

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center

0039651 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	2,552		1,450	4,002	8
9	SNF/PED					9
10	ICF	25,509	124		25,633	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,061	124	1,450	29,635	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.13%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 06/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES Date 06/01/94 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 27 and days of care provided 1,450

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Cent # 0039651 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	196,391	11,052	4,428	211,871		211,871		211,871		1
2	Food Purchase		167,394		167,394		167,394	(3,242)	164,152		2
3	Housekeeping	142,158	41,036		183,194		183,194	83	183,277		3
4	Laundry	59,766	6,321		66,087		66,087		66,087		4
5	Heat and Other Utilities			137,253	137,253		137,253	1,254	138,507		5
6	Maintenance	70,485	34,015	16,266	120,766		120,766	535	121,301		6
7	Other (specify):*										7
8	TOTAL General Services	468,800	259,818	157,947	886,565		886,565	(1,370)	885,195		8
	B. Health Care and Programs										
9	Medical Director			2,700	2,700		2,700		2,700		9
10	Nursing and Medical Records	1,425,796	36,561	930	1,463,287		1,463,287	(1,271)	1,462,016		10
10a	Therapy			339,275	339,275		339,275		339,275		10a
11	Activities	58,673	3,444	285	62,402		62,402		62,402		11
12	Social Services	58,339			58,339		58,339		58,339		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,542,808	40,005	343,190	1,926,003		1,926,003	(1,271)	1,924,732		16
	C. General Administration										
17	Administrative	79,115		110,400	189,515		189,515	(43,795)	145,720		17
18	Directors Fees										18
19	Professional Services			61,681	61,681		61,681	84	61,765		19
20	Dues, Fees, Subscriptions & Promotions			17,854	17,854		17,854	(2,898)	14,956		20
21	Clerical & General Office Expenses	249,528		30,857	280,385		280,385	44,867	325,252		21
22	Employee Benefits & Payroll Taxes			309,059	309,059		309,059	3,770	312,829		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,020	1,020		1,020	44	1,064		24
25	Other Admin. Staff Transportation			5,916	5,916		5,916	972	6,888		25
26	Insurance-Prop.Liab.Malpractice			11,805	11,805		11,805	672	12,477		26
27	Other (specify):* Mgmt Alloc of Benefit							12,944	12,944		27
28	TOTAL General Administration	328,643		548,592	877,235		877,235	16,660	893,895		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,340,251	299,823	1,049,729	3,689,803		3,689,803	14,019	3,703,822		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 Virgil Calvert Nursing & Rehabilitation Center #0039651 Report Period Beginning: 01/01/10 Ending: 12/31/10

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			50,225	50,225		50,225	122,890	173,115			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,098	42,098		42,098	315,406	357,504			32
33	Real Estate Taxes							86,944	86,944			33
34	Rent-Facility & Grounds			617,258	617,258		617,258	(617,258)				34
35	Rent-Equipment & Vehicles							918	918			35
36	Other (specify):* Mortgage Insurance							27,795	27,795			36
37	TOTAL Ownership			709,581	709,581		709,581	(63,305)	646,276			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		42,320		42,320		42,320		42,320			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):* Non-Allowable Cos			18,343	18,343		18,343	(18,343)				43
44	TOTAL Special Cost Centers		42,320	100,468	142,788		142,788	(18,343)	124,445			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,340,251	342,143	1,859,778	4,542,172		4,542,172	(67,629)	4,474,543			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	(7,429)	30		9
10	Interest and Other Investment Income	(41,986)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(251)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(228)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,457)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,200)	43		24
25	Fund Raising, Advertising and Promotional	(212)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(19,095)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (78,858)		\$	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)	11,229		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 11,229		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (67,629)		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

Virgil Calvert Nursing & Rehabilitation Center

ID# 0039651

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable Classified Advertising	\$ (1,427)	43	1
2	Labs - Part A	(5,665)	43	2
3	X-Rays - Part A	(7,766)	43	3
4	Theft & Damage Loss	(594)	43	4
5	Miscellaneous Income	(109)	21	5
6	Real Estate Taxes	(56)	33	6
7	COPE Fees	(3,478)	20	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
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26				26
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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	(19,095)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule 6A		See Schedule 6B		See Schedule 6B		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 Professional Services	\$	Virgil Calvert Property LLC	100.00%	\$ 5,750	\$ 5,750	1
2	V	21 Office Expense		Virgil Calvert Property LLC	100.00%	724	724	2
3	V	30 Depreciation		Virgil Calvert Property LLC	100.00%	127,818	127,818	3
4	V	32 Interest Income	112	Virgil Calvert Property LLC	100.00%		(112)	4
5	V	32 Interest		Virgil Calvert Property LLC	100.00%	352,834	352,834	5
6	V	33 Real Estate Taxes		Virgil Calvert Property LLC	100.00%	84,249	84,249	6
7	V	34 Rent-Facility & Grounds	617,258	Virgil Calvert Property LLC	100.00%		(617,258)	7
8	V	36 Mortgage Insurance		Virgil Calvert Property LLC	100.00%	27,795	27,795	8
9	V	20 Dues Fees Subscriptions		Virgil Calvert Property LLC	100.00%	492	492	9
10	V	26 Insurance		Virgil Calvert Property LLC	100.00%	219	219	10
11	V	32 Amortization		Virgil Calvert Property LLC	100.00%	4,670	4,670	11
12	V							12
13	V							13
14	Total		\$ 617,370			\$ 604,551	\$ * (12,819)	14

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

Virgil Calvert Nursing & Rehabilitation Center
Provider # 0039651
FYE: 12/31/10

Sch 6A

VII Related Parties - Page 6

Schedule 6A

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

SEE ACCOUNTANTS' COMPILATION REPORT

Virgil Calvert Nursing & Rehabilitation Center
Provider # 0039651
FYE: 12/31/10

Schedule 6 B

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

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

Out-of-State:

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

Other Related Business Entities

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 Food	\$	SW Management Co.	100.00%	\$ 144	\$	144	15
16	V	3 Housekeeping		SW Management Co.	100.00%	83		83	16
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	1,254		1,254	17
18	V	6 Maintenance		SW Management Co.	100.00%	535		535	18
19	V	17 Administrative	110,400	SW Management Co.	100.00%	66,605		(43,795)	19
20	V	19 Professional Services		SW Management Co.	100.00%	1,791		1,791	20
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	88		88	21
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	44,252		44,252	22
23	V	24 Travel & Seminar		SW Management Co.	100.00%	44		44	23
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	972		972	24
25	V	26 Insurance-Prop Liab. Malpractice		SW Management Co.	100.00%	453		453	25
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	12,944		12,944	26
27	V	30 Depreciation		SW Management Co.	100.00%	2,501		2,501	27
28	V	32 Interest		SW Management Co.	100.00%	57		57	28
29	V	33 Real Estate Taxes		SW Management Co.	100.00%	2,694		2,694	29
30	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	918		918	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 110,400			\$ 135,335	\$ *	24,935	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 Food	\$ 5,489	S & E Medical Supply Co	100.00%	\$ 5,873	\$ 384	15	
16	V	3 Housekeeping	1,311	S & E Medical Supply Co	100.00%	1,311		16	
17	V	10 Medical Supplies	2,331	S & E Medical Supply Co	100.00%	1,060	(1,271)	17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$ 9,131			\$ 8,244	\$ *	(887)	39

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

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Cen # 0039651 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	23.67	See Schedule 7A	5	12.00	Salary	\$ 23,452	L17,C7	1
2	Ronnie Klein	COO	Administrative	5.50	See Schedule 7B	5	10.00	Salary & Fees	19,700	L17,3 & 21,7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	5	12.00	Salary	23,452	L17,C7	3
4											4
5											5
6											6
7			Note: All individuals work in excess of 40 hours per week.								7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 66,604		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center # 0039651 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	Food	Bed Days Available	742,930	12	\$ 1,959	\$ 54,750	\$ 144	1	
2	3	Housekeeping	Bed Days Available	742,930	12	1,125	54,750	83	2	
3	5	Heat and Other Utilities	Bed Days Available	742,930	12	17,016	54,750	1,254	3	
4	6	Maintenace	Bed Days Available	742,930	12	7,264	54,750	535	4	
5	19	Professional Services	Bed Days Available	742,930	12	24,293	54,750	1,791	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	742,930	12	1,198	54,750	88	6	
7	21	Clerical & General Office Exp	Bed Days Available	742,930	12	600,468	509,094	54,750	44,252	7
8	24	Travel & Seminar	Bed Days Available	742,930	12	594	54,750	44	8	
9	25	Other Admin. Staff Transport	Bed Days Available	742,930	12	13,194	54,750	972	9	
10	26	Insurance-Prop., Liab. & Malp.	Bed Days Available	742,930	12	6,148	54,750	453	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	742,930	12	175,644	54,750	12,944	11	
12	32	Interest	Bed Days Available	742,930	12	778	54,750	57	12	
13	33	Real Estate Taxes	Bed Days Available	742,930	12	36,555	54,750	2,694	13	
14	35	Rent-Equipment & Vehicles	Bed Days Available	742,930	12	12,454	54,750	918	14	
15									15	
16	17	Administrative	Avg Hours Worked	84	12	394,000	394,000	10	46,905	16
17	17	Administrative	Avg Hours Worked	50	6	197,000	197,000	5	19,700	17
18									18	
19	30	Depreciation	Direct Cost	33,940					2,501	19
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,489,690	\$ 1,100,094	\$ 135,335	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center # 0039651 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost		\$	\$		\$ 5,873	1
2	3	Housekeeping	Direct Cost					1,311	2
3	10	Medical Supplies	Direct Cost					1,060	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				\$	\$		\$ 8,244	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Cent # 0039651 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Heartland Bank		X	Mortgage	\$23,524.00	11/27/01	\$ 6,359,200	\$ 5,521,388	12/01/36	0.0635	\$ 352,834	1							
2							Amortization of Mortgage Costs				4,670	2							
3												3							
4												4							
5												5							
Working Capital																			
6	N/P Stockholder	X		Working Capital				486,949	Demand	Variable	19,436	6							
7	Intercompany Loan	X		Working Capital				1,013,223	Demand	0.0400	22,662	7							
8												8							
9	TOTAL Facility Related				\$23,524.00		\$ 6,359,200	\$ 7,021,560			\$ 399,602	9							
B. Non-Facility Related*																			
10							Related Party Interest (Net of Income)				(41,986)	10							
11							Real Estate Entity Interest Income				(112)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (42,098)	14							
15	TOTALS (line 9+line14)						\$ 6,359,200	\$ 7,021,560			\$ 357,504	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 27,795 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.			\$ 118,500	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.)	2009		\$ 99,850	2																				
3. Under or (over) accrual (line 2 minus line 1).			\$ (18,650)	3																				
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 102,900	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. Mgmt. Alloc			\$ 365	5																				
		Allocated from Management Co.	2,329																					
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.			\$ 86,944	7																				
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2005	<u>182,236</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="3" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2009</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">16</td> </tr> </table>		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
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																					
	2006	<u>197,469</u>	9																					
	2007	<u>142,987</u>	10																					
	2008	<u>114,901</u>	11																					
	2009	<u>99,870</u>	12																					
2009 Tax Accrual = 99,850 X 1.03 = 102,846. use 102,900																								

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.

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center

0039651

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150	2001		\$ 4,801,297	\$	15-40	\$ 132,029	\$ 132,029	\$ 1,199,262	4
5										5
6	Mgmt Co	1995		31,898			911	911	14,267	6
7										7
8										8
Improvement Type**										
9	Various		1994	30,238	327	20	1,471	1,144	24,437	9
10	Various		1995	25,180	459	20	1,259	800	19,972	10
11	Various		1996	5,688	243	20	284	41	4,168	11
12	Various		1997	4,115	106	20	206	100	2,814	12
13	Various		1998	4,092		20	205	205	2,831	13
14	Various		1999	27,640		20	1,374	1,374	16,115	14
15	Concrete Work		2000	3,181	82	20	159	77	1,670	15
16	Concrete Work		2000	5,030	129	20	251	122	2,641	16
17	Concrete Work		2000	5,195	133	20	260	127	2,728	17
18	Exhaust Fan		2000	3,820		20	191	191	2,260	18
19	Water Heater		2000	5,300		20	265	265	3,092	19
20	Carpeting		2000	5,400		20	270	270	3,060	20
21	Mechanical Room Volv		2000	1,315		20	66	66	659	21
22	Check Valve		2000	877		20	44	44	439	22
23	Plumbing		2000	1,024		20	51	51	511	23
24	100 Gal. Waterheater		2001	4,642		20	232	232	3,392	24
25	Steamer		2001	2,545		20	127	127	1,858	25
26	Concentrator		2001	2,703		7			2,703	26
27	Air Conditioner		2001	1,895		20	95	95	1,384	27
28	Fire Protection		2001	6,752		20	338	338	4,934	28
29	Air Conditioner		2001	8,313		20	416	416	6,074	29
30	Sprinkler Heads		2001	3,273		20	164	164	2,392	30
31	Blinds		2001	1,212		20	61	61	887	31
32	Sprinkler System Rep		2001	1,827		20	91	91	852	32
33	Heating Systems Repr		2001	1,269		20	63	63	576	33
34	Dining Room Wall		2002	11,663	209	10	1,166	957	10,108	34
35	Dining Room Wall		2002	8,020	144	10	802	658	6,951	35
36			2002	1,659		7			1,659	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center

0039651

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Air Conditioners	2002	\$ 2,185	\$	7	\$	\$	\$ 2,185	37
38	Front Door	2003	9,860	253	20	493	240	3,944	38
39	Roof	2003	72,800	1,867	20	3,640	1,773	28,513	39
40	Gutters And Soffits	2003	24,221	621	20	1,211	590	9,284	40
41	Nursing Station	2003	2,901		20	145	145	1,124	41
42	Nursing Station	2003	13,285		20	664	664	5,148	42
43	Nursing Station	2003	12,188		20	609	609	4,519	43
44	Fire Sprinkler System	2003	2,075		20	104	104	788	44
45	Fire Suppression System	2003	2,030		20	102	102	762	45
46	100 Gl. Water Heater	2003	3,085		20	154	154	1,233	46
47	Resident Room Casework/counters	2003	7,259		20	363	363	2,783	47
48	Pipe/Dry system	2004	2,472	90	20	124	34	804	48
49	Air Compressor	2004	2,766	66	20	138	72	899	49
50	Condensing unit and evaporator	2004	2,230	90	20	112	22	725	50
51	Concrete removal/new pipe	2004	6,111	248	20	306	58	1,987	51
52	A/C unit in Laundry System	2004	3,329	121	20	166	45	1,081	52
53	Sprinkler System	2004	2,056	75	20	103	28	668	53
54	Duct Heater	2005	1,381	50	20	69	19	380	54
55	Freezer Door	2005	2,100	121	20	105	(16)	577	55
56	Wallpaper	2005	14,510	835	20	726	(109)	3,991	56
57	Water Heaters	2005	5,724	208	20	286	78	1,574	57
58	Security System	2005	25,534	929	20	1,277	348	7,022	58
59	Compressor	2005	1,090	40	20	54	14	299	59
60	Water Heater	2005	1,490	54	20	75	21	410	60
61	Painting & Wallcovering	2005	38,792	2,234	20	1,940	(294)	10,668	61
62	Carpet	2005	3,164	258	20	158	(100)	870	62
63	Vinyl floor	2005	6,327	182	20	316	134	1,740	63
64	Doors	2005	1,925	70	20	96	26	529	64
65	Asphalt-parking lot	2005	8,500	530	20	425	(105)	2,338	65
66	Custom built duct heater	2005	1,704	62	20	85	23	468	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,300,157	\$ 10,836		\$ 156,897	\$ 146,061	\$ 1,442,009	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center

0039651

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,300,157	\$ 10,836		\$ 156,897	\$ 146,061	\$ 1,442,009	1
2	Kitchen Floor	2006	10,000	364	20	500	136	2,250	2
3	A/C Units	2006	2,146		20	107	107	483	3
4	A/C Units	2006	2,576		20	129	129	580	4
5	2 Ton A/C Unit	2006	1,208	44	20	60	16	271	5
6	Sprinkler System-Replace Pipes	2006	8,357	304	20	418	114	1,881	6
7	Remodel Shower Hall - 500	2007	21,570	784	20	1,079	295	3,775	7
8	Remodel Shower Hall - 400	2007	21,570	784	20	1,079	295	3,775	8
9	Remodel Shower Hall - 200	2007	21,570	784	20	1,079	295	3,775	9
10	Handrail	2007	3,425		20	171	171	599	10
11	Freezer Compressor	2007	2,202	80	20	110	30	385	11
12	5 Ton Air Handler	2007	2,795	102	20	140	38	489	12
13	2 Ton Air Handler & 3 Ton Condensing Unit	2007	5,241	191	20	262	71	917	13
14	Asphalt Parking Lot	2008	28,482	1,218	20	1,424	206	3,560	14
15	Asphalt Path	2008	9,820	420	20	491	71	1,228	15
16	Sprinkler System Renovation	2008	16,034	583	20	802	219	2,005	16
17	Roof Repair-Burse Pipe in Kitchen	2009	10,868	395	20	543	148	815	17
18	Sprinkler System	2009	2,637	96	20	132	36	198	18
19	Pond w/2 Streams, Waterfalls & Crossing Bridges	2010	38,840	20,391	20	971	(19,420)	971	19
20	Gazebo	2010	8,034	4,218	20	201	(4,017)	201	20
21									21
22	SW Management Allocation - leasehold improvements	1995	3,570		20	178	178	3,037	22
23	SW Management Allocation - leasehold improvements	1996	594		20	30	30	433	23
24	SW Management Allocation - leasehold improvements	1997	689		20	34	34	550	24
25	SW Management Allocation - leasehold improvements	1998	589		20	29	29	376	25
26	SW Management Allocation - leasehold improvements	1999	1,636		20	82	82	907	26
27	SW Management Allocation - leasehold improvements	2005	3,384		20	169	169	931	27
28	SW Management Allocation - leasehold improvements	2007	1,916		20	96	96	335	28
29	SW Management Allocation - leasehold improvements	2009	4,000		20	200	200	300	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,533,910	\$ 41,594		\$ 167,413	\$ 125,819	\$ 1,477,036	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 45,589	\$ 885	\$ 4,543	\$ 3,658		\$ 27,711	71
72	Current Year Purchases	7,746	7,746	388	(7,358)		388	72
73	Fully Depreciated Assets	933,526					933,526	73
74	Allocated from Management Co	10,072		204	204	10	7,790	74
75	TOTALS	\$ 996,933	\$ 8,631	\$ 5,135	\$ (3,496)		\$ 969,415	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated from Management	2010 Infiniti	2010	\$ 5,667	\$	\$ 567	\$ 567	10	\$ 567	76
77										77
78										78
79										79
80	TOTALS			\$ 5,667	\$	\$ 567	\$ 567		\$ 567	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,936,510	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 50,225	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 173,115	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 122,890	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,447,018	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from Management Co</u>		\$	\$ <u>918</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>918</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	1,984	\$ 142,844	\$	1,984	\$ 142,844	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,539	70,800		1,539	70,800	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		1,927	123,306		1,927	123,306	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				42,320		42,320	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			\$	5,450	\$ 336,950	\$ 42,320	5,450	\$ 379,270	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center

0039651

Report Period Beginning: 01/01/10

Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (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	\$	\$	1
2	Cash-Patient Deposits	24,780	24,780	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>-0-</u>)	519,486	638,120	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,865	30,242	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	14,393	200,253	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 561,524	\$ 893,395	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		400,000	13
14	Buildings, at Historical Cost		4,833,195	14
15	Leasehold Improvements, at Historical Cost	534,329	700,715	15
16	Equipment, at Historical Cost	345,145	1,002,600	16
17	Accumulated Depreciation (book methods)	(550,020)	(2,447,018)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>See Sch 17A</u>)		121,022	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 329,454	\$ 4,610,514	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 890,978	\$ 5,503,909	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 105,797	\$ 70,191	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,997	24,997	28
29	Short-Term Notes Payable	1,500,172	1,500,172	29
30	Accrued Salaries Payable	64,756	64,756	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,915	11,915	31
32	Accrued Real Estate Taxes(Sch.IX-B)		102,900	32
33	Accrued Interest Payable		29,218	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	210,727	210,727	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,918,364	\$ 2,014,876	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,521,388	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)	\$	\$ 5,521,388	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,918,364	\$ 7,536,264	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,027,386)	\$ (2,032,355)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 890,978	\$ 5,503,909	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Virgil Calvert Nursing & Rehabilitation Center
 Provider # 0039651
 FYE: 12/31/10

Sch 17A

XV. Balance Sheet:

<u>Acct. #</u>	<u>Other Current Assets</u>	<u>Operating</u>	<u>After Consolidation</u>
8815	Due From/To Vir Vacant	14,393	14,393
1139	Replacement Reserve		101,245
4040	Other Escrow		84,615
	Total - Line #9 - Other Current Assets	<u>14,393</u>	<u>200,253</u>
4050	Capitalized Costs		163,434
4060	Accumulated Amortization		(42,412)
	Total - Line #22 - Other Long Term Assets	<u>0</u>	<u>121,022</u>
2070	Due From State	18,535	18,535
3010	Employee Loans	64	64
3029	Reimbursement Due	(56,128)	(56,128)
7055	Insurance Premiums Payable	732	732
7145	Accrued Retirement	300	300
7310	Accrued Expenses	126,333	126,333
8811	Due/From Virgil Properties	120,891	120,891
	Total - Line #36 - Other Current Liabilities	<u>210,727</u>	<u>210,727</u>

See Accountant's Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (667,478)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (667,478)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(359,908)	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)	\$ (359,908)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,027,386)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center # 0039651 Report Period Beginning: 01/01/10Ending: 12/31/10**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	\$ 3,746,018	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,746,018	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	366,428	6
7	Oxygen	3,234	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 369,662	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	17,665	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)	\$ 17,665	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Uniform Income</u>	602	28
28a	<u>Miscellaneous Income</u>	48,309	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 48,911	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,182,264	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	886,565	31
32	Health Care	1,926,003	32
33	General Administration	877,235	33
B. Capital Expense			
34	Ownership	709,581	34
C. Ancillary Expense			
35	Special Cost Centers	60,663	35
36	Provider Participation Fee	82,125	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,542,172	40
41	Income before Income Taxes (line 30 minus line 40)**	(359,908)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (359,908)	43

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

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

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

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

Facility Name & ID Number Virgil Calvert Nursing & Rehabilitation Center

0039651

Report Period Beginning: 01/01/10

Ending:

12/31/10

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	1,089	1,175	\$ 33,728	\$ 28.70	1
2	Assistant Director of Nursing	1,103	1,119	31,167	27.85	2
3	Registered Nurses	2,617	2,702	78,828	29.17	3
4	Licensed Practical Nurses	25,724	27,124	551,830	20.34	4
5	CNAs & Orderlies	60,306	63,550	633,267	9.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,016	6,578	96,976	14.74	8
9	Activity Director					9
10	Activity Assistants	5,308	5,586	58,673	10.50	10
11	Social Service Workers	4,183	4,626	58,339	12.61	11
12	Dietician					12
13	Food Service Supervisor	1,197	1,349	24,065	17.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,576	19,988	172,326	8.62	15
16	Dishwashers					16
17	Maintenance Workers	3,787	3,874	70,485	18.19	17
18	Housekeepers	14,747	15,776	142,158	9.01	18
19	Laundry	6,763	7,050	59,766	8.48	19
20	Administrator	2,040	2,248	79,115	35.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,424	10,952	249,528	22.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,880	173,697	\$ 2,340,251 *	\$ 13.47	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 4,428	1(3)	35
36	Medical Director	Monthly	2,700	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	930	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	2,325	10A(3)	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	285	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 10,668		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Virgil Calvert Nursing & Rehabilitation Center

Schedule 21A

Provider # 0039651

FYE: 12/31/10

XIX. Support Schedule

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 61,681

Non Allowable Legal (7,457)

Allocated from Virgil Calvert Property LLC: 5,750

Allocated from SW Management: Legal 793 (fr WP 6-2 (CW))

Accounting 998 (fr WP 6-2 (CW))

Total (agree to Schedule V, line 19, column 8) 61,765

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
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 Virgil Calvert Nursing & Rehabilitation Center# 0039651Report Period Beginning: 01/01/10Ending: 12/31/10**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on LTC, \$14,025
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 56 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES No NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 82,125
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 3,770 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT