

		FOR BHF USE					

LL1

**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:** 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
<b>IRS Exemption Code</b> _____	<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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Steven C. Wolf</u>	
	(Title) <u>Executive Administrator</u>	
<b>Paid Preparer</b>	(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: 01/01/06 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	<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>2,634</u>	<u>346</u>	<u>1,612</u>	<u>4,592</u>	8
9	SNF/PED					9
10	ICF	<u>39,097</u>	<u>3,112</u>		<u>42,209</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>41,731</u>	<u>3,458</u>	<u>1,612</u>	<u>46,801</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.84%

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 &amp; 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 1,612Medicare 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 Eldercare of Alton # 0023317 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
	<b>A. General Services</b>										
1	Dietary	188,847	15,202	11,237	215,286		215,286	(75)	215,211		1
2	Food Purchase		205,250		205,250		205,250		205,250		2
3	Housekeeping	181,830	25,686		207,516		207,516		207,516		3
4	Laundry	85,187	14,350		99,537		99,537		99,537		4
5	Heat and Other Utilities			112,043	112,043		112,043	1,812	113,855		5
6	Maintenance	65,100	26,378	25,678	117,156		117,156	3,105	120,261		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>520,964</b>	<b>286,866</b>	<b>148,958</b>	<b>956,788</b>		<b>956,788</b>	<b>4,842</b>	<b>961,630</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,753,508	144,167	148,270	2,045,945	(79,702)	1,966,243		1,966,243		10
10a	Therapy					78,881	78,881		78,881		10a
11	Activities	49,059	7,134	3,343	59,536		59,536		59,536		11
12	Social Services	73,245	26	4,480	77,751		77,751		77,751		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,875,812</b>	<b>151,327</b>	<b>180,093</b>	<b>2,207,232</b>	<b>(821)</b>	<b>2,206,411</b>		<b>2,206,411</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	156,543		79,912	236,455		236,455	(79,912)	156,543		17
18	Directors Fees										18
19	Professional Services			17,503	17,503		17,503	4,720	22,223		19
20	Dues, Fees, Subscriptions & Promotions			40,849	40,849		40,849	(14,433)	26,416		20
21	Clerical & General Office Expenses	324,506	9,259	46,187	379,952		379,952	15,904	395,856		21
22	Employee Benefits & Payroll Taxes			382,001	382,001		382,001	28,473	410,474		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,619	6,619		6,619	1,819	8,438		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			75,849	75,849		75,849	915	76,764		26
27	Other (specify):* <b>contrib</b>			76	76		76	(76)			27
28	<b>TOTAL General Administration</b>	<b>481,049</b>	<b>9,259</b>	<b>648,996</b>	<b>1,139,304</b>		<b>1,139,304</b>	<b>(42,590)</b>	<b>1,096,714</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,877,825</b>	<b>447,452</b>	<b>978,047</b>	<b>4,303,324</b>	<b>(821)</b>	<b>4,302,503</b>	<b>(37,748)</b>	<b>4,264,755</b>		<b>29</b>

\*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: 01/01/06 Ending: 12/31/06

## 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	
	<b>D. Ownership</b>											
30	Depreciation			114,492	114,492		114,492	6,235	120,727			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			36,202	36,202		36,202		36,202			33
34	Rent-Facility & Grounds			389,032	389,032		389,032	13,910	402,942			34
35	Rent-Equipment & Vehicles			207	207		207		207			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			539,933	539,933		539,933	20,145	560,078			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,458		50,458	821	51,279		51,279			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		8,341		8,341		8,341		8,341			41
42	Provider Participation Fee			99,370	99,370		99,370		99,370			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		58,799	99,370	158,169	821	158,990		158,990			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,877,825	506,251	1,617,350	5,001,426		5,001,426	(17,603)	4,983,823			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: 01/01/06

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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(75)	1		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	(5,330)	20		18
19	Entertainment				19
20	Contributions	(76)	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	(9,777)	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 <u>resident clothing</u>	(423)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (15,681)		\$	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)	(1,394)	var	34
35	Other- Attach Schedule	(528)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,922)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (17,603)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Eldercare of Alton

ID# 0023317  
 Report Period Beginning: 01/01/06  
 Ending: 12/31/06

Sch. V Line  
 Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Out of State Travel	\$ (528)	24	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	<b>Total</b>	(528)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Eldercare of Alton

# 0023317

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)	
	<b>A. General Services</b>													
1	Dietary	(75)	0	0	0	0	0	0	0	0	0	0	(75)	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	1,812	0	0	0	0	0	0	0	0	1,812	5
6	Maintenance	0	0	3,105	0	0	0	0	0	0	0	0	3,105	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	(75)	0	4,917	0	0	0	0	0	0	0	0	4,842	8
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	(79,912)	0	0	0	0	0	0	0	0	(79,912)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	4,720	0	0	0	0	0	0	0	0	4,720	19
20	Fees, Subscriptions & Promotions	(15,107)	0	674	0	0	0	0	0	0	0	0	(14,433)	20
21	Clerical & General Office Expenses	0	0	16,327	0	0	0	0	0	0	0	0	16,327	21
22	Employee Benefits & Payroll Taxes	0	0	28,473	0	0	0	0	0	0	0	0	28,473	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(528)	0	2,347	0	0	0	0	0	0	0	0	1,819	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	915	0	0	0	0	0	0	0	0	915	26
27	Other (specify):*	(76)	0	0	0	0	0	0	0	0	0	0	(76)	27
28	<b>TOTAL General Administration</b>	(15,711)	0	(26,456)	0	0	0	0	0	0	0	0	(42,167)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(15,786)	0	(21,539)	0	0	0	0	0	0	0	0	(37,325)	29

STATE OF ILLINOIS

Facility Name & ID Number Eldercare of Alton

# 0023317

Report Period Beginning:

01/01/06 Ending:

Summary B

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	6,235	0	0	0	0	0	0	0	0	6,235	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	13,910	0	0	0	0	0	0	0	0	13,910	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	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>20,145</b>	<b>0</b>	<b>20,145</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(15,786)</b>	<b>0</b>	<b>(1,394)</b>	<b>0</b>	<b>(17,180)</b>	<b>45</b>							

Facility Name & ID Number Eldercare of Alton

# 0023317

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	\$ 80,836	Eldercare Inc	0.00%	\$ 80,836	\$	1
2	V	21-1 Home Office Wages	141,552	Eldercare Inc	0.00%	141,552		2
3	V	21-3 Home Office Expenses	79,912	Eldercare Inc	0.00%	78,518	(1,394)	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		\$ 302,300			\$ 300,906	\$ * (1,394)	14

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

Facility Name & ID Number Eldercare of Alton# 0023317Report Period Beginning: 01/01/06Ending: 12/31/06

## 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%	\$ 1,812	\$ 1,812	15
16	V	6 Maintenance		Eldercare Inc	0.00%	3,105	3,105	16
17	V	17 Officer Salary	80,836	Eldercare Inc	0.00%	80,836		17
18	V	19 Legal & Acctg		Eldercare Inc	0.00%	4,720	4,720	18
19	V	20 Dues & Licenses		Eldercare Inc	0.00%	674	674	19
20	V	21 Home Office Wages	141,552	Eldercare Inc	0.00%	141,552		20
21	V	21 Admin/office expenses		Eldercare Inc	0.00%	16,327	16,327	21
22	V	22 Payroll Taxes/benefits		Eldercare Inc	0.00%	28,473	28,473	22
23	V	24 Travel		Eldercare Inc	0.00%	2,347	2,347	23
24	V	26 Liability and Property insurance		Eldercare Inc	0.00%	915	915	24
25	V	30 Depreciation		Eldercare Inc	0.00%	6,235	6,235	25
26	V	34 Building Lease		Eldercare Inc	0.00%	13,910	13,910	26
27	V	17 Home Office Expenses	79,912	Eldercare Inc	0.00%		(79,912)	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		\$ 302,300			\$ 300,906	\$ * (1,394)	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: 01/01/06 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	Executive Admin	30.00	A 106192	20	0.33	Salary	\$ 80,836	17-1	1
2					B 88628						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	\$ 80,836		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: 01/01/06

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 Pkwy 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	Patient Days	98,113	2	\$ 3,799	\$ 46,801	\$ 1,812	1
2	6	Maintenance	Patient Days	98,113	2	6,509	46,801	3,105	2
3	17	Home Office Adm Wages	Patient Days	98,113	2	169,464	169,464	80,836	3
4	19	Legal & Acctg	Patient Days	98,113	2	9,895	46,801	4,720	4
5	20	Dues & Licenses	Patient Days	98,113	2	1,414	46,801	674	5
6	21	Home Office Wages	Patient Days	98,113	2	296,747	46,801	141,552	6
7	21	Administrative expenses	Patient Days	98,113	2	34,230	46,801	16,328	7
8	22	Payroll Taxes/benefits	Patient Days	98,113	2	59,689	46,801	28,472	8
9	24	Travel	Patient Days	98,113	2	4,921	46,801	2,347	9
10	26	Liability and Property insur	Patient Days	98,113	2	1,919	46,801	915	10
11	30	Depreciation	Patient Days	98,113	2	13,071	46,801	6,235	11
12	34	Building Lease	Patient Days	98,113	2	29,160	46,801	13,910	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	\$ 300,906	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6						N/A				6										
7										7										
8										8										
9	<b>TOTAL Facility Related</b>					\$	\$		\$	9										
<b>B. Non-Facility Related*</b>																				
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Non-Facility Related</b>					\$	\$		\$	14										
15	<b>TOTALS (line 9+line14)</b>					\$	\$		\$	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.)



**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 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 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>23-1-08-17-10-105-027</u>	<u>Nursing Home &amp; 4.42 Acres</u>	\$ <u>91,921.00</u>	\$ <u>91,921.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>91,921.00</u>	\$ <u>91,921.00</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 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 Eldercare of Alton

# 0023317 Report Period Beginning:

01/01/06 Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 45,621 B. General Construction Type: Exterior Brick Frame concrete/steel 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).

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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 Eldercare of Alton

# 0023317

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
<b>Improvement Type**</b>											
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		20			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		7,076	15
16		Nurse Station Remodeling		1991	60,801	2,027	15	2,027		60,801	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		74,673	19
20		Roof & Remodeling		1993	68,700	4,580	15	4,580		60,685	20
21		Remodel Hall & Offices		1994	20,445	1,363	15	1,363		17,644	21
22		Concrete		1994	1,677	112	15	112		1,370	22
23		Roof Repairs & Asphalt		1995	2,150	179	12	179		2,060	23
24		Waste Line Renovations		1996	15,112	756	20	756		7,934	24
25		New Therapy Room		1996	3,782	252	15	252		2,710	25
26		Awnings		1996	12,500	625	10	625		12,500	26
27		Sidewalks & Parking Lot Seal		1996	8,930	524	5-15y	524		6,572	27
28		Landscape		1996	7,436	558	10	558		7,436	28
29		Concrete Walls & Signs		1997	14,479	965	15	965		9,170	29
30		Hall Renovations		1998	3,516	352	10	352		2,989	30
31		Laundry Boiler		1998	1,241	83	15	83		745	31
32		Parking Lot		1998	14,062	1,172	12	1,172		9,961	32
33		Landscape		1998	1,383	138	10	138		1,244	33
34		Drywall,Wall Carpet,Stained Glass Door,Lighting Chapel		1999	20,560	2,056	10	2,056		14,906	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 &amp; ID Number Eldercare of Alton

# 0023317

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	Tubesheets & Copper Tubes in Water Heater	1999	\$ 6,904	\$ 493	7	\$ 493	\$	\$ 6,904	37
38	Drywall,Wall Carpet,Electric Work,and Flooring	2000	23,534	2,353	10	2,353		15,297	38
39	Duro-last Roofing System	2000	165,440	16,294	10	16,294		101,900	39
40	Roof-top HVAC Unit & 2 HVAC/Heat Unit-DR&Kitchen	2000	60,000	7,500	8	7,500		46,875	40
41	Foutain, Brick & Keystone install, Bush removal	2000	1,178	118	10	118		766	41
42	Asphalt Parking Lot	2001	7,745	645	12	645		3,550	42
43	Sidewalk entrance	2001	11,061	737	15	737		4,055	43
44	PA System	2001	573	57	5	57		573	44
45	Rooftop A/C	2001	4,133	517	8	517		2,841	45
46	Fireplace Dining Room/Awning	2001	3,917	392	10	392		2,155	46
47	New lighting-all wings/handrails	2001	49,081	3,272	15	3,272		17,996	47
48	New lighting	2002	5,788	386	15	386		1,929	48
49	Concrete pads	2002	1,882	94	20	94		471	49
50	Electrical rewiring kitchen	2003	7,770	388	20	388		1,554	50
51	Boiler room door, bathroom renovations	2003	4,564	456	10	456		1,597	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		3,102	54
55	Handrails and installation	2004	13,980	932	15	932		2,796	55
56	Smoke detectors, emergency lighting, fire doors	2004	28,610	2,861	10	2,861		7,152	56
57	Carpeting, HVAC upgrades	2004	7,459	1,492	5	1,492		3,730	57
58	Electrical panel	2005	6,342	317	20	317		476	58
59	Fire alarm system upgrades	2005	19,966	1,997	10	1,997		2,995	59
60	Boiler repairs, heating, A/C	2005	2,788	558	5	558		836	60
61	Exterior drainage	2005	1,495	149	10	149		224	61
62	Electrical wiring	2006	970	49	20	49		49	62
63	Fire system repairs, lighting,new doors	2006	24,896	2,407	10	2,407		2,324	63
64	Awning, air conditioning	2006	3,719	372	5	372		372	64
65	Sidewalk	2006	2,400	240	10	240		240	65
66									66
67									67
68	Home Office allocation			6,235		6,235			68
69									69
70	TOTAL (lines 4 thru 69)		\$ 856,671	\$ 73,686		\$ 73,686	\$	\$ 562,524	70

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

Facility Name & ID Number Eldercare of Alton # 0023317 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	\$ 497,847	\$ 43,859	\$ 43,859	\$		\$ 288,939	71
72	Current Year Purchases	35,160	3,183	3,183		4-15 yrs	3,183	72
73	Fully Depreciated Assets	241,603					231,409	73
74		(10,194)						74
75	TOTALS	\$ 764,416	\$ 47,042	\$ 47,042	\$		\$ 523,531	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)	\$ 1,670,983	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 120,728	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 120,728	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)	\$ 1,135,951	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>4/1/77</u>	\$ <u>389,032</u>	<u>20</u>	<u>20</u>	3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>181</b>		\$ <b>389,032</b>			<b>7</b>

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. /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: \$ 207 Description: office equip

(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	<b>TOTAL</b>		\$ _____	\$ _____	<b>21</b>

\* 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)	
<b>TOTAL TRAINED</b>	

- (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	\$	413	\$ 26,138	\$ 37	413	\$ 26,175	1
2	Licensed Speech and Language Development Therapist	10A col 3	hrs		120	9,968	25	120	9,993	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A col 3	hrs		647	42,543	170	647	42,713	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39	# of prescrpts				49,651		49,651	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab costs	L39				1,628			1,628	13
14	TOTAL			\$	1,180	\$ 80,277	\$ 49,883	1,180	\$ 130,160	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: 01/01/06

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 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 58,700	\$	1
2	Cash-Patient Deposits	23,573		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,519,515		3
4	Supply Inventory (priced at <u>cost</u> )	31,875		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,701		6
7	Other Prepaid Expenses	7,015		7
8	Accounts Receivable (owners or related parties)	277,339		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,919,718	\$	10
	<b>B. Long-Term Assets</b>			
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	855,015		15
16	Equipment, at Historical Cost	815,968		16
17	Accumulated Depreciation (book methods)	(1,135,951)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 535,032	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,454,750	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 484,270	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,573		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	58,888		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,413		31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,680		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 637,824	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 637,824	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,816,926	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,454,750	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,014,207	1
2	Restatements (describe):		2
3	Write off Bad Debts	(6,791)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,007,416	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(190,490)	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)	\$ (190,490)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,816,926	24 *

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

Facility Name & ID Number Eldercare of Alton

# 0023317

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,303,843	1
2	Discounts and Allowances for all Levels	(244,120)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,059,723	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	366,754	6
7	Oxygen	43,888	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 410,642	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	15,098	12
13	Barber and Beauty Care	2,780	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	73,406	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,059	19
20	Radiology and X-Ray	822	20
21	Other Medical Services	200,445	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 308,610	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	1,689	24
25	Interest and Other Investment Income***	101	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,790	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Medicare settlement prior year bad debts	28,217	28
28a	Garnishment fees 1253/misc income 701	1,954	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 30,171	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,810,936	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	956,788	31
32	Health Care	2,207,232	32
33	General Administration	1,139,304	33
<b>B. Capital Expense</b>			
34	Ownership	539,933	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	58,799	35
36	Provider Participation Fee	99,370	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,001,426	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(190,490)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (190,490)	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:

01/01/06

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	1,973	2,093	\$ 55,201	\$ 26.37	1
2	Assistant Director of Nursing	1,784	1,864	43,597	23.39	2
3	Registered Nurses	4,228	4,385	102,969	23.48	3
4	Licensed Practical Nurses	26,491	28,421	527,213	18.55	4
5	CNAs & Orderlies	73,592	78,581	855,742	10.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,790	8,560	84,743	9.90	8
9	Activity Director					9
10	Activity Assistants	5,365	5,882	49,059	8.34	10
11	Social Service Workers	5,772	6,181	73,245	11.85	11
12	Dietician	2,000	2,080	26,100	12.55	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,281	21,758	162,747	7.48	15
16	Dishwashers					16
17	Maintenance Workers	5,807	6,182	65,100	10.53	17
18	Housekeepers	25,262	25,902	181,830	7.02	18
19	Laundry	10,861	11,832	85,187	7.20	19
20	Administrator	2,000	2,080	75,707	36.40	20
21	Assistant Administrator					21
22	Other Administrative	1,040	1,040	80,836	77.73	22
23	Office Manager					23
24	Clerical	18,805	19,972	324,506	16.25	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>	3,674	4,008	84,043	20.97	33
34	TOTAL (lines 1 - 33)	216,725	230,821	\$ 2,877,825 *	\$ 12.47	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	273	\$ 7,583	L1 C3	35
36	Medical Director	monthly	24,000	L9 C3	36
37	Medical Records Consultant	72	3,187	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	21	840	L10 C3	39
40	Physical Therapy Consultant	233	13,162	L10 C3	40
41	Occupational Therapy Consultant	59	3,946	L10 C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant			L10 C3	43
44	Activity Consultant	52	3,343	L11 C3	44
45	Social Service Consultant	77	4,480	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	787	\$ 60,541		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	79	\$ 2,881	L10 C3	50
51	Licensed Practical Nurses	1,659	45,184	L10 C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,737	\$ 48,064		53

Facility Name & ID Number Eldercare of Alton

# 0023317

Report Period Beginning: 01/01/06

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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	\$ 75,707	Workers' Compensation Insurance	\$ 63,627	IDPH License Fee	\$ 995	
Steven C. Wolf	owner/exec admin	30	80,836	Unemployment Compensation Insurance	58,302	Advertising: Employee Recruitment	19,637	
				FICA Taxes	198,176	Health Care Worker Background Check	2,852	
				Employee Health Insurance	44,077	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Secretary of State	639	
				Other Employee Benefits	17,819	City of Alton	120	
				Home Office allocation	28,473	CLIA Lab Fees	150	
						Alton Telegraph	531	
						Misc 818/ home office 674	1,492	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 156,543	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 410,474		\$ 26,416		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Eldercare Inc. Home Office allocation			\$ 79,912				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	6,091
							home office allocation	2,347
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 79,912	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)							\$ 8,438	
C. Professional Services								
Vendor/Payee	Type	Amount						
Wessells and Pautsch	Legal	\$ 2,120						
Flynn and Guymon	Legal	14,426						
P Michael Read	Legal	803						
Lathrop and Gage	Legal	75						
Moore Renner and Simonin	Accounting	79						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 17,503					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; 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. \$ 827 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. \$ 99,370  
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? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 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.