FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0023309

Facility Name: Calvin Johnson Care Center

Address: 727 North 17th Street (Number) Belleville (City) 62226 (Zip Code)

County: St. Clair

Telephone Number: 618-234-3323 **Fax #** 618-234-9477

HFS ID Number:

Date of Initial License for Current Owners: 04/01/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven C Wolf **Telephone Number:** 618-234-2273
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Steven C Wolf
(Title) Executive Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Calvin Johnson Care Center # 0023309 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	132	Skilled (SNF)	132	48,180	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,414	468	5,679	10,561	8
9	SNF/PED					9
10	ICF	32,984	3,065		36,049	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,398	3,533	5,679	46,610	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.94%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 04/01/1977

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 48 and days of care provided 1,998

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Calvin Johnson Care Center # 0023309 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	304,586	24,356	8,878	337,820	875	338,695		338,695			1
2	Food Purchase		230,961		230,961	(1,939)	229,022		229,022			2
3	Housekeeping	188,409	38,927		227,336		227,336		227,336			3
4	Laundry	107,474	22,041		129,515		129,515		129,515			4
5	Heat and Other Utilities			188,455	188,455		188,455	2,013	190,468			5
6	Maintenance	111,218	6,287	60,087	177,592		177,592	3,595	181,187			6
7	Other (specify):*											7
8	**TOTAL General Services**	711,687	322,572	257,420	1,291,679	(1,064)	1,290,615	5,608	1,296,223			8
	B. Health Care and Programs											
9	Medical Director			36,500	36,500		36,500		36,500			9
10	Nursing and Medical Records	2,951,458	477,697	146,383	3,575,538	(189,055)	3,386,483		3,386,483			10
10a	Therapy					104,621	104,621		104,621			10a
11	Activities	67,762	10,277	1,025	79,064		79,064		79,064			11
12	Social Services	116,300		3,235	119,535	400	119,935		119,935			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,135,520	487,974	187,143	3,810,637	(84,034)	3,726,603		3,726,603			16
	C. General Administration											
17	Administrative	259,778		89,027	348,805		348,805	(89,027)	259,778			17
18	Directors Fees											18
19	Professional Services			18,733	18,733		18,733	4,944	23,677			19
20	Dues, Fees, Subscriptions & Promotions			53,696	53,696		53,696	(38,173)	15,523			20
21	Clerical & General Office Expenses	328,082	17,797	49,557	395,436	1,150	396,586	9,865	406,451			21
22	Employee Benefits & Payroll Taxes			507,354	507,354	(3,436)	503,918	35,514	539,432			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,035	6,035		6,035	1,370	7,405			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			154,977	154,977		154,977	768	155,745			26
27	Other (specify):* Contrib			4,910	4,910		4,910	(4,910)				27
28	**TOTAL General Administration**	587,860	17,797	884,289	1,489,946	(2,286)	1,487,660	(79,649)	1,408,011			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,435,067	828,343	1,328,852	6,592,262	(87,384)	6,504,878	(74,041)	6,430,837			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.

Facility Name & ID Number Calvin Johnson Care Center #0023309 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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			98,688	98,688		98,688	2,767	101,455			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,521	1,521		1,521	(749)	772			32
33	Real Estate Taxes			65,274	65,274		65,274		65,274			33
34	Rent-Facility & Grounds			340,067	340,067		340,067	21,099	361,166			34
35	Rent-Equipment & Vehicles			6,883	6,883		6,883		6,883			35
36	Other (specify):*											36
37	**TOTAL Ownership**			512,433	512,433		512,433	23,117	535,550			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,845		50,845	87,384	138,229		138,229			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		13,363		13,363		13,363		13,363			41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		64,208	98,550	162,758	87,384	250,142		250,142			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,435,067	892,551	1,939,835	7,267,453		7,267,453	(50,924)	7,216,529			45

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

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(749)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(87)	21		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	(30,600)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,910)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(200)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,810)	20		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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (43,356)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 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)	(3,349)	var	34
35	Other- Attach Schedule	(4,219)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (7,568)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (50,924)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		4,265	39	42
43	Prescription Drugs	X		106,108	39	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 110,373		47

Calvin Johnson Care Center

ID# 0023309

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Cost of T-shirts sold	$ (2,769)	22	1
2	Lobbying expenses	(1,450)	20	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**	(4,219)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Calvin Johnson Care Center # 0023309 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,013	0	0	0	0	0	0	0	0	2,013	5
6	Maintenance	0	0	3,595	0	0	0	0	0	0	0	0	3,595	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	5,608	0	0	0	0	0	0	0	0	5,608	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	(89,027)	0	0	0	0	0	0	0	0	(89,027)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(200)	0	5,144	0	0	0	0	0	0	0	0	4,944	19
20	Fees, Subscriptions & Promotions	(38,860)	0	687	0	0	0	0	0	0	0	0	(38,173)	20
21	Clerical & General Office Expenses	(87)	0	9,952	0	0	0	0	0	0	0	0	9,865	21
22	Employee Benefits & Payroll Taxes	(2,769)	0	38,283	0	0	0	0	0	0	0	0	35,514	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,370	0	0	0	0	0	0	0	0	1,370	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	768	0	0	0	0	0	0	0	0	768	26
27	Other (specify):*	(4,910)	0	0	0	0	0	0	0	0	0	0	(4,910)	27
28	**TOTAL General Administration**	(46,826)	0	(32,823)	0	0	0	0	0	0	0	0	(79,649)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(46,826)	0	(27,215)	0	0	0	0	0	0	0	0	(74,041)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Calvin Johnson Care Center **#** 0023309 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	2,767	0	0	0	0	0	0	0	0	2,767	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(749)	0	0	0	0	0	0	0	0	0	0	(749)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	21,099	0	0	0	0	0	0	0	0	21,099	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(749)	0	23,866	0	0	0	0	0	0	0	0	23,117	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(47,575)	0	(3,349)	0	0	0	0	0	0	0	0	(50,924)	45

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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
Steven C Wolf	30	Eldercare of Alton	Alton	Eldercare Inc	Belleville, IL	Mgmt Co.
Steven C Wolf	50	Columbia Conv Ctr	Columbia			

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. [X] 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17-1	Home Office Adm Wages	$ 127,256	Eldercare Inc	0.00%	$ 127,256	$	1
2	V	21-1	Home Office Wages	191,801	Eldercare Inc	0.00%	191,801		2
3	V	17-3	Home Office Adm expenses	89,027	Eldercare Inc	0.00%	85,678	(3,349)	3
4	V								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			$ 408,084			$ 404,735	$ * (3,349)	14

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

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Eldercare Inc	0.00%	$ 2,013	$ 2,013	15
16	V	6	Maintenance		Eldercare Inc	0.00%	3,595	3,595	16
17	V	17	Administrative Wages	127,256	Eldercare Inc	0.00%	127,256		17
18	V	19	Professional Services		Eldercare Inc	0.00%	5,144	5,144	18
19	V	20	Fees,Subscriptions		Eldercare Inc	0.00%	687	687	19
20	V	21	Clerical and office wages	191,801	Eldercare Inc	0.00%	191,801		20
21	V	21	Admin &General Office		Eldercare Inc	0.00%	9,952	9,952	21
22	V	22	Employee Benefits		Eldercare Inc	0.00%	38,283	38,283	22
23	V	24	Travel&Seminars		Eldercare Inc	0.00%	1,370	1,370	23
24	V	26	Ins. Prop		Eldercare Inc	0.00%	768	768	24
25	V	30	Depreciation		Eldercare Inc	0.00%	2,767	2,767	25
26	V	34	Rent Facility		Eldercare Inc	0.00%	21,099	21,099	26
27	V	17	Home Office Admin expenses	89,027	Eldercare Inc	0.00%		(89,027)	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			$ 408,084			$ 404,735	$ * (3,349)	39

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

Facility Name & ID Number Calvin Johnson Care Center # 0023309 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Steve Wolf	President	Exec Admin	30.00	A 38249	20	40.00	Salary	$ 127,256	17-1	1
2					B 120992						2
3											3
4											4
5		A- Columbia Conv Ctr									5
6		B- Eldercare of Alton									6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 127,256		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 Calvin Johnson Care Center # 0023309 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 [X] NO [ ]

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

Name of Related Organization: Eldercare Inc
Street Address: 2810 Frank Scott Pkway West Ste 820
City / State / Zip Code: Belleville, IL 62223
Phone Number: (618-234-2273
Fax Number: (618-234-7777

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Census	90,926	2	$ 3,926	$	46,610	$ 2,013	1
2	6	Maintenance	Census	90,926	2	7,014		46,610	3,595	2
3	17	Administrative	Census	90,926	2	248,248	248,248	46,610	127,256	3
4	19	Professional Services	Census	90,926	2	10,035		46,610	5,144	4
5	20	Fees,Subscriptions	Census	90,926	2	1,340		46,610	687	5
6	21	Clerical and office wages	Census	90,926	2	374,163	374,163	46,610	191,801	6
7	21	Admin &General Office	Census	90,926	2	19,415		46,610	9,952	7
8	22	Employee Benefits	Census	90,926	2	74,681		46,610	38,283	8
9	24	Travel&Seminars	Census	90,926	2	2,672		46,610	1,370	9
10	26	Ins. Prop	Census	90,926	2	1,499		46,610	768	10
11	30	Depreciation	Census	90,926	2	5,397		46,610	2,767	11
12	34	Rent Facility	Census	90,926	2	41,160		46,610	21,099	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					$ 789,550	$ 622,411		$ 404,735	25

Facility Name & ID Number Calvin Johnson Care Center # 0023309 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	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	UMB Bank		X	Working Capital	varies/sweep	5/4/2010	2,000,000		5/4/2011	2.7500	1,521	6
7												7
8												8
9	TOTAL Facility Related						$ 2,000,000	$			$ 1,521	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,000,000	$			$ 1,521	15

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

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

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

Facility Name & ID Number Calvin Johnson Care Center # 0023309 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 60,960	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.)		$ 61,734	2
3. Under or (over) accrual (line 2 minus line 1).		$ 774	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 64,500	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.		$ 65,274	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	50,327	8
	2006	53,944	9
	2007	55,995	10
	2008	58,599	11
	2009	61,734	12

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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Calvin Johnson Care Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0023309

CONTACT PERSON REGARDING THIS REPORT Steve Wolf

TELEPHONE 618-234-2273 FAX #: 618-234-7777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-20.0-211-030	Nursing Home 4.18 Acres	$ 61,733.60	$ 61,733.60
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 61,733.60	$ 61,733.60

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,326 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Bldg Imp			1982	600		10			600	9
10	1983 Audit			1983	4,085		10				10
11	Bldg Imp			1983	39,106		10			39,106	11
12	Black Top			1983	1,033		12			1,033	12
13	Remodeling			1984	7,160		20			7,160	13
14	Landscaping			1984	3,604		10			3,604	14
15	Windows			1985	1,454		10			1,454	15
16	A/C System			1985	1,983		8			1,983	16
17	Rounding				3						17
18	Sidewalks			1985	7,800		15			7,800	18
19	Driveway Sealer			1985	810		5			810	19
20	Parking Stripes			1986	524		5			524	20
21	Renovate Halls			1988	21,660		10			21,660	21
22	Renovate Baths			1989	14,042		10			14,042	22
23	Roof Remodeling			1990	42,560		10-15y			42,560	23
24	Remodeling (less retirement in 2008 1621)			1991	46,957	506	5-10y	506		46,705	24
25	Remodeling			1992	107,939		5-15y			107,939	25
26	Remodeling (less retirement in 2008 9905)			1993	74,695		5-15y			74,695	26
27	Hall Monitor System			1994	3,208	29	15-20y	29		3,107	27
28	Improvements			1995	24,740	125	5-15y	125		24,740	28
29	Elevator			1996	4,929	329	15	329		4,765	29
30	rounding										30
31	Rooftop			1996	10,643		8			10,643	31
32											32
33	A/C Work & Carpeting			1997	6,164	269	5-15y	269		5,895	33
34	Fence			1998	1,250		8			1,250	34
35	Interior Renovation			1998	11,308	84	5-15y	84		11,141	35
36	Interior Renovation			1999	53,624	424	5-15y	424		52,353	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Cubicle Tracks	2000	$ 14,481	$ 965	15	$ 965	$	$ 10,136	37
38	Renovations Interior	2000	12,015	601	10	601		12,015	38
39	Renovations Interior	2000	4,776		5			4,776	39
40	Landscaping	2000	21,213	1,591	10	1,591		21,213	40
41	Renovations Interior	2001	8,725	1,552	10	1,552		7,949	41
42	Renovations Interior	2001	45,895	3,060	15	3,060		29,832	42
43	Kitchen hood- stainless steel	2002	21,235	1,416	15	1,416		11,679	43
44	Fire alarm control panel	2002	5,857	164	10	164		1,391	44
45	insurance proceeds for control panel	2003	(4,221)						45
46	Fire Alarm panel	2003	1,120	112	10	112		896	46
47	Bldg generator	2003	19,164	958	20	958		7,665	47
48	HVAC units	2003	6,158		10			6,158	48
49	Wiring Hall 400, new door	2004	3,361	168	20	168		1,177	49
50	guardrails, exhaust fan	2004	2,671	178	15	178		1,157	50
51	Fire alarm pulls, dampers, wiring	2004	4,749	475	10	475		3,324	51
52	Carpeting, vinyl base	2004	4,875		5			4,875	52
53	Roof, door locks, wall coverings	2005	39,288	3,929	10	3,929		21,609	53
54	Entrance Canopy	2005	10,641		5			10,641	54
55	Roof,ductwork, doors, plumbing	2006	57,665	5,766	10	5,766		25,949	55
56	Air conditioning	2006	7,999	1,600	5	1,600		7,199	56
57	lighting, sidewalks, patio	2006	31,149	2,077	15	2,077		9,345	57
58	New decking	2006	37,555	3,756	10	3,756		16,900	58
59	Heating/AC units, new carpeting	2007	13,017	2,603	5	2,603		9,112	59
60	New awnings, canopy, laundry	2007	11,508	1,151	10	1,151		4,028	60
61	Handrails, electrical work	2007	4,203	280	15	280		1,121	61
62	Boiler	2008	7,853	393	20	393		1,210	62
63	New wood doors and frames	2008	5,045	336	15	336		757	63
64	Steel fire doors	2008	1,262	63	10	63		157	64
65	mirrors, lighting, faucet Doctor's office	2008	635	63	10	63		157	65
66	Elevator repairs	2008	8,395	840	10	840		2,445	66
67	Covebase	2008	1,188	119	10	119		297	67
68	Smoke Alarm/Fire alarm wiring	2008	2,675	267	10	267		667	68
69	Windows and sills	2008	827	83	10	83		207	69
70	TOTAL (lines 4 thru 69)		$ 904,860	$ 36,332		$ 36,332	$	$ 721,613	70

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

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 904,860	$ 36,332		$ 36,332	$	$ 721,613	1
2	carpeting for doctor's office	2008	551	110	5	110		275	2
3	Sewer line replaced	2008	575	115	5	115		287	3
4	10 heating/air conditioning units	2008	4,650	930	5	930		2,325	4
5	Roof repairs	2008	608	122	5	122		305	5
6	Landscape paver stones	2008	1,457	146	10	146		437	6
7	Conduit and rewiring of office	2009	620	62	10	62		93	7
8	Replaced and repaired sections of water lines	2009	6,333	633	10	633		949	8
9	2 120 gal hot water heaters and new piping	2009	6,006	601	10	601		902	9
10	15 heating/air conditioning units	2009	7,624	1,525	5	1,525		2,523	10
11	600 feet of cove base	2009	719	144	5	144		288	11
12	Replaced walk in cooler door	2009	2,219	443	5	443		886	12
13	New doors	2009	7,357	490	15	490		981	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	New roof	2010	209,920	10,496	10	10,496		10,496	25
26	Rooftop Air conditioning units	2010	57,750	2,887	10	2,887		2,887	26
27	Annunciator panel Nurses station	2010	5,534	277	10	277		277	27
28	Heating/AC units	2010	5,097	1,019	5	1,019		1,019	28
29	Ventilator monitoring system	2010	10,910	545	10	545		545	29
30	Plumbing	2010	1,252	250	5	250		250	30
31	Front Door	2010	1,933	387	5	387		387	31
32	Wiring	2010	2,035	102	10	102		102	32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,238,010	$ 57,616		$ 57,616	$	$ 747,827	34

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

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 333,079	$ 35,008	$ 35,008	$		$ 214,352	71
72	Current Year Purchases	32,039	5,842	5,842			5,842	72
73	Fully Depreciated Assets	307,518					307,518	73
74	Home Office		2,767	2,767				74
75	TOTALS	$ 672,636	$ 43,617	$ 43,617	$		$ 527,712	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	Patient Transport	2- 1997 Ford Buses w/ lifts	2004	$ 8,269	$	$	$	3	$ 8,269	76
77	Facility Use	1999 Dodge Caravan	2005	7,214				3	7,214	77
78	Patient Transport	Wheel chair bracing	2009	1,112	222	222		5	445	78
79										79
80	TOTALS			$ 16,595	$ 222	$ 222	$		$ 15,928	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)	$ 1,927,241	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 101,455	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 101,455	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,291,467	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.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: National Nursing Homes Inc.
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. [X] 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:	1969	180	4/1/77	$ 340,067	20	15	3
4	Additions							4
5								5
6								6
7	TOTAL		180		$ 340,067 **			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 [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 08/01/2007
Ending 08/01/2012

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$ varies with net income
13.	/2012	$ varies with net income
14.	/2013	$ varies with net income

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 6,883 Description: office 225/air fluidized mattresses 6658
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* 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.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L 10A	hrs	$	582	$ 38,377	$ 200	582	$ 38,577	1
2	Licensed Speech and Language Development Therapist	L 10A	hrs		262	20,550		262	20,550	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L 10A	hrs		731	45,431	62	731	45,493	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39	# of prescrpts				106,108		106,108	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): lab/X-Ray	L39				4,265			4,265	12
13	Other (specify):	L39								13
14	TOTAL			$	1,575	$ 108,623	$ 106,370	1,575	$ 214,993	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.

STATE OF ILLINOIS

Facility Name & ID Number Calvin Johnson Care Center # 0023309 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 735,110	$	1
2	Cash-Patient Deposits	51,932		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	943,789		3
4	Supply Inventory (priced at cost)	86,715		4
5	Short-Term Investments			5
6	Prepaid Insurance	43,596		6
7	Other Prepaid Expenses	28,724		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other receivables,taxes	143,418		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,033,284	$	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	1,233,925		15
16	Equipment, at Historical Cost	689,231		16
17	Accumulated Depreciation (book methods)	(1,291,467)		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)**	$ 631,689	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,664,973	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 402,388	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	51,932		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	226,913		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,717		31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany payable	173,198		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 932,648	$	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)**	$ 932,648	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,732,325	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,664,973	$	48

*(See instructions.)

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,759,431	1
2	Restatements (describe):		2
3	**Prior period adju to income**	1,667	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,761,098	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(28,773)	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)**	$ (28,773)	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)**	$ 1,732,325	24 *

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

Facility Name & ID Number Calvin Johnson Care Center # 0023309 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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,732,843	1
2	Discounts and Allowances for all Levels	(780,571)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,952,272	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	135,189	6
7	Oxygen	213,802	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 348,991	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	16,092	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	196,300	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,214	19
20	Radiology and X-Ray	1,677	20
21	Other Medical Services	640,102	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 860,385	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	749	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 749	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Garn fees 1331/Tshirts 3514/other misc 111	4,955	28
28a	Utility adjustment	71,328	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 76,283	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,238,680	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,291,679	31
32	Health Care	3,810,637	32
33	General Administration	1,489,946	33
	B. Capital Expense		
34	Ownership	512,433	34
	C. Ancillary Expense		
35	Special Cost Centers	64,208	35
36	Provider Participation Fee	98,550	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,267,453	40
41	**Income before Income Taxes (line 30 minus line 40)****	(28,773)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (28,773)	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.**

*** **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 Calvin Johnson Care Center # 0023309 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 58,464	$ 28.11	1
2	Assistant Director of Nursing	4,000	4,160	107,881	25.93	2
3	Registered Nurses	14,945	15,863	429,402	27.07	3
4	Licensed Practical Nurses	29,862	31,887	722,568	22.66	4
5	CNAs & Orderlies	93,287	99,241	1,122,416	11.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,563	6,803	67,762	9.96	10
11	Social Service Workers	7,712	8,032	116,300	14.48	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	35,672	17.15	13
14	Head Cook	2,000	2,080	32,129	15.45	14
15	Cook Helpers/Assistants	24,869	26,309	236,785	9.00	15
16	Dishwashers					16
17	Maintenance Workers	7,352	7,777	111,218	14.30	17
18	Housekeepers	19,024	20,369	188,409	9.25	18
19	Laundry	10,800	11,915	107,474	9.02	19
20	Administrator	2,000	2,080	132,522	63.71	20
21	Assistant Administrator					21
22	Other Administrative	1,000	1,040	127,256	122.36	22
23	Office Manager					23
24	Clerical	15,387	16,545	328,082	19.83	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 C: Resp therapy	16,768	17,393	408,217	23.47	32
33	Other(specify) Inservice	4,000	4,160	102,510	24.64	33
34	TOTAL (lines 1 - 33)	263,569	279,814	$ 4,435,067 *	$ 15.85	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	199	$ 8,878	1-3	35
36	Medical Director	monthly	36,500	9-3	36
37	Medical Records Consultant	15	583	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	164	6,572	10-3	39
40	Physical Therapy Consultant	35	1,842	10-3	40
41	Occupational Therapy Consultant	21	1,059	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	20	1,369	10-3	43
44	Activity Consultant	28	1,025	11-3	44
45	Social Service Consultant	87	3,235	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	569	$ 61,063		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Debra Ford	Administrator	0	$ 132,522
Steven Wolf	Owner/Exec Admin	30	127,256
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 259,778

B. Administrative - Other

Description	Amount
Home Office allocation	$ 89,027
TOTAL (agree to Schedule V, line 17, col. 3)	$ 89,027
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Wessels & Sherman	legal	$ 200
Hinshaw & Culbertson	legal	5,179
Moore Renner & Simonin	accounting	138
Greensfelder, Hempke	legal	804
Becker, Paulson	legal	12,412
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 18,733

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 83,441
Unemployment Compensation Insurance	47,103
FICA Taxes	312,377
Employee Health Insurance	36,688
Employee Meals	1,939
Illinois Municipal Retirement Fund (IMRF)*	
Other benefits	22,370
Home Office allocation	35,514
TOTAL (agree to Schedule V, line 22, col.8)	$ 539,432

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	10,016
Health Care Worker Background Check	
(Indicate # of checks performed 30)	750
Patient Background Checks 52	1,290
Home Office allocation	687
Misc dues	430
Sec of State	554
St Clair County Health Dept	450
Misc Licenses	351
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,523

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	987
Seminar Expense	5,048
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,035

**See instructions.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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													
4													
5													
6						N/A							
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Calvin Johnson Care Center **#** 0023309 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **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? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **n/a** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **98,550**
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. $ **1,939** Has any meal income been offset against related costs? **no** Indicate the amount. $ **n/a**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.