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: 0048355

Facility Name: COMMUNITY CARE

Address: 4314 SOUTH WABASH AVENUE (Number) CHICAGO (City) 60653 (Zip Code)

County: COOK

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

HFS ID Number:

Date of Initial License for Current Owners: 11/1/06

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585
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) AVRUM WEINFELD
(Title) CEO

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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 COMMUNITY CARE # 0048355 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	145	Skilled (SNF)	145	52,925	1
2		Skilled Pediatric (SNF/PED)			2
3	59	Intermediate (ICF)	59	21,535	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,460	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	7,241	153	3,753	11,147	8
9	SNF/PED					9
10	ICF	55,116	277		55,393	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	62,357	430	3,753	66,540	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.36%

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 11/01/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 3,753

Medicare Intermediary ADMINISTAR OF ILLINOIS

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number COMMUNITY CARE # 0048355 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	339,693	40,543	21,600	401,836		401,836		401,836			1
2	Food Purchase		326,152		326,152		326,152	(465)	325,687			2
3	Housekeeping	237,288	34,714		272,002		272,002	945	272,947			3
4	Laundry	108,317	17,752	12,620	138,689		138,689		138,689			4
5	Heat and Other Utilities			164,162	164,162		164,162	491	164,653			5
6	Maintenance	69,965	29,989	65,126	165,080		165,080	8,656	173,736			6
7	Other (specify):* security	100,109		13,953	114,062		114,062	86	114,148			7
8	TOTAL General Services	855,372	449,150	277,461	1,581,983		1,581,983	9,713	1,591,696			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,363,875	109,333	12,300	2,485,508		2,485,508		2,485,508			10
10a	Therapy	14,922			14,922		14,922		14,922			10a
11	Activities	130,712	3,165		133,877		133,877		133,877			11
12	Social Services	191,481		7,015	198,496		198,496		198,496			12
13	CNA Training											13
14	Program Transportation			832	832		832		832			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,700,990	112,498	32,147	2,845,635		2,845,635		2,845,635			16
	C. General Administration											
17	Administrative	76,922		125,000	201,922		201,922	6,374	208,296			17
18	Directors Fees											18
19	Professional Services			63,379	63,379		63,379	6,877	70,256			19
20	Dues, Fees, Subscriptions & Promotions			31,903	31,903		31,903	(8,596)	23,307			20
21	Clerical & General Office Expenses	144,019	32,493	50,571	227,083		227,083	(1,600)	225,483			21
22	Employee Benefits & Payroll Taxes			476,091	476,091		476,091		476,091			22
23	Inservice Training & Education							14	14			23
24	Travel and Seminar			1,888	1,888		1,888		1,888			24
25	Other Admin. Staff Transportation			9,281	9,281		9,281	1,119	10,400			25
26	Insurance-Prop.Liab.Malpractice			100,628	100,628		100,628	1,326	101,954			26
27	Other (specify):*			417,799	417,799		417,799	(403,135)	14,664			27
28	TOTAL General Administration	220,941	32,493	1,276,540	1,529,974		1,529,974	(397,621)	1,132,353			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,777,303	594,141	1,586,148	5,957,592		5,957,592	(387,908)	5,569,684			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#: COMMUNITY CARE **#0048355** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	21,600	
	REPAIRS & MAINTENANCE		0	
			0	21,600
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		12,620	
			0	12,620
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		43,683	
	ELECTRICITY		70,185	
	WATER		46,965	
	CABLE TV - LOBBY		3,329	
			0	164,162
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,100	
	PAINTING & DECORATING		1,125	
	BUILDING REPAIRS		11,043	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		30,401	
	ELEVATOR MAINTENANCE & REPAIR		4,526	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,739	
	FIRE SERVICE		10,192	
			0	
			0	
			0	
			0	65,126
7	**OTHER**			
	SCAVENGER		13,953	
	SECURITY SERVICE		0	
			0	
			0	13,953
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000	12,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	8,700	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL CONSULTANT		3,600	
			0	12,300
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	7,015	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	7,015
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number COMMUNITY CARE **#0048355** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		832	832
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	125,000	125,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	15,125	
	ADMINISTRATIVE CONSULTANTS	XIX C	5,246	
	PROFESSIONAL FEES	XIX C	43,008	
			0	63,379
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	3,252	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	14,798	
	LICENSES & PERMITS	XIX F	5,074	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,366	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	
	PATIENT BACKGROUND CHECKS	XIX F	400	
	Staff Development		5513	31,903
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,344	
	EQUIPMENT REPAIR & MAINTENANCE		422	
	OUTSIDE CLERICAL SERVICES		27,500	
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,390	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		19,915	
	MESSENGER SERVICE		0	
			0	50,571

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	286,825	
	UNEMPLOYMENT COMPENSATION	XIX D	47,010	
	WORKERS COMPENSATION INSURANC	XIX D	59,404	
	HOSPITALIZATION INSURANCE	XIX D	53,738	
	EMPLOYEE BENEFITS - OTHER	XIX D	4,176	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	17,150	
	CHICAGO HEAD TAX	XIX D	7,788	
			0	476,091
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	
				0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	1,888	
	TRAVEL	XIX G	0	
				1,888
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		9,281	
				9,281
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		100,628	
				100,628
27	**OTHER**			
	BAD DEBTS	VI 24	417,799	
				417,799

GRAND TOTAL COLUMN 3 OTHER **1,586,148**

COMMUNITY CARE
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	326,152
LESS SALES TAX	(465)
NET FOOD	325,687
TOTAL PATIENT CENSUS	66,540
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	199,620
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	199,620
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	199,620
NET FOOD	325,687
DIVIDE TOTAL MEALS/YEAR	199,620
COST PER MEAL	1.63
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number COMMUNITY CARE #0048355 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			25,286	25,286		25,286	(9,083)	16,203			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,378	3,378		3,378	(3,378)				32
33	Real Estate Taxes			350,104	350,104		350,104	2,068	352,172			33
34	Rent-Facility & Grounds			1,522,500	1,522,500		1,522,500		1,522,500			34
35	Rent-Equipment & Vehicles			45,060	45,060		45,060	3,347	48,407			35
36	Other (specify):* IME			15,912	15,912		15,912	(15,912)				36
37	TOTAL Ownership			1,962,240	1,962,240		1,962,240	(22,958)	1,939,282			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		126,469	355,058	481,527		481,527		481,527			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,690	111,690		111,690		111,690			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		126,469	466,748	593,217		593,217		593,217			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,777,303	720,610	4,015,136	8,513,049		8,513,049	(410,866)	8,102,183			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 COMMUNITY CARE # 0048355 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	(10,680)	30		9
10	Interest and Other Investment Income	(5,933)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(465)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(1,390)	21		18
19	Entertainment		20		19
20	Contributions	(2,866)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(417,799)	27		24
25	Fund Raising, Advertising and Promotional	(3,252)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(18,857)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (461,242)		$	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)	50,376		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 50,376		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (410,866)		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.			$		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

COMMUNITY CARE

ID# 0048355

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2	MARKETING SALARIES	(12,000)	21	2
3	BANK CHARGES	(1,344)	21	3
4	STAFF DEVELOPMENT	(5,513)	20	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**	(18,857)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COMMUNITY CARE **#** 0048355 **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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(465)	0	0	0	0	0	0	0	0	0	0	(465)	2
3	Housekeeping	0	0	945	0	0	0	0	0	0	0	0	945	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	491	0	0	0	0	0	0	491	5
6	Maintenance	0	0	3,745	3,117	1,794	0	0	0	0	0	0	8,656	6
7	Other (specify):*	0	0	35	0	51	0	0	0	0	0	0	86	7
8	**TOTAL General Services**	(465)	0	4,725	3,117	2,336	0	0	0	0	0	0	9,713	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	26,708	9,050	(29,384)	0	0	0	0	0	0	0	6,374	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	92	6,186	514	85	0	0	0	0	0	0	6,877	19
20	Fees, Subscriptions & Promotions	(11,631)	0	2,952	0	83	0	0	0	0	0	0	(8,596)	20
21	Clerical & General Office Expenses	(14,734)	0	4,383	8,728	23	0	0	0	0	0	0	(1,600)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	14	0	0	0	0	0	0	0	0	14	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	939	180	0	0	0	0	0	0	0	1,119	25
26	Insurance-Prop.Liab.Malpractice	0	0	400	823	103	0	0	0	0	0	0	1,326	26
27	Other (specify):*	(417,799)	0	4,843	9,821	0	0	0	0	0	0	0	(403,135)	27
28	**TOTAL General Administration**	(444,164)	26,800	28,767	(9,318)	294	0	0	0	0	0	0	(397,621)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(444,629)	26,800	33,492	(6,201)	2,630	0	0	0	0	0	0	(387,908)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COMMUNITY CARE # 0048355 **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	(10,680)	0	121	0	1,476	0	0	0	0	0	0	(9,083)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,933)	0	0	0	2,555	0	0	0	0	0	0	(3,378)	32
33	Real Estate Taxes	0	0	0	0	2,068	0	0	0	0	0	0	2,068	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	2,290	380	677	0	0	0	0	0	0	3,347	35
36	Other (specify):*	0	0	0	0	(15,912)	0	0	0	0	0	0	(15,912)	36
37	TOTAL Ownership	(16,613)	0	2,411	380	(9,136)	0	0	0	0	0	0	(22,958)	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)	(461,242)	26,800	35,903	(5,821)	(6,506)	0	0	0	0	0	0	(410,866)	45

Facility Name & ID Number COMMUNITY CARE # 0048355 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
				6865 FINANCIAL INC	LINCOLNWOOD	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MANAGEMENT
				IME REALTY	LINCOLNWOOD	HOME OFFICE

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	MANAGEMENT FEES	$ 120,000	6865 FINANCIAL INC		$	$ (120,000)	1
2	V	17	EMI ENTERPRISES				44,784	44,784	2
3	V	17	PHILIP ESFORMES INC				61,284	61,284	3
4	V	17	MICHAEL ROSEN				16,499	16,499	4
5	V	17	DANIEL WEISS				4,256	4,256	5
6	V	17	AVRUM WEINFELD				19,885	19,885	6
7	V	19	ACCOUNTING FEES				92	92	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 120,000			$ 146,800	$ * 26,800	14

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

Facility Name & ID Number COMMUNITY CARE # 0048355 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	21	OUTSIDE CLERICAL	$ 27,500	EKS MANAGEMENT		$	$ (27,500)	15
16	V	3	HOUSEKEEPING SALARIES				945	945	16
17	V	6	PAINTER SALARIES				3,745	3,745	17
18	V	7	SCAVENGER				35	35	18
19	V	17	CFO SALARY - A. WEINFELD				9,050	9,050	19
20	V	19	PROFESSIONAL FEES				6,186	6,186	20
21	V	20	WANT ADS/BACKGR CKS				2,952	2,952	21
22	V	21	OFFICE				31,883	31,883	22
23	V	23	SEMINARS				14	14	23
24	V	25	TRANSPORTATION				939	939	24
25	V	26	INSURANCE				400	400	25
26	V	27	EMPLOYEE BENEFITS				4,843	4,843	26
27	V	30	DEPRECIATION (SL)				121	121	27
28	V	35	EQUIPMENT RENT				2,290	2,290	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			$ 27,500			$ 63,403	$ * 35,903	39

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

Facility Name & ID Number COMMUNITY CARE # 0048355 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	17	MANAGEMENT FEES	$ 49,784	EMI MANAGEMENT		$	$ (49,784)	15
16	V	6	DRIVERS SALARIES				3,117	3,117	16
17	V	17	OFFICER SALARY				15,350	15,350	17
18	V	17	REGIONAL DIRECTOR				5,050	5,050	18
19	V	19	ACCOUNTING FEES				514	514	19
20	V	21	OFFICE				8,728	8,728	20
21	V	25	TRANSPORTATION				180	180	21
22	V	26	INSURANCE				823	823	22
23	V	27	EMPLOYEE BENEFITS				9,821	9,821	23
24	V	35	AUTO LEASE				380	380	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			$ 49,784			$ 43,963	$ * (5,821)	39

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

Facility Name & ID Number COMMUNITY CARE # 0048355 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	36	OFFICE RENT	$ 15,912	IME REALTY		$	$ (15,912)	15
16	V	5	UTILITIES				491	491	16
17	V	6	PAINTERS FEES				523	523	17
18	V	6	REPAIRS MAINT				1,271	1,271	18
19	V	7	ALARM SERVICE				51	51	19
20	V	19	ACCOUNTING FEES				85	85	20
21	V	20	LICENSES & PERMITS				83	83	21
22	V	21	OFFICE EXPENSE				23	23	22
23	V	26	INSURANCE				103	103	23
24	V	30	DEPRECIATION S/L				1,476	1,476	24
25	V	32	INTEREST				2,555	2,555	25
26	V	33	R/E TAX				2,068	2,068	26
27	V	35	STORAGE FEES				677	677	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			$ 15,912			$ 9,406	$ * (6,506)	39

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

Facility Name & ID Number COMMUNITY CARE # 0048355 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		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES	ADMINISTRATIVE	Administrative						$ 15,350	17-7	1
2											2
3											3
4	PHILIP ESFORMES	ADMINISTRATIVE	Administrative						61,284	17-7	4
5						SEE					5
6						ATTACHED					6
7	DANIEL WEISS	ADMINISTRATIVE	Administrative			SCHEDULE			4,256	17-7	7
8											8
9											9
10	AVRUM WEINFELD	ADMINISTRATIVE	Administrative						19,885	17-7	10
11									9,050	17-7	11
12											12
13								TOTAL	$ 109,825		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 COMMUNITY CARE # 0048355 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: 6865 FINANCIAL INC
Street Address: 6865 N. LINCOLN AVE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	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	17	EMI ENTERPRISES	PATIENT DAYS	508,141	10	$ 342,000	$	66,540	$ 44,784	1
2	17	PHILIP ESFORMES INC	PATIENT DAYS	508,141	10	468,000	468,000	66,540	61,284	2
3	17	MICHAEL ROSEN	PATIENT DAYS	508,141	10	126,000	126,000	66,540	16,499	3
4	17	DANIEL WEISS	PATIENT DAYS	508,141	10	32,500	32,500	66,540	4,256	4
5	17	AVRUM WEINFELD	PATIENT DAYS	508,141	10	151,856		66,540	19,885	5
6	19	ACCOUNTING FEES	PATIENT DAYS	508,141	10	700		66,540	92	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					$ 1,121,056	$ 626,500		$ 146,800	25

Facility Name & ID Number COMMUNITY CARE # 0048355 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: EKS MANAGEMENT
Street Address: 6865 N. LINCOLN AVE
City / State / Zip Code: LINCOLWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	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	3	HOUSEKEEPING SALARIES	PATIENT DAYS	845,281	14	$ 12,000	$ 12,000	66,540	$ 945	1
2	6	PAINTERS SALARY	PATIENT DAYS	845,281	14	47,580	47,580	66,540	3,745	2
3	7	SCAVENGER	PATIENT DAYS	845,281	14	441		66,540	35	3
4	17	CFO SALARY -	PATIENT DAYS	845,281	14	114,971	114,971	66,540	9,050	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	845,281	14	78,585		66,540	6,186	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	845,281	14	37,500		66,540	2,952	6
7	21	OFFICE	PATIENT DAYS	845,281	14	405,027	296,143	66,540	31,883	7
8	23	SEMINARS	PATIENT DAYS	845,281	14	175		66,540	14	8
9	25	TRANSPORTATION	PATIENT DAYS	845,281	14	11,931		66,540	939	9
10	26	INSURANCE	PATIENT DAYS	845,281	14	5,077		66,540	400	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	845,281	14	61,528		66,540	4,843	11
12	30	DEPRECIATION S/L	PATIENT DAYS	845,281	14	1,536		66,540	121	12
13	35	EQUIPMENT RENT	PATIENT DAYS	845,281	14	29,093		66,540	2,290	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					$ 805,444	$ 470,694		$ 63,403	25

Facility Name & ID Number COMMUNITY CARE # 0048355 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: EMI MANAGEMENT
Street Address: 6865 N. LINCOLN AVE
City / State / Zip Code: LINCOLNWOOD , IL. 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	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	6	DRIVERS SALARIES	PATIENT DAYS	845,281	14	$ 39,600	$ 39,600	66,540	$ 3,117	1
2	17	OFFICER SALARY	PATIENT DAYS	845,281	14	195,000	195,000	66,540	15,350	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	845,281	14	64,150	64,150	66,540	5,050	3
4	19	ACCOUNTING FEES	PATIENT DAYS	845,281	14	6,525		66,540	514	4
5	21	OFFICE	PATIENT DAYS	845,281	14	110,874	58,558	66,540	8,728	5
6	25	TRANSPORTATION	PATIENT DAYS	845,281	14	2,287		66,540	180	6
7	26	INSURANCE	PATIENT DAYS	845,281	14	10,450		66,540	823	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	845,281	14	124,762		66,540	9,821	8
9	35	AUTO LEASE	PATIENT DAYS	845,281	14	4,824		66,540	380	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					$ 558,472	$ 357,308		$ 43,963	25

Facility Name & ID Number COMMUNITY CARE # 0048355 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: IME REALTY CORP
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 607712
Phone Number: (847) 674-5795
Fax Number: (847) 675-5794

	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	RENTAL INCOME	187,059	15	$ 5,775	$	15,912	$ 491	1
2	6	PAINTERS FEES	RENTAL INCOME	187,059	15	6,152		15,912	523	2
3	6	REPAIRS MAINT	RENTAL INCOME	187,059	15	14,941		15,912	1,271	3
4	7	ALARM SERVICE	RENTAL INCOME	187,059	15	601		15,912	51	4
5	19	ACCOUNTING FEES	RENTAL INCOME	187,059	15	998		15,912	85	5
6	20	LICENSES & PERMITS	RENTAL INCOME	187,059	15	971		15,912	83	6
7	21	OFFICE EXPENSE	RENTAL INCOME	187,059	15	274		15,912	23	7
8	26	INSURANCE	RENTAL INCOME	187,059	15	1,211		15,912	103	8
9	30	DEPRECIATION S/L	RENTAL INCOME	187,059	15	17,356		15,912	1,476	9
10	32	INTEREST	RENTAL INCOME	187,059	15	30,039		15,912	2,555	10
11	33	R/E TAX	RENTAL INCOME	187,059	15	24,313		15,912	2,068	11
12	35	STORAGE FEES	RENTAL INCOME	187,059	15	7,961		15,912	677	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					$ 110,592	$		$ 9,406	25

Facility Name & ID Number COMMUNITY CARE # 0048355 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	RELATED PARTY - IME										2,555	3
4												4
5												5
	Working Capital											
6	THE PRIVATE BANK		X	WORKING CAPITAL	INTEREST	REVOLV					3,378	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 5,933	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 5,933	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** 36

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

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

Facility Name & ID Number COMMUNITY CARE # 0048355 **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.**	$ 245,534	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.)		$ 297,819	2
3. Under or (over) accrual (line 2 minus line 1).		$ 52,285	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 297,819	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.		$ 350,104	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	288,520	8
	2006	245,718	9
	2007	243,095	10
	2008	245,534	11
	2009	297,819	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

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

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COMMUNITY CARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0048355

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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.	20-03-300-026-0000	NURSING HOME	$ 6,955.45	$ 6,955.45
2.	20-03-300-025-0000	NURSING HOME	$ 69,526.37	$ 69,526.37
3.	20-03-300-024-0000	NURSING HOME	$ 71,210.46	$ 71,210.46
4.	20-03-300-023-0000	NURSING HOME	$ 72,452.48	$ 72,452.48
5.	20-03-300-022-0000	NURSING HOME	$ 70,757.80	$ 70,757.80
6.	20-03-300-021-0000	NURSING HOME	$ 6,916.16	$ 6,916.16
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 297,818.72	$ 297,818.72

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 COMMUNITY CARE # 0048355 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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

Facility Name & ID Number COMMUNITY CARE # 0048355 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	RELATED PARTY				46,940	1,419	39	1,419			6
7	HOME OFFICE										7
8											8
	Improvement Type**										
9	WATER BOILER			2007	91,500	3,327	27.5	3,327		10,951	9
10	GENERATOR			2007	17,887	650	27.5	650		1,977	10
11	ROOF REPAIRS			2008	12,500	455	27.5	455		1,156	11
12	PUMPS			2008	14,870	540	27.5	540		1,373	12
13	A/C COMPRESSOR			2008	9,904	360	27.5	360		915	13
14	FENCE			2008	3,186	212	15	212		530	14
15	FIREALARM			2009	3,000	109	27.5	109		159	15
16	COOLING COIL			2009	5,694	207	27.5	207		285	16
17	ELEVATOR			2009	111,000	4,036	27.5	4,036		4,877	17
18	VALVES			2010	3,853	64	27.5	64		64	18
19	CARPETING & TILING			2010	2,904	2,904	5	581	(2,323)	581	19
20											20
21											21
22											22
23											23
24	WINDOWS- LANDLORD			2010	102,995						24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number COMMUNITY CARE # 0048355 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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 426,233	$ 14,283		$ 11,960	$ (2,323)	$ 22,868	70

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

Facility Name & ID Number COMMUNITY CARE # 0048355 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	$ 34,594	$ 4,315	$ 3,459	$ (856)		$ 9,642	71
72	Current Year Purchases	12,121	8,107	606	(7,501)		606	72
73	Fully Depreciated Assets							73
74	related party		178	178				74
75	TOTALS	$ 46,715	$ 12,600	$ 4,243	$ (8,357)		$ 10,248	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 472,948	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 26,883	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 16,203	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (10,680)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 33,116	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 COMMUNITY CARE # 0048355 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: GRANITE COMMUNITY CARE LLC
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:		204	11/01/06	$ 1,522,500	5.5	5	3
4	Additions							4
5								5
6								6
7	TOTAL		204		$ 1,522,500 **			7

10. Effective dates of current rental agreement:
    Beginning 11/01/06
    Ending 4/30/12

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 22,684 Description: SEE SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ SEE SCHEDULE ATTAC	$ 22,376	17
18					18
19					19
20					20
21	TOTAL		$	$ 22,376	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 COMMUNITY CARE # 0048355 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.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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 COMMUNITY CARE | STATE OF ILLINOIS # 0048355 | 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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 158,022	$		$ 158,022	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			16,884			16,884	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			174,701			174,701	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				117,187		117,187	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): supplies.lab,rental,					5,451	9,282		14,733	13
14	TOTAL			$		$ 355,058	$ 126,469		$ 481,527	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 COMMUNITY CARE # 0048355 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	$ 418,221	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (250,000))	2,870,907		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	139,757		6
7	Other Prepaid Expenses	41,640		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate & Ins Escrow	106,370		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,576,895	$	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	273,394		15
16	Equipment, at Historical Cost	49,619		16
17	Accumulated Depreciation (book methods)	(61,392)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	174,913		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 436,534	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,013,429	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 235,022	$	26
27	Officer's Accounts Payable	31,173		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,101,266		29
30	Accrued Salaries Payable	128,726		30
31	Accrued Taxes Payable (excluding real estate taxes)	55,166		31
32	Accrued Real Estate Taxes(Sch.IX-B)	297,819		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,849,172	$	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)**	$ 1,849,172	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,164,257	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,013,429	$	48

*(See instructions.)

Facility Name & ID Number COMMUNITY CARE # 0048355 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**	$ 1,604,504	1
2	Restatements (describe):		2
3	POST CLOSING - LOAN RECLASSIFIED AS CAPITAL	417,145	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,021,649	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	142,608	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)**	$ 142,608	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,164,257	24 *

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

Facility Name & ID Number COMMUNITY CARE # 0048355 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	$ 8,542,019	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,542,019	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	88,530	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 88,530	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	25,108	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25,108	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,655,657	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,581,983	31
32	Health Care	2,845,635	32
33	General Administration	1,529,974	33
	B. Capital Expense		
34	Ownership	1,962,240	34
	C. Ancillary Expense		
35	Special Cost Centers	481,527	35
36	Provider Participation Fee	111,690	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,513,049	40
41	**Income before Income Taxes (line 30 minus line 40)****	142,608	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 142,608	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.**
TAX RETURN PREPARED ON CASH BASIS

*** **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 COMMUNITY CARE # 0048355 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	867	867	$ 31,251	$ 36.04	1
2	Assistant Director of Nursing	157	157	4,812	30.65	2
3	Registered Nurses	5,948	6,176	230,062	37.25	3
4	Licensed Practical Nurses	26,824	28,331	953,907	33.67	4
5	CNAs & Orderlies	101,433	109,765	1,044,611	9.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,122	1,164	14,922	12.82	8
9	Activity Director					9
10	Activity Assistants	12,339	13,242	130,712	9.87	10
11	Social Service Workers	12,227	13,368	191,481	14.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,689	34,257	339,693	9.92	15
16	Dishwashers					16
17	Maintenance Workers	5,525	5,747	69,965	12.17	17
18	Housekeepers	25,971	28,095	237,288	8.45	18
19	Laundry	10,715	11,913	108,317	9.09	19
20	Administrator	2,073	2,073	76,922	37.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,656	14,007	144,019	10.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,539	1,665	19,159	11.51	31
32	Other Health C: mds,quality assur.	3,148	3,267	80,073	24.51	32
33	Other(specify) SECURITY	11,185	11,704	100,109	8.55	33
34	TOTAL (lines 1 - 33)	266,418	285,798	$ 3,777,303 *	$ 13.22	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	M	$ 21,600	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	8,700	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	7,015	12-3	45
46	Other(specify) DENTAL	S	3,600	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 52,915		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number COMMUNITY CARE # 0048355 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DENISE MARTIN	ADMINISTRATOR	0	$ 33,844
PATRICIA SIMMS	ADMINISTRATOR	0	43,078
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,922

B. Administrative - Other

Description	Amount
6865 FINANCIAL INS - MANAGEMENT FEE	$ 120,000
EMI ENTERPRISES, INC	5,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 125,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		63,379
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 63,379

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,404
Unemployment Compensation Insurance	47,010
FICA Taxes	286,825
Employee Health Insurance	53,738
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	4,176
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	17,150
CHICAGO HEAD TAX	7,788
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 476,091

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	0
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks 10	400
TRUST/FRANCHISE/CONTRIB/ETC	2,866
MARKETING/ADV/PROMO	3,252
LICENSES/DUES/SUBSCRIPTIONS	19,872
MGMT CO ALLOC	3,035
TRUST/FRANCHISE/CONTRIB/ETC	(2,866)
Less: Public Relations Expense	(0)
Non-allowable advertising	(3,252)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,307

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	1,888
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,888

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number COMMUNITY CARE # 0048355 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													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number COMMUNITY CARE **#** 0048355 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE $14,647

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 0 Line 10-2

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

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. 11/01/06

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
COMMUNITY CARE CENTER,INC 0029132 11/01/06

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 111,690
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. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.