

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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: 0023309

Facility Name: Calvin Johnson Care Center

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

County: St. Clair

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

HFS ID Number: 37-1024089001

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

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 01/01/06 to 12/31/06 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 Calvin Johnson Care Center

0023309 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	132	Skilled (SNF)	132	48,180	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	45,882	2,254	3,176	51,312	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,882	2,254	3,176	51,312	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.10%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

YES NO

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 48 and days of care provided 1,146

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	229,112	14,931	8,067	252,110	350	252,460		252,460			1
2	Food Purchase		222,929		222,929		222,929		222,929			2
3	Housekeeping	239,776	32,822		272,598		272,598		272,598			3
4	Laundry	92,124	16,709		108,833		108,833		108,833			4
5	Heat and Other Utilities			203,605	203,605		203,605	1,987	205,592			5
6	Maintenance	77,320	2,907	51,483	131,710		131,710	3,404	135,114			6
7	Other (specify):*											7
8	TOTAL General Services	638,332	290,298	263,155	1,191,785	350	1,192,135	5,391	1,197,526			8
	B. Health Care and Programs											
9	Medical Director			2,854	2,854		2,854		2,854			9
10	Nursing and Medical Records	2,303,388	337,311	91,907	2,732,606	(430,396)	2,302,210		2,302,210			10
10a	Therapy					29,912	29,912		29,912			10a
11	Activities	27,567	5,125	636	33,328		33,328		33,328			11
12	Social Services	56,536		2,056	58,592	50	58,642		58,642			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,387,491	342,436	97,453	2,827,380	(400,434)	2,426,946		2,426,946			16
	C. General Administration											
17	Administrative	173,284		88,868	262,152		262,152	(88,868)	173,284			17
18	Directors Fees											18
19	Professional Services			1,207	1,207		1,207	5,175	6,382			19
20	Dues, Fees, Subscriptions & Promotions			29,106	29,106		29,106	(7,793)	21,313			20
21	Clerical & General Office Expenses	368,953	7,807	48,041	424,801	1,250	426,051	17,902	443,953			21
22	Employee Benefits & Payroll Taxes			451,032	451,032	(2,550)	448,482	28,202	476,684			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,976	5,976		5,976	2,574	8,550			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			26,215	26,215		26,215	1,004	27,219			26
27	Other (specify):*			8,124	8,124		8,124	(8,124)				27
28	TOTAL General Administration	542,237	7,807	658,569	1,208,613	(1,300)	1,207,313	(49,928)	1,157,385			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,568,060	640,541	1,019,177	5,227,778	(401,384)	4,826,394	(44,537)	4,781,857			29

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

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

Facility Name & ID Number Calvin Johnson Care Center

#0023309

Report Period Beginning:

01/01/06

Ending:

12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			85,565	85,565		85,565	6,836	92,401			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			62,220	62,220		62,220	(12,185)	50,035			32
33	Real Estate Taxes			54,467	54,467		54,467		54,467			33
34	Rent-Facility & Grounds			386,883	386,883		386,883	15,250	402,133			34
35	Rent-Equipment & Vehicles			138	138		138		138			35
36	Other (specify):*											36
37	TOTAL Ownership			589,273	589,273		589,273	9,901	599,174			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		53,288		53,288	401,384	454,672		454,672			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		16,842		16,842		16,842		16,842			41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		70,130	98,550	168,680	401,384	570,064		570,064			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,568,060	710,671	1,707,000	5,985,731		5,985,731	(34,636)	5,951,095			45

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

Facility Name & ID Number Calvin Johnson Care Center

0023309

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	(12,185)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,409)	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	(500)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(5,715)	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	(2,588)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,345)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (28,742)		\$	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)	(2,779)	var	34
35	Other- Attach Schedule	(3,115)	var	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (5,894)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (34,636)		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.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY					
48		49		50	
				51	
					52

Calvin Johnson Care Center

ID# 0023309

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Cost of T-shirts sold to employees	\$ (3,015)	22	1
2	Lobbying fees	(100)	20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,115)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Calvin Johnson Care Center

0023309

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	1,987	0	0	0	0	0	0	0	0	1,987	5
6	Maintenance	0	0	3,404	0	0	0	0	0	0	0	0	3,404	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	5,391	0	0	0	0	0	0	0	0	5,391	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	(88,868)	0	0	0	0	0	0	0	0	(88,868)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	5,175	0	0	0	0	0	0	0	0	5,175	19
20	Fees, Subscriptions & Promotions	(8,533)	0	740	0	0	0	0	0	0	0	0	(7,793)	20
21	Clerical & General Office Expenses	0	0	17,902	0	0	0	0	0	0	0	0	17,902	21
22	Employee Benefits & Payroll Taxes	(3,015)	0	31,217	0	0	0	0	0	0	0	0	28,202	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,574	0	0	0	0	0	0	0	0	2,574	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	1,004	0	0	0	0	0	0	0	0	1,004	26
27	Other (specify):*	(8,124)	0	0	0	0	0	0	0	0	0	0	(8,124)	27
28	TOTAL General Administration	(19,672)	0	(30,256)	0	0	0	0	0	0	0	0	(49,928)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(19,672)	0	(24,865)	0	0	0	0	0	0	0	0	(44,537)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Calvin Johnson Care Center

0023309

Report Period Beginning:

01/01/06 Ending:

12/31/06

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	6,836	0	0	0	0	0	0	0	0	6,836	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,185)	0	0	0	0	0	0	0	0	0	0	(12,185)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	15,250	0	0	0	0	0	0	0	0	15,250	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	(12,185)	0	22,086	0	9,901	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)	(31,857)	0	(2,779)	0	(34,636)	45							

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	Eldercare of Alton	Alton	Eldercare Inc	Belleville	Nurs Home Mgt
Steve Wolf	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	\$ 88,628	Eldercare Inc	0.00%	\$ 88,628	\$	1
2	V	21-1 Home Office Wages	155,195	Eldercare Inc	0.00%	155,195		2
3	V	17-3 Home Office Adm expenses	88,868	Eldercare Inc	0.00%	86,089	(2,779)	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		\$ 332,691			\$ 329,912	\$ * (2,779)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 Utilities	\$	Eldercare Inc	0.00%	\$ 1,987	\$ 1,987	15
16	V	6 Maintenance		Eldercare Inc	0.00%	3,404	3,404	16
17	V	17 Administrative Wages	88,628	Eldercare Inc	0.00%	88,628		17
18	V	19 Professional Services		Eldercare Inc	0.00%	5,175	5,175	18
19	V	20 Fees,Subscriptions		Eldercare Inc	0.00%	740	740	19
20	V	21 Clerical and office wages	155,195	Eldercare Inc	0.00%	155,195		20
21	V	21 Admin &General Office		Eldercare Inc	0.00%	17,902	17,902	21
22	V	22 Employee Benefits		Eldercare Inc	0.00%	31,217	31,217	22
23	V	24 Travel&Seminars		Eldercare Inc	0.00%	2,574	2,574	23
24	V	26 Ins. Prop		Eldercare Inc	0.00%	1,004	1,004	24
25	V	30 Depreciation		Eldercare Inc	0.00%	6,836	6,836	25
26	V	34 Rent Facility		Eldercare Inc	0.00%	15,250	15,250	26
27	V	17 Home Office Admin expenses	88,868	Eldercare Inc	0.00%		(88,868)	27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 332,691			\$ 329,912	\$ * (2,779)	39

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

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	Exec. Admin.	30.00	A 106192	20	40.00	Salary	\$ 88,628	17-1	1
2					B 81359						2
3											3
4											4
5											5
6			A Columbia Conv Center								6
7			B Eldercare of Alton								7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 88,628		13

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

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

Facility Name & ID Number Calvin Johnson Care Center

0023309

Report Period Beginning:

01/01/06

Ending: 12/31/06

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

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

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

1	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	Census	98,113	2	\$ 3,799	\$ 51,312	\$ 1,987	1
2	6	Maintenance	Census	98,113	2	6,509	51,312	3,404	2
3	17	Administrative	Census	98,113	2	169,464	169,464	88,628	3
4	19	Professional Services	Census	98,113	2	9,895	51,312	5,175	4
5	20	Fees,Subscriptions	Census	98,113	2	1,414	51,312	740	5
6	21	Clerical and office wages	Census	98,113	2	296,747	296,747	155,195	6
7	21	Admin &General Office	Census	98,113	2	34,230	51,312	17,902	7
8	22	Employee Benefits	Census	98,113	2	59,689	51,312	31,217	8
9	24	Travel&Seminars	Census	98,113	2	4,921	51,312	2,574	9
10	26	Ins. Prop	Census	98,113	2	1,919	51,312	1,004	10
11	30	Depreciation	Census	98,113	2	13,071	51,312	6,836	11
12	34	Rent Facility	Census	98,113	2	29,160	51,312	15,250	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					\$ 630,818	\$ 466,211	\$ 329,912	25

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	Regions Bank	X	Open Line Of Credit	Demand	2/5/02	2,000,000	966,546	8/5/07	Prime	62,220	6									
7											7									
8											8									
9	TOTAL Facility Related					\$ 2,000,000	\$ 966,546			\$ 62,220	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 2,000,000	\$ 966,546			\$ 62,220	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

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.		\$	48,180	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.)		\$	50,327	2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,147	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	52,320	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.		\$	54,467	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	47,005	8	
	2002	38,527	9	
	2003	42,305	10	
	2004	46,776	11	
	2005	50,327	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2005	\$	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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Calvin Johnson Care Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0023309

CONTACT PERSON REGARDING THIS REPORT 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 2005 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 2005.

(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>08-20.0-211-030</u>	<u>Nursing Home 4.18 Acres</u>	<u>\$ 50,327.10</u>	<u>\$ 50,327.10</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ 50,327.10	\$ 50,327.10

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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Calvin Johnson Care Center

0023309 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

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

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

Facility Name & ID Number Calvin Johnson Care Center

0023309

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Bldg Imp			1982	600		10			600	9
10	1983 Audit			1983	4,085		10				10
11	Bldg Imp			1983	39,106		10			39,106	11
12	Black Top			1983	1,033		12			1,033	12
13	Remodeling			1984	7,160		20			7,160	13
14	Landscaping			1984	3,604		10			3,604	14
15	Windows			1985	1,454		10			1,454	15
16	A/C System			1985	1,983		8			1,983	16
17	Canopies			1985	6,333		10			6,333	17
18	Sidewalks			1985	7,800		15			7,800	18
19	Driveway Sealer			1985	810		5			810	19
20	Parking Stripes			1986	524		5			524	20
21	Renovate Halls			1988	21,660		10			21,660	21
22	Renovate Baths			1989	14,042		10			14,042	22
23	Roof Remodeling			1990	44,045		10-15y			44,045	23
24	Remodeling			1991	51,920	506	5-10y	506		49,643	24
25	Remodeling			1992	140,195	6,912	5-15y	6,912		136,735	25
26	Remodeling			1993	52,694	4,876	5-15y	4,876		45,379	26
27	Hall Monitor System			1994	3,208	204	15-20y	204		2,597	27
28	Improvements			1995	27,040	625	5-15y	625		25,978	28
29	Elevator			1996	4,929	329	15	329		3,451	29
30	Awnings			1996	4,195	315	10	315		4,195	30
31	Rooftop			1996	10,643		8			10,643	31
32	Renovations Paint/Wallpaper			1996	1,000		5			1,000	32
33	A/C Work & Carpeting			1997	7,032	269	5-15y	269		5,689	33
34	Fence			1998	1,250		8			1,250	34
35	Interior Renovation			1998	11,308	1,054	5-15y	1,054		9,351	35
36	Interior Renovation			1999	53,624	4,555	5-15y	4,555		40,331	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Calvin Johnson Care Center

0023309

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	Cubicle Tracks	2000	\$ 14,481	\$ 965	15	\$ 965	\$	\$ 6,275	37
38	Renovations Interior	2000	12,015	1,202	10	1,202		7,810	38
39	Renovations Interior	2000	7,124		5			7,124	39
40	Landscaping	2000	21,213	2,121	10	2,121		13,261	40
41	Renovations Interior	2001	15,525	1,552	10	1,552		8,539	41
42	Renovations Interior	2001	45,895	3,060	15	3,060		17,593	42
43	Kitchen hood- stainless steel	2002	21,235	1,416	15	1,416		6,017	43
44	Fire alarm control panel	2002	5,857	164	10	164		736	44
45	insurance proceeds for control panel	2003	(4,221)						45
46	Fire Alarm panel	2003	1,120	112	10	112		448	46
47	Bldg generator	2003	19,164	958	20	958		3,833	47
48	HVAC units	2003	6,158	1,232	10	1,232		4,310	48
49	Wiring Hall 400, new door	2004	3,361	168	20	168		504	49
50	guardrails, exhaust fan	2004	2,671	178	15	178		445	50
51	Fire alarm pulls, dampers, wiring	2004	4,749	475	10	475		1,425	51
52	Carpeting, vinyl base	2004	4,875	975	5	975		2,437	52
53	Roof, door locks, wall coverings	2005	39,288	3,929	10	3,929		5,893	53
54	Entrance Canopy	2005	11,688	2,338	5	2,338		4,675	54
55	Roof,ductwork, doors, plumbing	2006	57,665	2,883	10	2,883		2,883	55
56	Air conditioning	2006	7,999	800	5	800		800	56
57	lighting, sidewalks, patio	2006	31,149	1,038	15	1,038		1,038	57
58	New decking	2006	37,555	1,878	10	1,878		1,878	58
59									59
60									60
61									61
62	retirements Air conditioning	1990	(1,485)					(1,485)	62
63	Home Office allocation			6,836		6,836			63
64	retirements Air conditioning	1991	(3,341)					(3,341)	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 885,017	\$ 53,925		\$ 53,925	\$	\$ 579,494	70

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

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	\$ 388,298	\$ 31,173	\$ 31,173	\$		\$ 282,018	71
72	Current Year Purchases	28,388	2,142	2,142			2,142	72
73	Fully Depreciated Assets	189,205					189,205	73
74	retirements	(9,857)					(9,857)	74
75	TOTALS	\$ 596,034	\$ 33,315	\$ 33,315	\$		\$ 463,508	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	1971 Bus & lift	1977	\$ 8,638	\$	\$	\$	5	\$ 8,638	76
77	Patient Transport	2- 1997 Ford Buses w/ lifts	2004	8,269	2,756	2,756		3	6,201	77
78	Facility Use	1999 Dodge Caravan	2005	7,214	2,405	2,405		3	3,607	78
79										79
80	TOTALS			\$ 24,121	\$ 5,161	\$ 5,161	\$		\$ 18,446	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)		\$ 1,505,172	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 92,401	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 92,401	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)		\$ 1,061,448	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>1969</u>	<u>180</u>	<u>4/1/77</u>	\$ <u>386,883</u>	<u>20</u>	<u>5</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		180		\$ 386,883			7

10. Effective dates of current rental agreement:

Beginning 08/01/2002

Ending 08/01/2007

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

Fiscal Year Ending Annual Rent

12. /2007 \$ varies with Prime Rate

13. /2008 \$ varies with Prime Rate

14. /2009 \$ 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: \$ 138 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-3	hrs	\$	129	\$ 9,329	\$	129	\$ 9,329	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		14	1,246		14	1,246	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		255	19,337		255	19,337	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				46,610		46,610	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39		272,728			90,909		363,637	12
13	Other (specify): Lab,Xray/Oxygen	39				1,758	42,667		44,425	13
14	TOTAL			\$ 272,728	398	\$ 31,670	\$ 180,186	398	\$ 484,584	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 Calvin Johnson Care Center

0023309

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(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	\$ 259,022	\$	1
2	Cash-Patient Deposits	53,975		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,028,866		3
4	Supply Inventory (priced at cost)	54,466		4
5	Short-Term Investments			5
6	Prepaid Insurance	607		6
7	Other Prepaid Expenses	28,274		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,425,210	\$	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	880,931		15
16	Equipment, at Historical Cost	620,155		16
17	Accumulated Depreciation (book methods)	(1,061,448)		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)	\$ 439,638	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,864,848	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 393,753	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,975		28
29	Short-Term Notes Payable	966,546		29
30	Accrued Salaries Payable	84,753		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,495		31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,320		32
33	Accrued Interest Payable	3,479		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Accrued Liability claims	78,596		36
37	Intercompany payable	244,303		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,889,220	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,889,220	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 975,629	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,864,848	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 895,756	1
2	Restatements (describe):		2
3	To write off Accounts receivable	(5,362)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 890,394	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	85,235	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 85,235	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)	\$ 975,629	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Calvin Johnson Care Center

0023309

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	\$ 5,635,214	1
2	Discounts and Allowances for all Levels	(534,739)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,100,475	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	50,737	6
7	Oxygen	151,569	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 202,306	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	27,490	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	86,229	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,656	19
20	Radiology and X-Ray	1,112	20
21	Other Medical Services	605,927	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 733,414	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	12,185	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,185	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc 124/Bad debt recov 208/Medicare settle 14833	15,165	28
28a	Fund raising 4821/garnishment fees 2600	7,421	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 22,586	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,070,966	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,191,785	31
32	Health Care	2,827,380	32
33	General Administration	1,208,613	33
B. Capital Expense			
34	Ownership	589,273	34
C. Ancillary Expense			
35	Special Cost Centers	70,130	35
36	Provider Participation Fee	98,550	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,985,731	40
41	Income before Income Taxes (line 30 minus line 40)**	85,235	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 85,235	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? n/a 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 Calvin Johnson Care Center

0023309

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,940	2,100	\$ 57,920	\$ 27.58	1
2	Assistant Director of Nursing	964	964	24,867	25.80	2
3	Registered Nurses	6,998	7,520	180,855	24.05	3
4	Licensed Practical Nurses	33,602	35,727	694,885	19.45	4
5	CNAs & Orderlies	89,591	95,787	1,020,131	10.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,000	2,080	21,973	10.56	8
9	Activity Director					9
10	Activity Assistants	3,626	3,808	27,567	7.24	10
11	Social Service Workers	4,718	4,918	56,536	11.50	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	33,120	15.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,781	23,500	195,992	8.34	15
16	Dishwashers					16
17	Maintenance Workers	5,933	6,438	77,320	12.01	17
18	Housekeepers	28,179	30,198	239,776	7.94	18
19	Laundry	10,526	11,245	92,124	8.19	19
20	Administrator	2,000	2,120	84,656	39.93	20
21	Assistant Administrator					21
22	Other Administrative	1,040	1,040	88,628	85.22	22
23	Office Manager					23
24	Clerical	20,584	21,798	368,953	16.93	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 Respiratory	8,864	9,345	198,591	21.25	32
33	Other(specify) Q/A, Inservice	5,124	5,484	104,166	18.99	33
34	TOTAL (lines 1 - 33)	250,470	266,152	\$ 3,568,060 *	\$ 13.41	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	293	\$ 8,067	L1C3	35
36	Medical Director	monthly	2,854	L9C3	36
37	Medical Records Consultant	16	560	L10C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	900	L10C3	39
40	Physical Therapy Consultant	147	9,191	L10C3	40
41	Occupational Therapy Consultant	1	67	L10C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	84	L10C3	43
44	Activity Consultant	19	636	L11 C3	44
45	Social Service Consultant	57	1,907	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	534	\$ 24,266		49

C. CONTRACT NURSES

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

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? 5-20 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26 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. \$ 98,550
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? n/a Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? _____
- 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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? n/a 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? n/a
Attach invoices and a summary of services for all architect and appraisal fees.