

Facility Name & ID Number West Grove

0033548 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,356			4,356	13
14	TOTALS	4,356			4,356	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.59%

D. How many bed-hold days during this year were paid by the Department? 156 (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 05/26/1988

J. Was the facility purchased or leased after January 1, 1978?
YES Date Built 05/26/1988 NO

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

Medicare Intermediary N/A

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: 12/31/2009

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

Facility Name & ID Number West Grove # 0033548 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	21,270	3,136	1,475	25,881	(2,001)	23,880		23,880		1
2	Food Purchase		32,458		32,458	(2,510)	29,948		29,948		2
3	Housekeeping	4,368	2,952	135	7,455		7,455		7,455		3
4	Laundry		92		92		92		92		4
5	Heat and Other Utilities			11,398	11,398		11,398		11,398		5
6	Maintenance	36	371	9,901	10,308		10,308		10,308		6
7	Other (specify):*										7
8	TOTAL General Services	25,674	39,009	22,909	87,592	(4,511)	83,081		83,081		8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	146,267	2,167	2,500	150,934		150,934		150,934		10
10a	Therapy		19	441	460		460		460		10a
11	Activities	10,271	170	575	11,016		11,016		11,016		11
12	Social Services	9,720		1,895	11,615		11,615		11,615		12
13	CNA Training										13
14	Program Transportation			652	652		652		652		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	166,258	2,356	7,263	175,877		175,877		175,877		16
	C. General Administration										
17	Administrative	13,500		129,188	142,688	(61,880)	80,808	(72,982)	7,826		17
18	Directors Fees										18
19	Professional Services			50,127	50,127	1,442	51,569		51,569		19
20	Dues, Fees, Subscriptions & Promotions			2,068	2,068		2,068		2,068		20
21	Clerical & General Office Expenses		2,349	4,269	6,618	46,666	53,284	(361)	52,923		21
22	Employee Benefits & Payroll Taxes			25,907	25,907	12,484	38,391		38,391		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,433	2,433	951	3,384	(397)	2,987		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			9,585	9,585	277	9,862		9,862		26
27	Other (specify):*										27
28	TOTAL General Administration	13,500	2,349	223,577	239,426	(60)	239,366	(73,740)	165,626		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	205,432	43,714	253,749	502,895	(4,571)	498,324	(73,740)	424,584		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number West Grove

#0033548

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			27,441	27,441		27,441	(13,417)	14,024			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,885	23,885	209	24,094	(20,965)	3,129			32
33	Real Estate Taxes			8,681	8,681		8,681		8,681			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			672	672	1,824	2,496		2,496			35
36	Other (specify):*											36
37	TOTAL Ownership			60,679	60,679	2,033	62,712	(34,382)	28,330			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			159	159		159		159			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,932	31,932		31,932		31,932			42
43	Other (specify):* Contributions					2,538	2,538	(2,538)				43
44	TOTAL Special Cost Centers			32,091	32,091	2,538	34,629	(2,538)	32,091			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	205,432	43,714	346,519	595,665		595,665	(110,660)	485,005			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(83)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(161)	24		15
16	Personal Expenses (Including Transportation)	(233)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(236)	24		19
20	Contributions	(2,538)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(128)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(34,299)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (37,678)		\$	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)	(36,491)	17	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (36,491)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (74,169)		37

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' COMPILATION REPORT

West Grove

ID# 0033548

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Interest on Mortgage in excess of original debt	\$ (20,882)	32	1
2				2
3	Depreciation on Stepped-Up Basis	(13,417)	30	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(34,299)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number West Grove# 0033548

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 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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	(36,491)	(36,491)	0	0	0	0	0	0	0	0	0	(72,982)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(361)	0	0	0	0	0	0	0	0	0	0	(361)	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	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(397)	0	0	0	0	0	0	0	0	0	0	(397)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(37,249)	(36,491)	0	0	0	0	0	0	0	0	0	(73,740)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(37,249)	(36,491)	0	0	0	0	0	0	0	0	0	(73,740)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number West Grove# 0033548

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	(13,417)	0	0	0	0	0	0	0	0	0	0	(13,417)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(20,965)	0	0	0	0	0	0	0	0	0	0	(20,965)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(34,382)	0	0	0	0	0	0	0	0	0	0	(34,382)	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):*	(2,538)	0	0	0	0	0	0	0	0	0	0	(2,538)	43
44	TOTAL Special Cost Centers	(2,538)	0	0	0	0	0	0	0	0	0	0	(2,538)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(74,169)	(36,491)	0	0	0	0	0	0	0	0	0	(110,660)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See page 29						

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Management Fees	\$ 127,200	Rincker Healthcare Corporation	100.00%	\$ 90,709	\$	(36,491)
2	V							
3	V							
4	V							
5	V							
6	V							
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 127,200			\$ 90,709	\$ *	(36,491)

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

Facility Name & ID Number

West Grove

0033548

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	William Rincker		Administrative	0.25	26,819			Wages	\$ 6,180	1
2	Angela West		Administrative	0.25	26,819			Wages	6,180	2
3	Deanna Gillis	Administrator	Administrative	0.25	26,819	10	0.50	Wages	19,680	3
4	Jane Rincker	Accounting Supv.	Bookkeeping	0.25	156,691	10	0.25	Wages	36,107	4
5	Rob Gillis	Administrator	Administrative		122,785	2.5	0.06	Wages	8,652	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 76,799	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 West Grove # 0033548 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 Rincker Healthcare Corporation
 Street Address 900 East Corporation
 City / State / Zip Code Bridgeport, IL 62417
 Phone Number (618) 945-2091
 Fax Number (618) 945-9030

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	See Attached Schedule, Pg. 25				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

West Grove

0033548

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	First Financial Bank NA		X	Real Estate Mortgage	\$5,390.56	08/01/96	\$ 773,710	\$ 390,182	09/15/2017	6.5000	\$ 23,885	1							
2	First Financial Bank NA		X	Purchase - Rincker Healthcare							209	2							
3				See Page 25								3							
4												4							
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$5,390.56		\$ 773,710	\$ 390,182			\$ 24,094	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 773,710	\$ 390,182			\$ 24,094	15							

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

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

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 West Grove

0033548

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,000 Main Floor B. General Construction Type: Exterior Brick/Vinyl Frame Wood/Masonry Number of Stories 1w/1,000 sq ft basement

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Ground for Facility</u>	<u>34,200</u>	<u>1987</u>	<u>\$ 7,531</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	34,200		\$ 7,531	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Grove

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	16		1988	\$ 289,571	\$ 11,583	25	\$ 11,583	\$	\$ 249,030	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Land Improvements		1988	4,365					4,365	9
10	Land Improvements		1990	600					600	10
11	Building Improvements		2000	3,800	152	25	152		1,381	11
12	Exit Light		2001	1,077	108	10	108		916	12
13	Building Roof		2004	10,000	400	25	400		2,067	13
14	Bathroom Flooring		2007	2,255	226	10	226		508	14
15	Wood Flooring		2007	5,407	541	10	541		1,172	15
16	Vinyl Flooring		2008	1,564	156	7	156		286	16
17	Vinyl Flooring		2008	1,572	157	7	157		183	17
18	Fixtures, Counter Tops, Etc.		2008	2,699	180	7	180		195	18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	\$ 322,910		\$ 13,503	\$	\$ 13,503	\$	260,703	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number West Grove

0033548

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	\$ 5,219	\$ 521	\$ 521		10 Yrs	\$ 4,341	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	33,565				5-10 Yrs	33,565	73
74								74
75	TOTALS	\$ 38,784	\$ 521	\$ 521			\$ 37,906	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	Client Medical, Social, & Program Transportation	1994 Ford Van	1999	\$ 18,099	\$	\$		5	\$ 18,099	76
77										77
78										78
79										79
80	TOTALS			\$ 18,099	\$	\$			\$ 18,099	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)	\$ 387,324	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,024	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 14,024	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 316,708	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	2000 Ford E-250 HD Van	\$ 36,009	\$	\$ 36,009	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 36,009	\$	\$ 36,009	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	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>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist		hrs	\$				\$		\$			\$			1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													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	TOTAL			\$				\$		\$			\$			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 West Grove# 0033548Report Period Beginning: 01/01/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 26,592	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	121,356		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	587		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 148,535	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	27,320		13
14	Buildings, at Historical Cost	653,374		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	142,481		16
17	Accumulated Depreciation (book methods)	(485,811)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	63,333		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 400,697	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 549,232	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 22,713	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	566		30
31	Accrued Taxes Payable (excluding real estate taxes)	213		31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,390		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37	Accrued Management Fees	53,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 84,911	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	390,182		40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	Advances Owners	47,300		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 437,482	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 522,393	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 26,839	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 549,232	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 106,524	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 106,524	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(79,685)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (79,685)	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)	\$ 26,839	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Grove

0033548

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	\$ 511,411	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 511,411	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education	4,484	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)	\$ 4,484	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	85	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 85	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)	\$ 515,980	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	87,592	31
32	Health Care	175,877	32
33	General Administration	239,426	33
B. Capital Expense			
34	Ownership	60,679	34
C. Ancillary Expense			
35	Special Cost Centers	159	35
36	Provider Participation Fee	31,932	36
D. Other Expenses (specify):			
37	<u>Rounding</u>		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 595,665	40
41	Income before Income Taxes (line 30 minus line 40)**	(79,685)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (79,685)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No See Pg 26 If not, please attach a reconciliation.

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

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

Facility Name & ID Number West Grove

0033548

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses	160	3,709	23.04	3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies	12,925	109,666	8.32	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,080	10,271	9.46	9
10	Activity Assistants				10
11	Social Service Workers	1,080	9,720	9.00	11
12	Dietician				12
13	Food Service Supervisor	1,920	16,841	8.26	13
14	Head Cook				14
15	Cook Helpers/Assistants	563	4,428	7.87	15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers	480	4,368	9.10	18
19	Laundry				19
20	Administrator	540	13,536	25.02	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	2,032	32,893	16.14	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)	20,780	205,432 *	9.70	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	48	\$ 1,475	1-3	35
36	Medical Director	24	1,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	175	2,500	10-3	38
39	Pharmacist Consultant	2	87	39-3	39
40	Physical Therapy Consultant	10	441	10A-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	575	11-3	44
45	Social Service Consultant	16	575	12-3	45
46	Other(specify)				46
47	Psychology Consultant	13	1,320	12-3	47
48	Administrative Consultant	46	1,988	17-3	48
49	TOTAL (lines 35 - 48)	350	\$ 10,161		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Deanna Gillis	Administrator	25%	\$ 13,500	Workers' Compensation Insurance	\$ 4,987	IDPH License Fee	\$		
				Unemployment Compensation Insurance	4,669	Advertising: Employee Recruitment	603		
				FICA Taxes	20,109	Health Care Worker Background Check	160		
				Employee Health Insurance	3,410	(Indicate # of checks performed)			
				Employee Meals	4,511	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Purchasing Group Dues	1,112		
				Other Employee Benefits	705	Licenses	193		
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 13,500						
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees - Rincker Healthcare Corporation			\$ 127,200				Out-of-State Travel	\$	
Administrative Consultants			1,988						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 129,188	TOTAL (agree to Schedule V, line 22, col.8)			\$ 38,391	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount						
Kemper CPA Group LLP	Accounting		\$ 11,772						
James Stout	Legal		50						
Duane Morris	Legal		35,400						
Michigan Peer Review Org	Facility Review		2,905						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 50,127						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Grove

0033548

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 31,932
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? Yes 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. \$ 4,511 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT

Page 5 Adjustments, line 29

	<u>Amount</u>	<u>Line</u>
Interest on mortgage amount in excess of original debt	(20,882)	32
Depreciation of stepped-up basis	<u>(13,417)</u>	30
	<u><u>(34,299)</u></u>	

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There are no training fees because West Grove only hires fully-trained employees.

SEE ACCOUNTANTS' COMPILATION REPORT.

Page 8 - Allocation of costs of Related Party - Rincker Healthcare, Inc.

<u>Line Description</u>	<u>Amount</u>	<u>Line Ref</u>
Administrative	28,829	17
Professional Services	1,442	19
Clerical & General Office Expenses	46,666	21
Employee Benefits & Payroll Taxes	7,973	22
Travel and Seminar	951	24
Insurance - Prop.Liab.Malpractice	277	26
Interest	209	32
Rent - Equipment & Vehicles	1,824	35
Donations	2,538	43
Administrative	<u>90,709</u>	17
Grand Total of allocated costs	<u><u>90,709</u></u>	

SEE ACCOUNTANTS' COMPILATION REPORT.

Page 19 - Reconciliation of taxable income to book net income

Book Net income(loss)	(79,685)
Difference book vs. tax depreciation	9,007
Difference book vs. tax amortization	(6,667)
Disallowed Meals & Entertainment	5
Accrued Management Fees - Related Party	<u>53,000</u>
Taxable Income	<u><u>(24,340)</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT.

Breakdown of owner salaries from other nursing homes.

	William J. Rincker	Angie West	Deanna Gillis	Jane Rincker	William Gillis
Friendship Manor	\$ 6,996.00	\$ 6,996.00	\$ 6,996.00	\$ 40,876.00	\$ 9,795.00
West Grove	6,180.00	6,180.00	19,680.00	36,107.00	8,652.00
Lawrence Comm. Healthcare Center	12,827.00	12,827.00	12,827.00	74,939.00	103,195.00
Rincker Residential	6,996.00	6,996.00	6,996.00	40,876.00	9,795.00
	<u>32,999.00</u>	<u>32,999.00</u>	<u>46,499.00</u>	<u>192,798.00</u>	<u>131,437.00</u>
Salaries reported on this cost report	<u>6,180.00</u>	<u>6,180.00</u>	<u>19,680.00</u>	<u>36,107.00</u>	<u>8,652.00</u>
Salaries reported by other homes	<u><u>\$ 26,819.00</u></u>	<u><u>\$ 26,819.00</u></u>	<u><u>\$ 26,819.00</u></u>	<u><u>\$ 156,691.00</u></u>	<u><u>\$ 122,785.00</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT.

Fixed Assets Reconciliation

	<u>Land</u>	<u>Building & Improvements</u>	<u>Equipment & Vehicles</u>	<u>Total</u>
Schedule XV Balance Sheet	\$ 27,320	\$ 653,374	\$ 142,481	\$ 823,175
Non-Care Assets	-	-	36,009	36,009
Schedule XI Ownership Costs	<u>7,531</u>	<u>322,910</u>	<u>92,892</u>	<u>423,333</u>
Difference	<u>\$ 19,789</u>	<u>\$ 330,464</u>	<u>\$ 13,580</u>	<u>\$ 363,833</u>

The difference arises from July 15, 1996 sale of all assets of the corporation to William F. Rincker who also purchased the corporate stock. After the former shareholders distributed all cash from the corporation, Mr. Rincker contributed the property and the equipment to the corporation.

SEE ACCOUNTANTS' COMPILATION REPORT.

List of Related Parties (attachment to pg. 6)

VII. RELATED PARTIES

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Angela West Trust	20%	Lawrence Community Healthcare Corporation	Bridgeport			
Angela West Trust	25%	Rincker Healthcare Corporation	Bridgeport			
Angela West Trust	25%	Friendship Manor	St. Elmo			
Mary Jane Rincker Trust	20%	Lawrence Community Healthcare Corporation	Bridgeport			
Mary Jane Rincker Trust	25%	Rincker Healthcare Corporation	Bridgeport			
Mary Jane Rincker Trust	25%	Friendship Manor	St. Elmo			
Deanna Gillis Trust	20%	Lawrence Community Healthcare Corporation	Bridgeport			
Deanna Gillis Trust	25%	Rincker Healthcare Corporation	Bridgeport			
Deanna Gillis Trust	25%	Friendship Manor	St. Elmo			
William J. Rincker Trust	20%	Lawrence Community Healthcare Corporation	Bridgeport			
William J. Rincker Trust	25%	Rincker Healthcare Corporation	Bridgeport			
William J. Rincker Trust	25%	Friendship Manor	St. Elmo			

SEE ACCOUNTANTS' COMPILATION REPORT.