FOR BHF USE

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

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.

I. IDPH License ID Number: 0045617

Facility Name: Lawrence Community Healthcare Center

Address: 900 East Corporation Street (Number) Bridgeport (City) 62417 (Zip Code)

County: Lawrence

Telephone Number: (618) 945-2091 **Fax #** (618) 945-9030

HFS ID Number:

Date of Initial License for Current Owners: 08/02/1996

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: John Knoblett, CPA **Telephone Number:** (217) 351-2073
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) William R. Gillis
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) John Knoblett, CPA, Partner
(Firm Name & Address) Kemper CPA Group LLP, 1701 Broadmoor Drive, Suite 120
(Telephone) (217) 351-2073 Fax # (217) 351-3487

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 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 N/A

	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	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	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	15,305	7,670	4,046	27,021	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,305	7,670	4,046	27,021	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.78%

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)

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 08/02/1996

J. Was the facility purchased or leased after January 1, 1978? YES [X] Date 08/02/1996 NO [ ]

K. Was the facility certified for Medicare during the reporting year? YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 4,046

Medicare Intermediary National Government Services, Inc.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 **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	174,207	24,385	9,527	208,119		208,119	(8,351)	199,768			1
2	Food Purchase		180,893		180,893		180,893	(254)	180,639			2
3	Housekeeping	178,116	41,998		220,114		220,114		220,114			3
4	Laundry	35,930	40,652	305	76,887		76,887		76,887			4
5	Heat and Other Utilities			92,032	92,032		92,032		92,032			5
6	Maintenance	26,666	13,322	81,195	121,183		121,183		121,183			6
7	Other (specify):*											7
8	**TOTAL General Services**	414,919	301,250	183,059	899,228		899,228	(8,605)	890,623			8
	B. Health Care and Programs											
9	Medical Director			2,200	2,200		2,200		2,200			9
10	Nursing and Medical Records	1,259,618	65,222	6,811	1,331,651		1,331,651		1,331,651			10
10a	Therapy			371,572	371,572		371,572		371,572			10a
11	Activities	65,132	925	1,861	67,918		67,918		67,918			11
12	Social Services	41,751		1,492	43,243		43,243		43,243			12
13	CNA Training											13
14	Program Transportation			485	485		485		485			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,366,501	66,147	384,421	1,817,069		1,817,069		1,817,069			16
	C. General Administration											
17	Administrative	91,651		267,194	358,845	(128,511)	230,334	(75,820)	154,514			17
18	Directors Fees											18
19	Professional Services			23,191	23,191	2,974	26,165		26,165			19
20	Dues, Fees, Subscriptions & Promotions			18,534	18,534		18,534	(8,501)	10,033			20
21	Clerical & General Office Expenses	51,382		92,915	144,297	104,864	249,161	(37,781)	211,380			21
22	Employee Benefits & Payroll Taxes			238,758	238,758	16,828	255,586		255,586			22
23	Inservice Training & Education			8,566	8,566		8,566		8,566			23
24	Travel and Seminar			16,170	16,170	1,861	18,031	(7,041)	10,990			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			62,176	62,176	401	62,577		62,577			26
27	Other (specify):*											27
28	**TOTAL General Administration**	143,033		727,504	870,537	(1,583)	868,954	(129,143)	739,811			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,924,453	367,397	1,294,984	3,586,834	(1,583)	3,585,251	(137,748)	3,447,503			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lawrence Community Healthcare Center #0045617 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			43,912	43,912	23,250	67,162	(10,098)	57,064			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,761	3,761	33,518	37,279	(4,195)	33,084			32
33	Real Estate Taxes			31,781	31,781		31,781		31,781			33
34	Rent-Facility & Grounds					(55,995)	(55,995)	(89,498)	(145,493)			34
35	Rent-Equipment & Vehicles			145,493	145,493	487	145,980		145,980			35
36	Other (specify):*											36
37	**TOTAL Ownership**			224,947	224,947	1,260	226,207	(103,791)	122,416			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			192,401	192,401		192,401		192,401			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):* **Contributions**			583	583	323	906	(906)				43
44	**TOTAL Special Cost Centers**			247,187	247,187	323	247,510	(906)	246,604			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,924,453	367,397	1,767,118	4,058,968		4,058,968	(242,445)	3,816,523			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 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	(8,351)	1		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	(4,195)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(254)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(196)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(6,732)	24		19
20	Contributions	(906)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,540)	21		24
25	Fund Raising, Advertising and Promotional	(8,501)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,704)	17		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(23,452)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (78,831)		$	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)	(163,614)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (163,614)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (242,445)		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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Lawrence Community Healthcare Center

ID# 0045617

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Owner out-of-state Travel	$ (309)	24	1
2	Depreciation on Non-Care Assets	(10,098)	30	2
3	Miscellaneous Income	(13,045)	21	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**	(23,452)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Lawrence Community Healthcare Center **#** 0045617 **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	(8,351)	0	0	0	0	0	0	0	0	0	0	(8,351)	1
2	Food Purchase	(254)	0	0	0	0	0	0	0	0	0	0	(254)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,605)	0	0	0	0	0	0	0	0	0	0	(8,605)	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	(1,704)	(74,116)	0	0	0	0	0	0	0	0	0	(75,820)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(8,501)	0	0	0	0	0	0	0	0	0	0	(8,501)	20
21	Clerical & General Office Expenses	(37,781)	0	0	0	0	0	0	0	0	0	0	(37,781)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(7,041)	0	0	0	0	0	0	0	0	0	0	(7,041)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(55,027)	(74,116)	0	0	0	0	0	0	0	0	0	(129,143)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(63,632)	(74,116)	0	0	0	0	0	0	0	0	0	(137,748)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Lawrence Community Healthcare Center** **#** **0045617** **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	(10,098)	0	0	0	0	0	0	0	0	0	0	(10,098)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,195)	0	0	0	0	0	0	0	0	0	0	(4,195)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(89,498)	0	0	0	0	0	0	0	0	0	(89,498)	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**	(14,293)	(89,498)	0	0	0	0	0	0	0	0	0	(103,791)	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):*	(906)	0	0	0	0	0	0	0	0	0	0	(906)	43
44	**TOTAL Special Cost Centers**	(906)	0	0	0	0	0	0	0	0	0	0	(906)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(78,831)	(163,614)	0	0	0	0	0	0	0	0	0	(242,445)	45

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 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
See Page 29						

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

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

1 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	$ 264,000	Rincker Healthcare Corporation	100.00%	$ 189,884	$ (74,116)	1
2	V	34	Facility Rental	145,493	William F. Rincker Trust		55,995	(89,498)	2
3	V								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			$ 409,493			$ 245,879	$ * (163,614)	14

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

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 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	William J. Rincker		Management	20.00	20,173			Wages	$ 12,827	17-1	1
2	Jane Rincker	Accounting Suprv.	Bookkeeping	20.00	122,384	10	0.25	Wages	77,817	21-1	2
3	Angela West		Management	20.00	20,173			Wages	12,827	17-1	3
4	Deanna Gillis		Management	20.00	34,958	5	0.25	Wages	13,962	17-1	4
5	William R. Gillis	Administrator	Management	20.00	28,242	32.5	0.81	Wages	109,341	17-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 226,774		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 Lawrence Community Healthcare Center # 0045617 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: Rincker Healthcare Corporation
Street Address: 900 E. Corporation
City / State / Zip Code: Bridgeport, IL 62417
Phone Number: (618) 945-2091
Fax Number: (618) 945-9030

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

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First Financial Bank NA		X	Purchase	$8,437.77	08/02/96	$ 1,014,000	$ 524,933	09/15/2017	8.7500	$ 32,745	1
2	First Financial Bank NA		X	Purchase - Rincker Healthcare, See Page 25						7.2500	773	2
3	Toyota Financial		X	Purchase - 2008 Sequoia	$750.64	05/10/09	38,832	27,714	05/10/2014	5.9000	1,865	3
4	First Financial Bank NA		X	Purchase - 2009 Ford E250	$755.40	03/16/09	41,052	27,474	02/16/2014	5.9900	1,896	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$9,943.81		$ 1,093,884	$ 580,121			$ 37,279	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,093,884	$ 580,121			$ 37,279	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 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.**	$ 30,509	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.)		$ 31,145	2
3. Under or (over) accrual (line 2 minus line 1).		$ 636	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 31,145	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.		$ 31,781	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	30,729	8
	2006	30,731	9
	2007	29,747	10
	2008	30,509	11
	2009	31,145	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 Lawrence Community Healthcare Center COUNTY Lawrence

FACILITY IDPH LICENSE NUMBER 0045617

CONTACT PERSON REGARDING THIS REPORT John Knoblett, CPA

TELEPHONE (217) 351-2073 FAX #: (217) 351-3487

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.	06-000-701-0A	Land & Building	$ 31,145.30	$ 31,145.30
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 31,145.30	$ 31,145.30

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 Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,766 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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	Facility	52,541	1996	$ 20,000	1
2					2
3	TOTALS	52,541		$ 20,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 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	99		1996		$ 664,000	$ 16,600	40	$ 16,600	$	$ 240,700	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various Fully Depreciated Assets thru 2010				56,381					56,381	9
10	Siding			1997	5,300	133	40	133		1,789	10
11	Fire Alarm System			1998	17,000	1,133	15	1,133		14,733	11
12	Concrete Pads			1998	734	49	15	49		604	12
13	Awning at back door			1998	890	59	15	59		732	13
14	Carpentry Work			1999	3,645	243	15	243		2,876	14
15	Bathroom Renovation			1999	3,570	238	15	238		2,797	15
16	Hot Water System			1999	10,500	700	15	700		8,225	16
17	Hand Rails			1999	3,520	235	15	235		2,757	17
18	Alarm System			1999	5,297	353	15	353		4,090	18
19	Replacement Windows			2000	3,864	258	15	258		2,791	19
20	Water Heater			2000	4,350	109	10	109		4,350	20
21	Flooring/ Tiling			2000	3,200	107	10	107		3,200	21
22	Plumbing			2000	1,719	86	20	86		910	22
23	Fire Suppression System			2000	1,849	74	25	74		770	23
24	Flooring/ Tiling			2000	2,600	152	10	152		2,600	24
25	Flooring/ Tiling			2001	4,450	445	10	445		4,450	25
26	Flooring/ Tiling			2001	3,340	334	10	334		3,312	26
27	Flooring/ Tiling			2001	3,150	315	10	315		3,124	27
28	Flooring/ Tiling			2001	4,450	445	10	445		4,413	28
29	Flooring/ Tiling			2001	2,625	263	10	263		2,603	29
30	Bi-fold doors			2001	1,665	166	10	166		1,623	30
31	120 gal Water Heater			2001	2,483	245	10	245		2,276	31
32	Water Heater			2002	2,961	296	10	296		2,640	32
33	Temperature Control Valve			2002	980	98	10	98		874	33
34	Chandaliers			2002	1,532	153	10	153		1,354	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 Lawrence Community Healthcare Center # 0045617 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	Windows	2002	$ 1,900	$ 190	10	$ 190	$	$ 1,568	37
38	Carpet	2003	3,378	338	10	338		2,505	38
39	Carpet	2003	1,570	157	10	157		1,125	39
40	Water Softner	2003	2,103	211	10	211		1,489	40
41	Air Conditioning Units	2003	77,655	7,766	10	7,766		57,594	41
42	Sidewalk	2005	7,600	507	15	507		2,744	42
43	Storage Barn	2005	3,390	226	15	226		1,299	43
44	Doors	2005	5,042	252	20	252		1,450	44
45	Painting	2005	10,455	1,046	10	1,046		5,576	45
46	Hall Flooring	2007	1,987	199	10	199		728	46
47	Concrete Path	2007	3,045	203	15	203		727	47
48	Carpeting for Hall 4	2008	2,229	446	5	446		1,300	48
49	Roof Improvements	2008	18,117	1,812	10	1,812		4,680	49
50	Roof Improvements	2008	13,165	1,316	10	1,316		2,962	50
51	Water System	2009	9,570	957	10	957		1,436	51
52	3 Ton Rooftop A/C Unit	2009	2,874	575	5	575		862	52
53	Kitchen Air Conditioner	2010	5,100	255	15	255		255	53
54	Replacement Windows	2010	3,950	88	15	88		88	54
55	Water Heater	2010	4,693	156	10	156		156	55
56	Hall Carpeting	2010	13,430	112	10	112		112	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)		$ 1,007,308	$ 40,101		$ 40,101	$	$ 465,630	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 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	$ 60,850	$ 5,928	$ 5,928	$		$ 36,955	71
72	Current Year Purchases	23,227	773	773			773	72
73	Fully Depreciated Assets	512,594					512,594	73
74								74
75	TOTALS	$ 596,670	$ 6,701	$ 6,701	$		$ 550,322	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	Transport Residents	2008 Ford E250 Van	2009	$ 41,052	$ 10,262	$ 10,262	$	4	$ 15,394	76
77										77
78										78
79										79
80	TOTALS			$ 41,052	$ 10,262	$ 10,262	$		$ 15,394	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)	$ 1,665,030	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 57,064	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 57,064	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)	$ 1,031,345	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	2008 Toyota Sequoia	$ 40,393	$ 10,098	$ 15,147	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 40,393	$ 10,098	$ 15,147	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 Lawrence Community Healthcare Center # 0045617 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:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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 Lawrence Community Healthcare Center # 0045617 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 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	10a-3	hrs	$	2,499	$	$ 144,451	2,499	$ 144,451	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,015		60,389	1,015	60,389	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,163		166,382	3,163	166,382	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	6,677	$	$ 371,222	6,677	$ 371,222	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 **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	$ 268,627	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	337,880		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,515		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	160,000		8
9	Other(specify): Employee Advances	4,350		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 775,372	$	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	189,126		15
16	Equipment, at Historical Cost	678,114		16
17	Accumulated Depreciation (book methods)	(671,645)		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)**	$ 195,595	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 970,967	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 117,655	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	37,447		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	1,704		31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,145		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Insurance	281		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 188,232	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	55,187		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Owner Advances	511,113		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 566,300	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 754,532	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 216,435	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 970,967	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lawrence Community Healthcare Center **#** 0045617 **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**	$ 129,676	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 129,676	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	386,759	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	(300,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 86,759	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)**	$ 216,435	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 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	$ 4,038,809	1
2	Discounts and Allowances for all Levels	(646,858)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,391,951	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	609,753	6
7	Oxygen	138,421	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 748,174	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	8,351	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	179,878	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	28,406	19
20	Radiology and X-Ray	15,007	20
21	Other Medical Services	56,720	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 288,362	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,195	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,195	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	13,045	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,045	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,445,727	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	899,228	31
32	Health Care	1,817,069	32
33	General Administration	870,537	33
	B. Capital Expense		
34	Ownership	224,947	34
	C. Ancillary Expense		
35	Special Cost Centers	192,401	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37	Contributions	583	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,058,968	40
41	**Income before Income Taxes (line 30 minus line 40)****	386,759	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 386,759	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** See Pg 26 **If not, please attach a reconciliation.**

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

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

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 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	2,080	2,091	$ 66,391	$ 31.75	1
2	Assistant Director of Nursing	2,080	2,080	47,490	22.83	2
3	Registered Nurses	11,689	12,780	222,802	17.43	3
4	Licensed Practical Nurses	17,639	18,830	295,395	15.69	4
5	CNAs & Orderlies	65,650	69,132	607,478	8.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,918	1,951	18,179	9.32	9
10	Activity Assistants	5,439	5,728	46,953	8.20	10
11	Social Service Workers	3,703	3,837	41,751	10.88	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,091	27,299	13.06	13
14	Head Cook	3,165	3,569	30,067	8.42	14
15	Cook Helpers/Assistants	12,348	13,205	109,775	8.31	15
16	Dishwashers	840	883	7,066	8.00	16
17	Maintenance Workers	1,992	2,091	26,666	12.75	17
18	Housekeepers	20,833	21,651	178,116	8.23	18
19	Laundry	4,178	4,410	35,930	8.15	19
20	Administrator	2,080	2,091	91,651	43.83	20
21	Assistant Administrator	1,184	1,255	27,296	21.75	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,024	2,091	24,086	11.52	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	1,694	1,837	20,062	10.92	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	162,520	171,603	$ 1,924,453 *	$ 11.21	34

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	181	$ 9,527	1-03	35
36	Medical Director	48	2,200	9-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	2,295	39-3	39
40	Physical Therapy Consultant	144	6,212	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	1,861	11-3	44
45	Social Service Consultant	30	1,492	12-3	45
46	Other(specify) Admin Consultant	37	1,490	21-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	566	$ 25,077		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William R. Gillis	Administrator	20	$ 91,651
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 91,651

B. Administrative - Other

Description	Amount
Replacement Taxes	$ 1,704
Management Fees	264,000
Consultant Fees	1,490
TOTAL (agree to Schedule V, line 17, col. 3)	$ 267,194
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Kemper CPA Group LLP	Accounting	$ 20,214
Duane Morris	Legal	110
James Stout	Legal	50
Kemper Technology Consulting	Computer Services	2,817
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 23,191

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,391
Unemployment Compensation Insurance	30,577
FICA Taxes	153,803
Employee Health Insurance	48,815
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 255,586

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	3,771
Health Care Worker Background Check	816
(Indicate # of checks performed 51)	
Patient Background Checks	
Dues & Subscriptions	2,794
License Fees	2,652
Other Advertising	8,501
Less: Public Relations Expense	( )
Non-allowable advertising	(8,501)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,033

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Administrative Travel - Airfare/gas	309
In-State Travel	
Program Transportation - Gas/oil, etc.	10,990
Entertainment & Meals	6,732
Seminar Expense	
Administrative Travel	(309)
Entertainment Expense	(6,732)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,990

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 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		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 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? **No** If YES, have these costs been properly adjusted out of the cost report?

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

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

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

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **54,203**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

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

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

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

Page 5 Adjustments, line 29

	Amount	Line
Owner out-of-state travel	$ 309.00	24
Miscellaneous Income	13,045.00	21
Depreciation on Non-Care Assets	10,098.00	30
	$ 23,452.00	

Page 15

There are no training fees because Lawrence Community Healthcare Center only hires fully-trained employees.

SEE ACCOUNTANTS' COMPILATION REPORT.

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

Line Description	Amount	Line Ref
Administrative	61,373	17
Professional Services	2,974	19
Clerical & General Office Expenses	104,864	21
Employee Benefits & Payroll Taxes	16,828	22
Travel and Seminar	1,861	24
Insurance - Prop.Liab.Malpractice	401	26
Interest	773	32
Rent - Equipment & Vehicles	487	35
Contributions	323	43
Administrative	189,884	17
Depreciation	23,250	30
Interest	32,745	32
Rent - Facility Grounds	55,995	34
Grand Total of allocated costs	245,879	

SEE ACCOUNTANTS' COMPILATION REPORT.

Reconciliation of taxable income to book net income

Book Net Income	$ 386,759
Rounding Difference	(1)
Difference book vs. tax depreciation	(17,177)
Disallowed Meals & Entertainment	3,095
Accrual to cash conversion	203,661
Taxable Income	$ 576,337

SEE ACCOUNTANTS' COMPILATION REPORT.

Breakdown of owner salaries from other nursing homes.

	William J. Rincker	Angie West	Deanna Gillis	Jane Rincker	William Gillis
Friendship Manor	$ 6,996.00	$ 6,996.00	$ 7,616.00	$ 42,445.00	$ 9,795.00
West Grove	6,180.00	6,180.00	19,726.00	37,494.00	8,652.00
Lawrence Comm. Healthcare Center	12,827.00	12,827.00	13,962.00	77,817.00	109,341.00
Rincker Residential	6,997.00	6,997.00	7,616.00	42,445.00	9,795.00
	33,000.00	33,000.00	48,920.00	200,201.00	137,583.00
Salaries reported on this cost report	12,827.00	12,827.00	13,962.00	77,817.00	109,341.00
Salaries reported by other homes	$ 20,173.00	$ 20,173.00	$ 34,958.00	$ 122,384.00	$ 28,242.00

SEE ACCOUNTANTS' COMPILATION REPORT.

Fixed Assets Reconciliation

	Land	Building & Improvements	Equipment	Vehicles	Total
Schedule XV Balance Sheet	$ -	$ 189,126	$ 596,669	$ 81,445	$ 867,240
Non-Care Assets	-	-	-	40,393	40,393
Schedule XI Ownership Costs	20,000	1,007,308	596,669	41,052	1,665,029
Difference	$ (20,000)	$ (818,182)	$ -	$ -	$ (838,182)

On January 1, 2002, Lawrence Community Healthcare Center was incorporated. The real estate, building, and building improvements were not included. The facility is rented from a related party and the appropriate adjustments have been made on the cost report.

SEE ACCOUNTANTS' COMPILATION REPORT.

List of Related Parties (attachment to pg. 6)

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		OTHER RE
Name	**Ownership %**	**Name**	**City**	**Name**
Angela West Trust	25%	West Grove, Inc.	Lawrenceville	
Angela West Trust	25%	Rincker Healthcare Corporation	Bridgeport	
Angela West Trust	25%	Friendship Manor	St. Elmo	
Mary Jane Rincker Trust	25%	West Grove, Inc.	Lawrenceville	
Mary Jane Rincker Trust	25%	Rincker Healthcare Corporation	Bridgeport	
Mary Jane Rincker Trust	25%	Friendship Manor	St. Elmo	
Deanna Gillis Trust	25%	West Grove, Inc.	Lawrenceville	
Deanna Gillis Trust	25%	Rincker Healthcare Corporation	Bridgeport	
Deanna Gillis Trust	25%	Friendship Manor	St. Elmo	
William J. Rincker Trust	25%	West Grove, Inc.	Lawrenceville	
William J. Rincker Trust	25%	Rincker Healthcare Corporation	Bridgeport	
William J. Rincker Trust	25%	Friendship Manor	St. Elmo	

SEE ACCOUNTANTS' COMPILATION REPORT.

3		
LATED BUSINESS ENTITIES		
	City	**Type of Business**