

		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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 Facility ID Number: 0023317

Facility Name: Eldercare of Alton

Address: 3523 Wickenhauser Alton 62002
 Number City Zip Code

County: Madison

Telephone Number: 618-465-8887 **Fax #** 618-465-1811

HFS ID Number: 37-1024089002

Date of Initial License for Current Owners: 4/1/1977

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: David Read **Telephone Number:** 618-234-2273

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 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) <u>Steven C. Wolf</u>	
	(Title) <u>Executive Administrator</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

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

Facility Name & ID Number Eldercare of Alton# 0023317 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>132</u>	Skilled (SNF)	<u>132</u>	<u>48,180</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>49</u>	Intermediate (ICF)	<u>49</u>	<u>17,885</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>181</u>	TOTALS	<u>181</u>	<u>66,065</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>12,422</u>	<u>1,073</u>	<u>1,226</u>	<u>14,721</u>	8
9	SNF/PED					9
10	ICF	<u>33,461</u>	<u>2,890</u>		<u>36,351</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>45,883</u>	<u>3,963</u>	<u>1,226</u>	<u>51,072</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.31%

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)

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 04/01/1977

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 40 and days of care provided 1,217Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	207,018	14,548	7,879	229,445		229,445		229,445		1
2	Food Purchase		241,843		241,843		241,843		241,843		2
3	Housekeeping	199,224	22,597		221,821		221,821		221,821		3
4	Laundry	94,130	15,900		110,030		110,030		110,030		4
5	Heat and Other Utilities			113,020	113,020		113,020	1,839	114,859		5
6	Maintenance	64,917	19,037	16,454	100,408		100,408	2,701	103,109		6
7	Other (specify):*										7
8	TOTAL General Services	565,289	313,925	137,353	1,016,567		1,016,567	4,540	1,021,107		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,854,466	130,168	126,848	2,111,482	(42,052)	2,069,430		2,069,430		10
10a	Therapy					50,862	50,862		50,862		10a
11	Activities	47,114	8,170	2,381	57,665		57,665		57,665		11
12	Social Services	71,208	23	4,475	75,706		75,706		75,706		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,972,788	138,361	157,704	2,268,853	8,810	2,277,663		2,277,663		16
	C. General Administration										
17	Administrative	154,517		77,656	232,173		232,173	(77,656)	154,517		17
18	Directors Fees										18
19	Professional Services			5,360	5,360		5,360	2,119	7,479		19
20	Dues, Fees, Subscriptions & Promotions			19,172	19,172		19,172	(10,927)	8,245		20
21	Clerical & General Office Expenses	333,418	10,697	44,771	388,886		388,886	12,343	401,229		21
22	Employee Benefits & Payroll Taxes			423,561	423,561		423,561	33,038	456,599		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,124	4,124		4,124	1,170	5,294		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			140,229	140,229		140,229	991	141,220		26
27	Other (specify):* sales tax/contrib			3,603	3,603		3,603	(3,603)			27
28	TOTAL General Administration	487,935	10,697	718,476	1,217,108		1,217,108	(42,525)	1,174,583		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,026,012	462,983	1,013,533	4,502,528	8,810	4,511,338	(37,985)	4,473,353		29

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

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

Facility Name & ID Number Eldercare of Alton #0023317 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			118,813	118,813		118,813	5,791	124,604			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			106,130	106,130		106,130		106,130			33
34	Rent-Facility & Grounds			363,245	363,245		363,245	14,000	377,245			34
35	Rent-Equipment & Vehicles			212	212		212		212			35
36	Other (specify):*											36
37	TOTAL Ownership			588,400	588,400		588,400	19,791	608,191			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		47,733		47,733	(8,810)	38,923		38,923			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		8,262		8,262		8,262		8,262			41
42	Provider Participation Fee			99,098	99,098		99,098		99,098			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		55,995	99,098	155,093	(8,810)	146,283		146,283			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,026,012	518,978	1,701,031	5,246,021		5,246,021	(18,194)	5,227,827			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 Eldercare of Alton

0023317

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(950)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,278)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,500)	20		18
19	Entertainment				19
20	Contributions	(325)	27		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
25	Fund Raising, Advertising and Promotional	(8,865)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (15,918)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(2,276)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,276)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (18,194)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY						
48		49		50		51
						52

Eldercare of Alton

ID# 0023317

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eldercare of Alton

0023317

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,839	0	0	0	0	0	0	0	0	1,839	5
6	Maintenance	0	0	2,701	0	0	0	0	0	0	0	0	2,701	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	4,540	0	4,540	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(77,656)	0	0	0	0	0	0	0	0	(77,656)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	2,119	0	0	0	0	0	0	0	0	2,119	19
20	Fees, Subscriptions & Promotions	(11,365)	0	438	0	0	0	0	0	0	0	0	(10,927)	20
21	Clerical & General Office Expenses	(950)	0	13,293	0	0	0	0	0	0	0	0	12,343	21
22	Employee Benefits & Payroll Taxes	0	0	33,038	0	0	0	0	0	0	0	0	33,038	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,170	0	0	0	0	0	0	0	0	1,170	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	991	0	0	0	0	0	0	0	0	991	26
27	Other (specify):*	(3,603)	0	0	0	0	0	0	0	0	0	0	(3,603)	27
28	TOTAL General Administration	(15,918)	0	(26,607)	0	(42,525)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(15,918)	0	(22,067)	0	(37,985)	29							

STATE OF ILLINOIS

Facility Name & ID Number Eldercare of Alton

0023317

Report Period Beginning:

01/01/2005 Ending:

Summary B

12/31/2005

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	5,791	0	0	0	0	0	0	0	0	5,791	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	14,000	0	0	0	0	0	0	0	0	14,000	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	0	0	19,791	0	19,791	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):*	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)	(15,918)	0	(2,276)	0	(18,194)	45							

Facility Name & ID Number Eldercare of Alton

0023317

Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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
Steve Wolf	30	Calvin Johnson Care Center	Belleville	Eldercare Inc	Belleville	Nurs Home Mgt
	50	Columbia Convalescent Center	Columbia			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17-1 Home Office Adm Wages	\$ 81,359	Eldercare Inc	0.00%	\$ 81,359	\$	1
2	V	21-1 Home Office Wages	145,636	Eldercare Inc	0.00%	145,636		2
3	V	21-3 Home Office Expenses	75,380	Eldercare Inc	0.00%		(75,380)	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		\$ 302,375			\$ 226,995	\$ * (75,380)	14

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

Facility Name & ID Number Eldercare of Alton# 0023317Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 Utilities	\$	Eldercare Inc	0.00%	\$ 1,839	\$ 1,839	15
16	V	6 Maintenance		Eldercare Inc	0.00%	2,701	2,701	16
17	V	17 Officer Salary	81,359	Eldercare Inc	0.00%	81,359		17
18	V	19 Legal & Acctg		Eldercare Inc	0.00%	2,119	2,119	18
19	V	20 Dues & Licenses		Eldercare Inc	0.00%	438	438	19
20	V	21 Home Office Wages	145,636	Eldercare Inc	0.00%	145,636		20
21	V	21 Admin/office expenses		Eldercare Inc	0.00%	13,293	13,293	21
22	V	22 Payroll Taxes/benefits		Eldercare Inc	0.00%	33,038	33,038	22
23	V	24 Travel		Eldercare Inc	0.00%	1,170	1,170	23
24	V	26 Liability and Property insurance		Eldercare Inc	0.00%	991	991	24
25	V	30 Depreciation		Eldercare Inc	0.00%	5,791	5,791	25
26	V	34 Building Lease		Eldercare Inc	0.00%	14,000	14,000	26
27	V	Equipment Lease		Eldercare Inc	0.00%			27
28	V	17 Home Office Expenses	77,656	Eldercare Inc	0.00%		(77,656)	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		\$ 304,651			\$ 302,375	\$ * (2,276)	39

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

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Steve Wolf	President	Executive Admin	30.00	A 89548	20	0.33	Salary	\$ 81,359	17-1	1
2					B 88105						2
3											3
4											4
5											5
6											6
7											7
8			A Columbia Conv. Ctr								8
9			B Calvin Johnson Care Ctr								9
10											10
11											11
12											12
13								TOTAL	\$ 81,359		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 Eldercare of Alton

0023317 Report Period Beginning: 01/01/2005

Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	106,379	2	\$ 3,831	\$ 51,072	\$ 1,839	1
2	6	Maintenance	Patient Days	106,379	2	5,627	51,072	2,701	2
3	17	Home Office Adm Wages	Patient Days	106,379	2	169,464	169,464	81,359	3
4	19	Legal & Acctg	Patient Days	106,379	2	4,415	51,072	2,120	4
5	20	Dues & Licenses	Patient Days	106,379	2	913	51,072	438	5
6	21	Home Office Wages	Patient Days	106,379	2	303,347	303,347	145,635	6
7	21	Administrative expenses	Patient Days	106,379	2	27,689	51,072	13,293	7
8	22	Payroll Taxes/benefits	Patient Days	106,379	2	68,816	51,072	33,038	8
9	24	Travel	Patient Days	106,379	2	2,436	51,072	1,170	9
10	26	Liability and Property insur	Patient Days	106,379	2	2,064	51,072	991	10
11	30	Depreciation	Patient Days	106,379	2	12,062	51,072	5,791	11
12	34	Building Lease	Patient Days	106,379	2	29,160	51,072	14,000	12
13	35	Equipment Lease	Patient Days	106,379	2		51,072	0	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					\$ 629,824	\$ 472,811	\$ 302,375	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7						N/A				7										
8										8										
9	TOTAL Facility Related					\$	\$		\$	9										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$	14										
15	TOTALS (line 9+line14)					\$	\$		\$	15										

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2004 report.		\$ 92,040	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.)		\$ 96,590	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 4,550	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 99,480	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.)		\$ 2,100	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.		\$ 106,130	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	82,765	8
	2001	85,655	9
	2002	86,689	10
	2003	90,696	11
	2004	96,590	12
	FOR OHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2004 \$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eldercare of Alton COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0023317

CONTACT PERSON REGARDING THIS REPORT David Read

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>23-1-08-17-10-105-027</u>	<u>Nursing Home & 4.42 Acres</u>	\$ <u>96,590.00</u>	\$ <u>96,590.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>96,590.00</u>	\$ <u>96,590.00</u>

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 NO

If YES, attach an explanation & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Eldercare of Alton

0023317 Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,621 B. General Construction Type: Exterior Brick Frame concrete/steel Number of Stories 1

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements		1982		2,080		10			2,080	9
10	Improvements		1983		1,825		10			1,825	10
11	Improvements		1985		3,728		7			3,728	11
12	Improvements		1985		10,578	264	20	264		10,578	12
13	Improvements		1986		5,506		10			5,506	13
14	Heat Range		1988		1,190		10			1,190	14
15	Door Alarm		1991		8,986	449	20	449		6,627	15
16	Nurse Station Remodeling		1991		60,801	4,053	15	4,053		58,775	16
17	Carpet		1991		1,482		5			1,482	17
18	Asphalet Sealer		1992		2,900		12			2,900	18
19	Remodeling		1992		77,249	5,150	15	5,150		69,524	19
20	Roof & Remodeling		1993		68,700	4,580	15	4,580		56,105	20
21	Remodel Hall & Offices		1994		20,445	1,363	15	1,363		16,280	21
22	Concrete		1994		1,677	112	15	112		1,258	22
23	Roof Repairs & Asphalt		1995		2,150	179	12	179		1,881	23
24	Waste Line Renovations		1996		15,112	756	20	756		7,178	24
25	New Therapy Room		1996		3,782	252	15	252		2,458	25
26	Awnings		1996		12,500	1,251	10	1,251		11,875	26
27	Sidewalks & Parking Lot Seal		1996		8,930	524	5-15y	524		6,048	27
28	Landscape		1996		7,436	744	10	744		6,878	28
29	Concrete Walls & Signs		1997		14,479	965	15	965		8,205	29
30	Hall Renovations		1998		3,516	352	10	352		2,637	30
31	Laundry Boiler		1998		1,241	83	15	83		662	31
32	Parking Lot		1998		14,062	1,172	12	1,172		8,789	32
33	Landscape		1998		1,383	138	10	138		1,106	33
34	Drywall,Wall Carpet,Stained Glass Door,Lighting Chapel		1999		20,560	2,056	10	2,056		12,850	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 Eldercare of Alton

0023317

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Tubesheets & Copper Tubes in Water Heater	1999	\$ 6,904	\$ 986	7	\$ 986	\$	\$ 6,411	37
38	Drywall,Wall Carpet,Electric Work,and Flooring	2000	23,534	2,353	10	2,353		12,944	38
39	Duro-last Roofing System	2000	165,440	16,294	10	16,294		85,606	39
40	Roof-top HVAC Unit & 2 HVAC/Heat Unit-DR&Kitchen	2000	60,000	7,500	8	7,500		39,375	40
41	Fountain, Brick & Keystone install, Bush removal	2000	1,178	118	10	118		648	41
42	Asphalt Parking Lot	2001	7,745	645	12	645		2,904	42
43	Sidewalk entrance	2001	11,061	737	15	737		3,318	43
44	PA System	2001	573	115	5	115		515	44
45	Rooftop A/C	2001	4,133	517	8	517		2,325	45
46	Fireplace Dining Room/Awning	2001	3,917	392	10	392		1,763	46
47	New lighting-all wings/handrails	2001	49,081	3,272	15	3,272		14,724	47
48	New lighting	2002	5,788	386	15	386		1,543	48
49	Concrete pads	2002	1,882	94	20	94		376	49
50	Electrical rewiring kitchen	2003	7,770	388	20	388		1,165	50
51	Boiler room door, bathroom renovations	2003	4,564	456	10	456		1,141	51
52									52
53	Insurance proceeds on roofing system from 2000	2000	(2,500)						53
54	Generator, wiring, cable	2004	20,678	1,034	20	1,034		2,068	54
55	Handrails and installation	2004	13,980	932	15	932		1,864	55
56	Smoke detectors, emergency lighting, fire doors	2004	28,610	2,861	10	2,861		4,291	56
57	Carpeting, HVAC upgrades	2004	7,459	1,492	5	1,492		2,238	57
58	Electrical panel	2005	6,342	159	20	159		159	58
59	Fire alarm system upgrades	2005	19,966	998	10	998		998	59
60	Boiler repairs, heating, A/C	2005	2,788	278	5	278		278	60
61	Exterior drainage	2005	1,495	75	10	75		75	61
62									62
63	Home Office allocation			5,791		5,791			63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 824,686	\$ 72,316		\$ 72,316	\$	\$ 495,154	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 551,977	\$ 50,897	\$ 50,897	\$		\$ 306,465	71
72	Current Year Purchases	20,420	1,391	1,391		5 to 10 yr	1,391	72
73	Fully Depreciated Assets	178,747					178,747	73
74	retirements	(11,694)						74
75	TOTALS	\$ 739,450	\$ 52,288	\$ 52,288	\$		\$ 486,603	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1985 Van	1985	\$ 10,041	\$	\$	\$		\$ 10,041	76
77	Patient Transportation	1991 Bus	1991	39,855					39,855	77
78										78
79										79
80	TOTALS			\$ 49,896	\$	\$	\$		\$ 49,896	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)	\$ 1,614,032	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 124,604	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 124,604	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)	\$ 1,031,653	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: National Nursing Homes Inc.

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

If NO, see instructions. 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:	<u>1971</u>	<u>181</u>	<u>4/1/1977</u>	\$ <u>363,245</u>	<u>20</u>	<u>20</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		181		\$ 363,245			7

10. Effective dates of current rental agreement:

Beginning 08/01/2002

Ending 07/31/2007

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

Fiscal Year Ending Annual Rent

12. /2006 \$ varies with Prime Rate

13. /2007 \$ varies with Prime Rate

14. /2008 \$ varies with Prime Rate

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: \$ 212 Description: Office equipment

(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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A col 3	hrs	\$	197	\$ 13,775	\$ 37	197	\$ 13,812	1
2	Licensed Speech and Language Development Therapist	10A col 3	hrs		84	6,985	12	84	6,997	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A col 3	hrs		447	29,881	172	447	30,053	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				27,691		27,691	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	728	\$ 50,641	\$ 27,912	728	\$ 78,553	14

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

Facility Name & ID Number Eldercare of Alton# 0023317Report Period Beginning: 01/01/2005

Ending:

12/31/2005**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2005

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 119,209	\$	1
2	Cash-Patient Deposits	27,369		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,639,220		3
4	Supply Inventory (priced at <u>cost</u>)	35,016		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,521		6
7	Other Prepaid Expenses	6,655		7
8	Accounts Receivable (owners or related parties)	172,209		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,017,199	\$	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	824,687		15
16	Equipment, at Historical Cost	789,346		16
17	Accumulated Depreciation (book methods)	(1,031,653)		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)	\$ 582,380	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,599,579	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 398,305	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,369		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	55,526		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,691		31
32	Accrued Real Estate Taxes(Sch.IX-B)	99,480		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)	\$ 585,371	\$	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)	\$ 585,371	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,014,207	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,599,579	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,364,906	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,364,906	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(350,697)	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) Rounding	(2)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (350,699)	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)	\$ 2,014,207	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Eldercare of Alton

0023317

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,607,641	1
2	Discounts and Allowances for all Levels	(246,898)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,360,743	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	225,202	6
7	Oxygen	26,376	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 251,578	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	15,353	12
13	Barber and Beauty Care	3,180	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	51,228	17
18	Sale of Supplies to Non-Patients	194,989	18
19	Laboratory	11,533	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 276,283	23
D. Non-Operating Revenue			
24	Contributions	450	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 450	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc	6,270	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,270	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,895,324	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,016,567	31
32	Health Care	2,268,853	32
33	General Administration	1,217,108	33
B. Capital Expense			
34	Ownership	588,400	34
C. Ancillary Expense			
35	Special Cost Centers	55,995	35
36	Provider Participation Fee	99,098	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,246,021	40
41	Income before Income Taxes (line 30 minus line 40)**	(350,697)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (350,697)	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.

consolidated return

*** 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 Eldercare of Alton

0023317

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 52,520	\$ 25.25	1
2	Assistant Director of Nursing	2,000	2,080	46,408	22.31	2
3	Registered Nurses	4,314	4,487	102,082	22.75	3
4	Licensed Practical Nurses	28,881	30,036	556,566	18.53	4
5	CNAs & Orderlies	81,531	84,792	923,379	10.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,521	8,862	86,961	9.81	8
9	Activity Director					9
10	Activity Assistants	5,419	5,636	47,114	8.36	10
11	Social Service Workers	6,113	6,358	71,208	11.20	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	26,100	12.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,604	24,548	180,918	7.37	15
16	Dishwashers					16
17	Maintenance Workers	6,008	6,248	64,917	10.39	17
18	Housekeepers	27,327	28,420	199,224	7.01	18
19	Laundry	12,694	13,202	94,130	7.13	19
20	Administrator	2,000	2,080	73,158	35.17	20
21	Assistant Administrator					21
22	Other Administrative	1,040	1,040	81,359	78.23	22
23	Office Manager					23
24	Clerical	15,337	15,951	333,418	20.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Inservice</u>	4,138	4,304	86,550	20.11	33
34	TOTAL (lines 1 - 33)	232,927	242,204	\$ 3,026,012 *	\$ 12.49	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	286	\$ 7,879	L1 C3	35
36	Medical Director	Monthly	24,000	L9 Col 3	36
37	Medical Records Consultant	56	2,149	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	840	L10 C3	39
40	Physical Therapy Consultant	378	20,170	L 10A C 3	40
41	Occupational Therapy Consultant	63	4,265	L 10A C 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	46	L 10A C 3	43
44	Activity Consultant	43	2,381	L11C3	44
45	Social Service Consultant	82	4,475	L12C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	933	\$ 66,205		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	296	\$ 10,932	L10C3	50
51	Licensed Practical Nurses	1,186	36,015	L10C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,482	\$ 46,947		53

Facility Name & ID Number Eldercare of Alton

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Report Period Beginning: 01/01/2005

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Deborah Cutright	Administrator	0	\$ 73,158	Workers' Compensation Insurance	\$ 83,130	IDPH License Fee	\$ 995	
Steven C. Wolf	Owner/exec admin	30	81,359	Unemployment Compensation Insurance	65,592	Advertising: Employee Recruitment	3,296	
				FICA Taxes	206,630	Health Care Worker Background Check	1,499	
				Employee Health Insurance	54,101	(Indicate # of checks performed <u>150</u>)		
				Employee Meals		LTCNA	105	
				Illinois Municipal Retirement Fund (IMRF)*		CLIA lab fees	150	
				employee benefits	14,108	Secretary of State vehicle tags	674	
				home office allocation	33,038	various dues and subscriptions	1,088	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 154,517			home office allocation	438	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
Eldercare Inc. Home Office allocation			\$ 77,656			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 77,656	TOTAL (agree to Schedule V, line 22, col.8)		\$ 456,599	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Wessels & Pautsch	Legal		\$ 120				Out-of-State Travel	\$
Burroughs Hepler Broom	Legal		2,000					
Lathrop & Gage	Legal		2,063	N/A				
Van Ostrand Kelley	Legal		403				In-State Travel	
Charles Crecelius	Legal expert		650					
P Michael Read	Legal		46					
Moore Renner Simonin	accounting		79					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Seminar Expense	4,124
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 5,361				home office allocation	1,170
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 5,294

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Eldercare of Alton

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? 5 to 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,574 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (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. \$ 47,733
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. \$ N/A Has any meal income been offset against related costs? _____ 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? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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 \$2500, 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.