

Facility Name & ID Number SKOKIE MEADOWS NURSING CENTER #2

0048942 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	<u>111</u>	Skilled (SNF)	<u>111</u>	<u>40,515</u>	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	<u>111</u>	TOTALS	<u>111</u>	<u>40,515</u>	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
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>27,098</u>	<u>589</u>	<u>9,839</u>	<u>37,526</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>27,098</u>	<u>589</u>	<u>9,839</u>	<u>37,526</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.62%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/01/07

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/01/07 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 0

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number SKOKIE MEADOWS NURSING CENTER # # 0048942 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	159,225	11,097	7,458	177,780		177,780		177,780		1
2	Food Purchase		181,549		181,549	(29,565)	151,984	(163)	151,821		2
3	Housekeeping	161,913	21,124		183,037		183,037		183,037		3
4	Laundry		16,825		16,825		16,825		16,825		4
5	Heat and Other Utilities			121,178	121,178		121,178		121,178		5
6	Maintenance	24,042	15,031	34,997	74,070		74,070		74,070		6
7	Other (specify):*			5,782	5,782		5,782		5,782		7
8	TOTAL General Services	345,180	245,626	169,415	760,221	(29,565)	730,656	(163)	730,493		8
	B. Health Care and Programs										
9	Medical Director			15,160	15,160		15,160		15,160		9
10	Nursing and Medical Records	1,059,425	135,244	60,148	1,254,817		1,254,817		1,254,817		10
10a	Therapy										10a
11	Activities	82,664	17,238	2,024	101,926		101,926		101,926		11
12	Social Services	153,441		770	154,211		154,211		154,211		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,295,530	152,482	78,102	1,526,114		1,526,114		1,526,114		16
	C. General Administration										
17	Administrative	73,184		312,000	385,184		385,184		385,184		17
18	Directors Fees										18
19	Professional Services			20,904	20,904		20,904		20,904		19
20	Dues, Fees, Subscriptions & Promotions			40,892	40,892		40,892	(32,173)	8,719		20
21	Clerical & General Office Expenses	26,227	10,376	17,965	54,568		54,568		54,568		21
22	Employee Benefits & Payroll Taxes			312,245	312,245	29,565	341,810		341,810		22
23	Inservice Training & Education			569	569		569		569		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			8,063	8,063		8,063		8,063		25
26	Insurance-Prop.Liab.Malpractice			65,875	65,875		65,875		65,875		26
27	Other (specify):*										27
28	TOTAL General Administration	99,411	10,376	778,513	888,300	29,565	917,865	(32,173)	885,692		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,740,121	408,484	1,026,030	3,174,635		3,174,635	(32,336)	3,142,299		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	7,384
	REPAIRS & MAINTENANCE	74
		0
		7,458
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	37,438
	ELECTRICITY	67,582
	WATER	13,188
	CABLE TV - LOBBY	2,970
		0
		121,178
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,100
	PAINTING & DECORATING	11,259
	BUILDING REPAIRS	4,288
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	5,445
	ELEVATOR MAINTENANCE & REPAIR	1,450
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	675
	FIRE SERVICE	7,836
	CONTRACTED BUILDING MAINTENANCE	2,944
		0
		0
		0
		34,997
7	OTHER	
	SCAVENGER	5,747
	SECURITY SERVICE	35
		0
		0
		5,782
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	15,160
		15,160

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	4,969
	PURCHASED SERVICES	21,946
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,416
	PHARMACY CONSULTANT XVIII B 39-2	4,817
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	24,000
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		60,148
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,024
		0
		2,024
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	770
		0
		770
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	312,000 312,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0 0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	10,204
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	10,700
		0 20,904
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	21,463
	EMPLOYEE WANT ADS XIX F	845
	CONTRIBUTIONS VI 20 XIX F	4,050
	DUES & SUBSCRIPTIONS XIX F	5,555
	LICENSES & PERMITS XIX F	949
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	6,660
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	870
	PATIENT BACKGROUND CHECKS XIX F	500
		40,892
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	121
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	17,844
	MESSENGER SERVICE	0
		0 17,965

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	132,175
	UNEMPLOYMENT COMPENSATION XIX D	8,318
	WORKERS COMPENSATION INSURANC XIX D	0
	HOSPITALIZATION INSURANCE XIX D	144,775
	EMPLOYEE BENEFITS - OTHER XIX D	2,800
	EMPLOYEE PHYSICAL EXAMS XIX D	1,381
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	22,796
	CHICAGO HEAD TAX XIX D	0
		0 312,245
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	569
		569
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	8,063
		8,063
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	65,875
		65,875
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,026,030

SKOKIE MEADOWS NURSING CENTER #2
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	181,549
LESS SALES TAX	<u>(163)</u>
NET FOOD	181,386

TOTAL PATIENT CENSUS	37,526
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	112,578

ADD # EMPLOYEE MEALS/DAY	60
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	21,900

PATIENT MEALS	112,578
ADD EMPLOYEE MEALS	<u>21,900</u>
TOTAL MEALS/YEAR	134,478

NET FOOD	181,386
DIVIDE TOTAL MEALS/YEAR	<u>134,478</u>

COST PER MEAL	1.35
TIME EMPLOYEE MEALS	<u>21,900</u>
EMPLOYEE MEAL RECLASSIFICATION	29,565

=====

Facility Name & ID Number SKOKIE MEADOWS NURSING CENTER #2 #0048942 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			57,655	57,655		57,655	53,656	111,311			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							411,218	411,218			32
33	Real Estate Taxes			141,107	141,107		141,107		141,107			33
34	Rent-Facility & Grounds			903,121	903,121		903,121	(903,121)				34
35	Rent-Equipment & Vehicles			10,637	10,637		10,637		10,637			35
36	Other (specify):*							32,917	32,917			36
37	TOTAL Ownership			1,112,520	1,112,520		1,112,520	(405,330)	707,190			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,773	60,773		60,773		60,773			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			60,773	60,773		60,773		60,773			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,740,121	408,484	2,199,323	4,347,928		4,347,928	(437,666)	3,910,262			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(22,848)	30		9
10	Interest and Other Investment Income	(4,050)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(163)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(10,710)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(21,463)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (59,234)		\$	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)	(378,432)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (378,432)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (437,666)		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	
----	--	----	--	----	--	----	--	----	--

SKOKIE MEADOWS NURSING CENTER #2

ID# 0048942

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SKOKIE MEADOWS NURSING CENTER #2# 0048942

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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	(163)	0	0	0	0	0	0	0	0	0	0	(163)	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	(163)	0	0	0	0	0	0	0	0	0	0	(163)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	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	(32,173)	0	0	0	0	0	0	0	0	0	0	(32,173)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(32,173)	0	0	0	0	0	0	0	0	0	0	(32,173)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(32,336)	0	0	0	0	0	0	0	0	0	0	(32,336)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SKOKIE MEADOWS NURSING CENTER #2# 0048942

Report Period Beginning:

01/01/2010 Ending:12/31/2010

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	(22,848)	76,504	0	0	0	0	0	0	0	0	0	53,656	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,050)	415,268	0	0	0	0	0	0	0	0	0	411,218	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(903,121)	0	0	0	0	0	0	0	0	0	(903,121)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	32,917	0	0	0	0	0	0	0	0	0	32,917	36
37	TOTAL Ownership	(26,898)	(378,432)	0	(405,330)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(59,234)	(378,432)	0	0	0	0	0	0	0	0	0	(437,666)	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
PAUL APPEL	50	CAMBRIDGE NURSING REHAB CENTER	SKOKIE	SKOKIE CAMBRIDGE		
JOAN WILLEY	50			REALTY LLC	SKOKIE	REAL ESTATE

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	34 RENT	\$ 903,121	SKOKIE CAMBRIDGE REALTY, LLC		\$	(903,121)	1
2	V	30 DEPRECIATION				76,504	76,504	2
3	V	32 INTEREST				415,268	415,268	3
4	V	36 MIP INSURANCE				32,917	32,917	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 903,121			\$ 524,689	\$ * (378,432)	14

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

Facility Name & ID Number **SKOKIE MEADOWS NURSING CENTER** # **0048942** Report Period Beginning: **01/01/2010** Ending: **12/31/2010**

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	JOAN WILLEY	CEO	ADMINISTRATIV	50.00				MGMT FEE	\$ 312,000	17-3	1
2											2
3											3
4	MARK APPEL	CFO	FINANCIAL	50.00	312,000						4
5					CAMBRIDGE NURSING						5
6					REHAB CENTER						6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 312,000		13

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

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

Facility Name & ID Number SKOKIE MEADOWS NURSING CENTER #2 # 0048942 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 SKOKIE CAMBRIDGE REALTY
 Street Address 9615 N KNOX
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847)679-4161
 Fax Number (847)679-3241

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	30	DEPRECIATION	DIRECT	1	1	\$ 76,504	\$ 1	\$ 76,504	1
2	32	INTEREST	DIRECT	1	1	415,268	1	415,268	2
3	36	MIP INSURANCE	DIRECT	1	1	32,917	1	32,917	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					\$ 524,689	\$	\$ 524,689	25

Facility Name & ID Number

SKOKIE MEADOWS NURSING CENTER #

0048942

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1	SKOKIE CAMBRIDGE REALTY, LLC					\$	\$			\$	1							
2	CAMBRIDGE REALTY		X	MORTGAGE	\$37,760.00	10/17/07	6,822,050	6,617,293	11/1/42	5.7500	382,369	2						
3	JACOB GRAF		X	WORKING CAPITAL	\$8,333.00	11/1/07	773,986	347,463	2/1/15	7.0000	28,467	3						
4	DIAMOND BANK		X	WORKING CAPITAL	\$3,700.00		200,000	81,356	12/24/12	4.2500	4,432	4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$49,793.00		\$ 7,796,036	\$ 7,046,112			\$ 415,268	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 7,796,036	\$ 7,046,112			\$ 415,268	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 32,917 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.)

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.	\$	196,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	147,107	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(48,893)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	190,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	141,107	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	_____	8
	2006	_____	9
	2007	180,527	10
	2008	185,185	11
	2009	147,107	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 130% OF THE PRIOR YEAR REAL ESTATE TAX BILL THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2009	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,213 B. General Construction Type: Exterior Frame Number of Stories

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

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

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

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>NURSING HOME</u>		<u>2007</u>	<u>\$ 275,250</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 275,250	3

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	111	2007		\$ 2,365,250	\$ 60,647	39	\$ 60,647	\$	\$ 192,049	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	WALL UNITS		2008	8,200	210	39	210		526	9
10	BASEMENT STAIRCASE		2008	4,895	126	39	126		314	10
11	INSTALLED REMOTE ANNAUNCIATOR PANEL		2008	6,850	176	39	176		440	11
12	INSTALL NEW GUIDES FOR ELEVATOR		2008	3,578	92	39	92		230	12
13	INSTALLED NEW TEKMAR CONTROL FOR BOILERS		2008	2,549	65	39	65		163	13
14	ELECTRICAL SERVICE		2008	2,650	68	39	68		170	14
15	ROOF TOP UNIT		2008	12,800	328	39	328		820	15
16	FIRE ALARM SYSTEM DEVICES		2009	29,065	745	39	745		1,456	16
17	SPRINKLER SYSTEM		2009	8,076	207	39	207		408	17
18	WALCOVERING CORRIDOR AND LOBBY		2010	9,190	226	39	226		226	18
19	SHOWERS ROOMS FLOOR REPLACEMENT		2010	18,730	460	39	460		460	19
20	NORT DINING ROOM PARTITION		2010	4,650	114	39	114		114	20
21	MAIN DINING ROOM NEW CEILING		2010	7,385	181	39	181		181	21
22	DOCTOR OFFICE NEW WALL & CEILING		2010	3,072	76	39	76		76	22
23	NURSING OFFICE WALL COVERING		2010	3,188	78	39	78		78	23
24	BASEMENT FLOORING NEW TILES		2010	15,600	383	39	383		383	24
25	FRONT ENTRY WAY WALL COVERING		2010	15,600	383	39	383		383	25
26	PAINTING CEILING		2010	26,720	657	39	657		657	26
27	DOORS		2010	14,175	348	39	348		348	27
28	MOLDED TO RAIL FINISH BLACK PAINT		2010	6,000	148	39	148		148	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

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)	\$ 2,568,223	\$ 65,718		\$ 65,718	\$	\$ 199,630	70

**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	\$ 162,450	\$ 32,490	\$ 16,245	\$ (16,245)	10 YRS	\$ 28,306	71
72	Current Year Purchases	6,951	6,951	348	(6,603)	10 YRS	348	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		15,857	15,857				74
75	TOTALS	\$ 169,401	\$ 55,298	\$ 32,450	\$ (22,848)		\$ 28,654	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	ADMINISTRATOR	2008 LEXUS ES350	2008	\$ 39,429	\$ 13,143	\$ 13,143	\$	3 YRS	\$ 39,429	76
77										77
78										78
79										79
80	TOTALS			\$ 39,429	\$ 13,143	\$ 13,143	\$		\$ 39,429	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)	\$ 3,052,303	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 134,159	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 111,311	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (22,848)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 267,713	85

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

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: \$ 9,061 Description: SEE SCHEDULE ATTACHED

(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	FACILITY	2005 FORD E350	394.00	1,576	18
19					19
20					20
21	TOTAL		\$ 394.00	\$ 1,576	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. _____ \$ _____

13. _____ \$ _____

14. _____ \$ _____

* 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>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	39-3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs			N/A				7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts							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.

Facility Name & ID Number **SKOKIE MEADOWS NURSING CENTER #2**

0048942

Report Period Beginning: **01/01/2010**

Ending: **12/31/2010**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2010** (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	\$ 32,141	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (147,700))	194,489		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due From Cambridge	2,006,257		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,232,887	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	202,973		15
16	Equipment, at Historical Cost	208,830		16
17	Accumulated Depreciation (book methods)	(98,354)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 313,449	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,546,336	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 91,759	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	52,645		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	190,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 334,404	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 334,404	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,211,932	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,546,336	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,769,248	1
2	Restatements (describe):		2
3	CAMBRIDGE ELIMINATION	249,390	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,018,638	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	503,294	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	(310,000)	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)	\$ 193,294	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)	\$ 2,211,932	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **SKOKIE MEADOWS NURSING CENTER #2** # **0048942** Report Period Beginning: **01/01/2010** Ending: **12/31/2010**

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	\$ 4,843,578	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,843,578	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		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,050	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,050	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	3,594	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,594	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,851,222	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	760,221	31
32	Health Care	1,526,114	32
33	General Administration	888,300	33
B. Capital Expense			
34	Ownership	1,112,520	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	60,773	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,347,928	40
41	Income before Income Taxes (line 30 minus line 40)**	503,294	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 503,294	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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.

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

Facility Name & ID Number **SKOKIE MEADOWS NURSING CENTER #2**

0048942

Report Period Beginning: **01/01/2010**

Ending:

12/31/2010

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	2,200	\$ 75,312	\$ 34.23	1
2	Assistant Director of Nursing	1,928	2,101	69,007	32.84	2
3	Registered Nurses	12,416	13,734	387,251	28.20	3
4	Licensed Practical Nurses	1,398	1,430	32,231	22.54	4
5	CNAs & Orderlies	33,545	37,079	429,399	11.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,840	2,120	24,694	11.65	9
10	Activity Assistants	4,270	4,646	57,970	12.48	10
11	Social Service Workers	7,048	7,860	153,441	19.52	11
12	Dietician					12
13	Food Service Supervisor	1,736	2,080	28,230	13.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,804	13,803	130,995	9.49	15
16	Dishwashers					16
17	Maintenance Workers	1,724	1,948	24,042	12.34	17
18	Housekeepers	13,666	14,930	161,913	10.84	18
19	Laundry					19
20	Administrator	1,992	2,080	73,184	35.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,849	2,009	26,227	13.05	23
24	Clerical					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 MDS	1,856	2,125	66,225	31.16	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	100,096	110,145	\$ 1,740,121 *	\$ 15.80	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	157	\$ 7,384	1-3	35
36	Medical Director	60	15,160	9-3	36
37	Medical Records Consultant	96	4,416	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	107	4,817	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	96	2,024	11-3	44
45	Social Service Consultant	13	770	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	529	\$ 34,571		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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ALLIANCE FOR LIVING \$6,660
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? 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. \$ 60,773
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. \$ 29,565 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
 - d. Have vehicle usage logs been maintained? NO
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
 - g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.