	Custom built duct heater	2005	1,704	62	20	85	23	383	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,304,290	\$ 14,696		\$ 157,284	\$ 142,588	\$ 1,286,845	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Virgil Calvert Nursing &amp; Rehabilitation Center

# 0039651

Report Period Beginning:

01/01/09

Ending:

12/31/09

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,304,290	\$ 14,696		\$ 157,284	\$ 142,588	\$ 1,286,845	1
2	Kitchen Floor	2006	9,998	364	20	500	136	1,750	2
3	A/C Units	2006	2,146		20	107	107	376	3
4	A/C Units	2006	2,576		20	129	129	451	4
5	2 Ton A/C Unit	2006	1,208	44	20	60	16	211	5
6	Sprinkler System-Replace Pipes	2006	8,357	304	20	418	114	1,462	6
7	Remodel Shower Hall - 500	2007	21,570	784	20	1,079	295	2,696	7
8	Remodel Shower Hall - 400	2007	21,570	784	20	1,079	295	2,696	8
9	Remodel Shower Hall - 200	2007	21,570	784	20	1,079	295	2,696	9
10	Handrail	2007	3,425		20	171	171	428	10
11	Freezer Compressor	2007	2,202	80	20	110	30	275	11
12	5 Ton Air Handler	2007	2,795	102	20	140	38	349	12
13	2 Ton Air Handler & 3 Ton Condensing Unit	2007	5,241	191	20	262	71	655	13
14	Asphalt Parking Lot	2008	28,482	1,353	20	1,424	71	2,136	14
15	Asphalt Path	2008	9,820	466	20	491	25	737	15
16	Sprinkler System Renovation	2008	16,034	583	20	802	219	1,203	16
17	Roof Repair-Burse Pipe in Kitchen	2009	10,868	346	20	272	(74)	272	17
18	Sprinkler System	2009	2,637	20	20	66	46	66	18
19									19
20									20
21									21
22									22
23	SW Management Allocation - leasehold improvements	1995	3,844		20	192	192	3,088	23
24	SW Management Allocation - leasehold improvements	1996	671		20	34	34	455	24
25	SW Management Allocation - leasehold improvements	1997	967		20	48	48	724	25
26	SW Management Allocation - leasehold improvements	1998	666		20	33	33	391	26
27	SW Management Allocation - leasehold improvements	1999	1,848		20	92	92	932	27
28	SW Management Allocation - leasehold improvements	2005	3,823		20	191	191	860	28
29	SW Management Allocation - leasehold improvements	2007	2,164		20	108	108	271	29
30	SW Management Allocation - leasehold improvements	2009	4,518		20	113	113	113	30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,493,290	\$ 20,901		\$ 166,284	\$ 145,383	\$ 1,312,138	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 77,142	\$ 1,934	\$ 5,811	\$ 3,877	10	\$ 54,721	71
72	Current Year Purchases					10		72
73	Fully Depreciated Assets	901,973				10	901,973	73
74	Allocated from Management Co.	11,374		231	231	10	8,569	74
75	TOTALS	\$ 990,489	\$ 1,934	\$ 6,042	\$ 4,108		\$ 965,263	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated from Management	2004 Cadillac	2004	\$ 4,825	\$	\$ 482	\$ 482	5	\$ 4,825	76
77										77
78										78
79										79
80	TOTALS			\$ 4,825	\$	\$ 482	\$ 482		\$ 4,825	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,888,604	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,835	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 172,808	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 149,973	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,282,226	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions				<u>N/A</u>			4
5								5
6								6
7	TOTAL				\$			7

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ N/A Description: N/A

(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	<u>Allocated from Management Co.</u>		\$	\$ <u>1,045</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>1,045</u>	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

\* 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>It is the policy of this facility to only hire certified nurses aides. 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	2,262	\$ 135,697	\$	2,262	\$ 135,697	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		2,814	50,652		2,814	50,652	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		2,437	126,742		2,437	126,742	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				48,011		48,011	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$	7,513	\$ 313,091	\$ 48,011	7,513	\$ 361,102	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center

# 0039651

Report Period Beginning: 01/01/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits	33,523	33,523	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>7,359</u> )	883,786	972,018	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,538	4,757	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	14,393	203,174	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 936,240	\$ 1,213,472	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		400,000	13
14	Buildings, at Historical Cost		4,837,327	14
15	Leasehold Improvements, at Historical Cost	488,863	655,963	15
16	Equipment, at Historical Cost	335,991	995,314	16
17	Accumulated Depreciation (book methods)	(499,795)	(2,282,226)	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 (spe <u>See Schedule 17A</u> )		125,692	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 325,059	\$ 4,732,070	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,261,299	\$ 5,945,542	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 327,678	\$ 285,628	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,754	37,754	28
29	Short-Term Notes Payable	1,269,811	1,269,811	29
30	Accrued Salaries Payable	50,599	50,599	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,795	9,795	31
32	Accrued Real Estate Taxes(Sch.IX-B)		118,500	32
33	Accrued Interest Payable		29,849	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Schedule 17A</u>	233,139	233,139	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,928,776	\$ 2,035,075	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,602,269	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 5,602,269	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,928,776	\$ 7,637,344	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (667,477)	\$ (1,691,802)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,261,299	\$ 5,945,542	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Virgil Calvert Nursing & Rehabilitation Center, Inc.  
 Provider #: 0039651  
 12/31/09

Schedule 17A

XV. BALANCE SHEET -

<b>Other Current Assets (specify):</b>	<b>Operating</b>	<b>After Consolidation</b>
Replacement Reserve	-	71,411
Other - Escrow	-	117,370
Due From/To Vir Vacant Land	14,393	14,393
<b>Total Line 9 - Other Current Assets (specify):</b>	<b>14,393</b>	<b>203,174</b>

<b>Other Long-Term Assets (specify):</b>	<b>Operating</b>	<b>After Consolidation</b>
Capitalized Costs	-	163,434
Accumulated Amortization	-	(37,742)
<b>Total Line 22 - Other Long-Term Assets (specify):</b>	<b>-</b>	<b>125,692</b>

<b>Other Current Liabilities (specify):</b>	<b>Operating</b>	<b>After Consolidation</b>
Due from state	(32,642)	(32,642)
Grant Monies	(24,100)	(24,100)
Insurance Premiums Payable	(1,238)	(1,238)
Accrued Expenses	(77,311)	(77,311)
Due/from Virgil Property LLC	(97,848)	(97,848)
<b>Total Line 36 - Other Current Liabilities (specify):</b>	<b>(233,139)</b>	<b>(233,139)</b>

See Accountants' Compilation Report

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(653,451)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(653,451)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(14,024)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Rounding</b>	<b>(2)</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(14,026)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(667,477)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center # 0039651 Report Period Beginning: 01/01/09Ending: 12/31/09**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,208,842	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,208,842	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	343,119	6
7	Oxygen	4,408	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 347,527	8
<b>C. Other Operating Revenue</b>			
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	5,283	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 5,283	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous Income	1,210	28
28a	Beauty Shop / Uniforms	46	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,256	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,562,908	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	924,105	31
32	Health Care	1,780,814	32
33	General Administration	992,259	33
<b>B. Capital Expense</b>			
34	Ownership	735,495	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	62,134	35
36	Provider Participation Fee	82,125	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,576,932	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(14,024)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (14,024)	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.  
This entity is a cash basis taxpayer.

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

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

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center

# 0039651

Report Period Beginning: 01/01/09

Ending:

12/31/09

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	2,024	2,056	\$ 58,796	\$ 28.60	1
2	Assistant Director of Nursing	755	975	23,620	24.23	2
3	Registered Nurses	1,630	1,747	39,015	22.33	3
4	Licensed Practical Nurses	23,011	24,320	491,557	20.21	4
5	CNAs & Orderlies	58,155	62,542	619,982	9.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,145	5,767	78,729	13.65	8
9	Activity Director					9
10	Activity Assistants	5,354	5,570	55,097	9.89	10
11	Social Service Workers	3,965	4,382	58,735	13.40	11
12	Dietician					12
13	Food Service Supervisor	1,780	1,895	27,846	14.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,322	20,025	192,013	9.59	15
16	Dishwashers					16
17	Maintenance Workers	4,026	4,276	79,633	18.62	17
18	Housekeepers	17,815	19,148	165,964	8.67	18
19	Laundry	4,210	4,476	40,171	8.97	19
20	Administrator	1,984	2,080	69,707	33.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,583	10,078	214,415	21.28	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 Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,759	169,337	\$ 2,215,280 *	\$ 13.08	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 4,036	L1, C3	35
36	Medical Director	Monthly	3,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,763	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	1,133	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	165	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 16,097		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

SEE ACCOUNTANTS' COMPILATION REPORT



Virgil Calvert Nursing & Rehabilitation Center, Inc.

Provider # 0039651

12/31/2009

Schedule 21A

XIX. Support Schedule

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	98,797
Non Allowable Legal	(4,658)
Allocated from Virgil Calvert Property LLC:	26,256
Allocated from SW Management:	4,110
Total (agree to Schedule V, line 19, column 8)	<u>124,505</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3							N/A													
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

**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? Yes  
If YES, give association name and amount. Illinois Council on Long Term Care-\$17,100
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 62 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 82,125  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 3,438 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? Adequate records have been maintained.
  - 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: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**