

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0023317

Facility Name: Eldercare of Alton

Address: 3523 Wickenhauser Alton 62002
 Number City Zip Code

County: Madison

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

HFS ID Number: 37-1024089002

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Steven C. Wolf</u>	
	(Title) <u>Executive Administrator</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

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

Facility Name & ID Number Eldercare of Alton

0023317 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	181	TOTALS	181	66,065	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	2,358	491	1,946	4,795	8
9	SNF/PED					9
10	ICF	39,552	3,402		42,954	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,910	3,893	1,946	47,749	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.28%

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 40 and days of care provided 1,946

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 Fiscal Year: 12/31

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

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	195,114	13,909	9,804	218,827		218,827		218,827		1
2	Food Purchase		216,596		216,596		216,596	(81)	216,515		2
3	Housekeeping	213,778	31,913		245,691		245,691		245,691		3
4	Laundry	92,439	22,052		114,491		114,491		114,491		4
5	Heat and Other Utilities			136,977	136,977		136,977	1,967	138,944		5
6	Maintenance	67,381	9,655	52,854	129,890		129,890	3,674	133,564		6
7	Other (specify):*										7
8	TOTAL General Services	568,712	294,125	199,635	1,062,472		1,062,472	5,560	1,068,032		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,880,788	126,452	195,431	2,202,671	(119,599)	2,083,072		2,083,072		10
10a	Therapy					105,256	105,256		105,256		10a
11	Activities	53,117	8,143	3,977	65,237		65,237		65,237		11
12	Social Services	77,807	22	4,197	82,026		82,026		82,026		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,011,712	134,617	227,605	2,373,934	(14,343)	2,359,591		2,359,591		16
	C. General Administration										
17	Administrative	166,241		75,675	241,916		241,916	(75,675)	166,241		17
18	Directors Fees										18
19	Professional Services			9,158	9,158		9,158	4,714	13,872		19
20	Dues, Fees, Subscriptions & Promotions			45,903	45,903		45,903	(8,307)	37,596		20
21	Clerical & General Office Expenses	348,337	13,278	55,725	417,340		417,340	11,705	429,045		21
22	Employee Benefits & Payroll Taxes			372,315	372,315		372,315	30,072	402,387		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,296	4,296		4,296	1,840	6,136		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			56,333	56,333		56,333	994	57,327		26
27	Other (specify):*			200	200		200	(200)			27
28	TOTAL General Administration	514,578	13,278	619,605	1,147,461		1,147,461	(34,857)	1,112,604		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,095,002	442,020	1,046,845	4,583,867	(14,343)	4,569,524	(29,297)	4,540,227		29

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

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

Facility Name & ID Number Eldercare of Alton #0023317 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			109,138	109,138		109,138	7,561	116,699			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			543	543		543		543			32
33	Real Estate Taxes			63,780	63,780		63,780		63,780			33
34	Rent-Facility & Grounds			341,766	341,766		341,766	14,814	356,580			34
35	Rent-Equipment & Vehicles			1,303	1,303		1,303		1,303			35
36	Other (specify):*											36
37	TOTAL Ownership			516,530	516,530		516,530	22,375	538,905			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		68,144		68,144	14,343	82,487		82,487			39
40	Barber and Beauty Shops		8,431		8,431		8,431		8,431			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			99,098	99,098		99,098		99,098			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		76,575	99,098	175,673	14,343	190,016		190,016			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,095,002	518,595	1,662,473	5,276,070		5,276,070	(6,922)	5,269,148			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:

01/01/07

Ending:

12/31/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				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	(81)	2		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				18
19	Entertainment				19
20	Contributions	(200)	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	(9,239)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (9,520)		\$	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)	2,598	var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,598		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (6,922)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Eldercare of Alton

ID# 0023317

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eldercare of Alton

0023317

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	(81)	0	0	0	0	0	0	0	0	0	0	(81)	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	1,967	0	0	0	0	0	0	0	0	1,967	5
6	Maintenance	0	0	3,674	0	0	0	0	0	0	0	0	3,674	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(81)	0	5,641	0	5,560	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	(75,675)	0	0	0	0	0	0	0	0	(75,675)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	4,714	0	0	0	0	0	0	0	0	4,714	19
20	Fees, Subscriptions & Promotions	(9,239)	0	932	0	0	0	0	0	0	0	0	(8,307)	20
21	Clerical & General Office Expenses	0	0	11,705	0	0	0	0	0	0	0	0	11,705	21
22	Employee Benefits & Payroll Taxes	0	0	30,072	0	0	0	0	0	0	0	0	30,072	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,840	0	0	0	0	0	0	0	0	1,840	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	994	0	0	0	0	0	0	0	0	994	26
27	Other (specify):*	(200)	0	0	0	0	0	0	0	0	0	0	(200)	27
28	TOTAL General Administration	(9,439)	0	(25,418)	0	(34,857)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(9,520)	0	(19,777)	0	(29,297)	29							

STATE OF ILLINOIS

Facility Name & ID Number Eldercare of Alton

0023317

Report Period Beginning:

01/01/07

Ending:

Summary B

12/31/07

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	7,561	0	0	0	0	0	0	0	0	7,561	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	14,814	0	0	0	0	0	0	0	0	14,814	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	22,375	0	22,375	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)	(9,520)	0	2,598	0	(6,922)	45							

Facility Name & ID Number Eldercare of Alton

0023317

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	\$ 86,095	Eldercare Inc	0.00%	\$ 86,095	\$	1
2	V	21-1 Home Office Wages	158,073	Eldercare Inc	0.00%	158,073		2
3	V	21-3 Home Office Expenses	75,675	Eldercare Inc	0.00%	78,273	2,598	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		\$ 319,843			\$ 322,441	\$ * 2,598	14

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

Facility Name & ID Number Eldercare of Alton# 0023317Report Period Beginning: 01/01/07Ending: 12/31/07**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%	\$ 1,967	\$ 1,967	15
16	V	6 Maintenance		Eldercare Inc	0.00%	3,674	3,674	16
17	V	17 Officer Salary	86,095	Eldercare Inc	0.00%	86,095		17
18	V	19 Legal & Acctg		Eldercare Inc	0.00%	4,714	4,714	18
19	V	20 Dues & Licenses		Eldercare Inc	0.00%	932	932	19
20	V	21 Home Office Wages	158,073	Eldercare Inc	0.00%	158,073		20
21	V	21 Admin/office expenses		Eldercare Inc	0.00%	11,705	11,705	21
22	V	22 Payroll Taxes/benefits		Eldercare Inc	0.00%	30,072	30,072	22
23	V	24 Travel		Eldercare Inc	0.00%	1,840	1,840	23
24	V	26 Liability and Property insurance		Eldercare Inc	0.00%	994	994	24
25	V	30 Depreciation		Eldercare Inc	0.00%	7,561	7,561	25
26	V	34 Building Lease		Eldercare Inc	0.00%	14,814	14,814	26
27	V	17 Home Office Expenses	75,675	Eldercare Inc	0.00%		(75,675)	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		\$ 319,843			\$ 322,441	\$ * 2,598	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: 01/01/07 Ending: 12/31/07

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									\$		1
2											2
3											3
4		SEE ATTACHED									4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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: 01/01/07

Ending: 12/31/07

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	93,987	2	\$ 3,871	\$ 47,749	\$ 1,967	1
2	6	Maintenance	Patient Days	93,987	2	7,232	47,749	3,674	2
3	17	Home Office Adm Wages	Patient Days	93,987	2	169,465	169,465	86,095	3
4	19	Legal & Acctg	Patient Days	93,987	2	9,279	47,749	4,714	4
5	20	Dues & Licenses	Patient Days	93,987	2	1,834	47,749	932	5
6	21	Home Office Wages	Patient Days	93,987	2	311,144	47,749	158,073	6
7	21	Administrative expenses	Patient Days	93,987	2	23,041	47,749	11,706	7
8	22	Payroll Taxes/benefits	Patient Days	93,987	2	59,193	47,749	30,072	8
9	24	Travel	Patient Days	93,987	2	3,621	47,749	1,840	9
10	26	Liability and Property insur	Patient Days	93,987	2	1,957	47,749	994	10
11	30	Depreciation	Patient Days	93,987	2	14,882	47,749	7,561	11
12	34	Building Lease	Patient Days	93,987	2	29,160	47,749	14,814	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					\$ 634,679	\$ 169,465	\$ 322,442	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>23-1-08-17-10-105-027</u>	<u>Nursing Home & 4.42 Acres</u>	<u>\$ 58,028.58</u>	<u>\$ 58,028.58</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ 58,028.58	\$ 58,028.58

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/07 Ending:

12/31/07

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).

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

	1 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		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		7,526	15
16		Nurse Station Remodeling		1991	60,801		15			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	2,575	15	2,575		77,249	19
20		Roof & Remodeling		1993	68,700	4,580	15	4,580		65,265	20
21		Remodel Hall & Offices		1994	20,445	1,363	15	1,363		19,007	21
22		Concrete		1994	1,677	112	15	112		1,481	22
23		Roof Repairs & Asphalt		1995	2,150	90	12	90		2,150	23
24		Waste Line Renovations		1996	15,112	756	20	756		8,690	24
25		New Therapy Room		1996	3,782	252	15	252		2,963	25
26		Sidewalks & Parking Lot Seal		1996	8,930	524	5-15y	524		7,096	26
27		Landscape		1996	7,436		10			7,436	27
28		Concrete Walls & Signs		1997	14,479	965	15	965		10,136	28
29		Hall Renovations		1998	3,516	352	10	352		3,340	29
30		Laundry Boiler		1998	1,241	83	15	83		828	30
31		Parking Lot		1998	14,062	1,172	12	1,172		11,132	31
32		Landscape		1998	1,383	138	10	138		1,383	32
33		Drywall,Wall Carpet,Stained Glass Door,Lighting Chapel		1999	20,560	2,056	10	2,056		16,962	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Eldercare of Alton

0023317

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	\$	7	\$	\$	\$ 6,904	37
38	Drywall,Wall Carpet,Electric Work,and Flooring	2000	23,534	2,353	10	2,353		17,650	38
39	Duro-last Roofing System	2000	165,440	16,294	10	16,294		118,194	39
40	Roof-top HVAC Unit & 2 HVAC/Heat Unit-DR&Kitchen	2000	60,000	7,500	8	7,500		54,375	40
41	Fountain, Brick & Keystone install, Bush removal	2000	1,178	118	10	118		883	41
42	Asphalt Parking Lot	2001	7,745	645	12	645		4,195	42
43	Sidewalk entrance	2001	11,061	737	15	737		4,793	43
44	PA System	2001	573		5			573	44
45	Rooftop A/C	2001	4,133	517	8	517		3,358	45
46	Fireplace Dining Room/Awning	2001	3,917	392	10	392		2,546	46
47	New lighting-all wings/handrails	2001	49,081	3,272	15	3,272		21,269	47
48	New lighting	2002	5,788	386	15	386		2,315	48
49	Concrete pads	2002	1,882	94	20	94		565	49
50	Electrical rewiring kitchen	2003	7,770	388	20	388		1,942	50
51	Boiler room door, bathroom renovations	2003	4,564	456	10	456		2,054	51
52	Insurance proceeds on roofing system from 2000	2000	(2,500)						52
53	Generator, wiring, cable	2004	20,678	1,034	20	1,034			53
54	Handrails and installation	2004	13,980	932	15	932		4,137	54
55	Smoke detectors, emergency lighting, fire doors	2004	28,610	2,861	10	2,861		3,728	55
56	Carpeting, HVAC upgrades	2004	7,459	1,492	5	1,492		10,013	56
57	Electrical panel	2005	6,342	317	20	317		5,222	57
58	Fire alarm system upgrades	2005	19,966	1,997	10	1,997		793	58
59	Boiler repairs, heating, A/C	2005	2,788	558	5	558		4,992	59
60	Exterior drainage	2005	1,495	149	10	149		1,394	60
61	Electrical wiring	2006	970	48	20	48		374	61
62	Fire system repairs, lighting,new doors	2006	24,896	2,490	10	2,490		97	62
63	Awning, air conditioning	2006	3,719	744	5	744		4,896	63
64	Sidewalk	2006	2,400	240	10	240		1,116	64
65	Concrete steps and railings	2007	11,200	560	20	560		480	65
66	New awnings, boiler	2007	18,142	907	10	907		560	66
67	Heating/AC units	2007	8,114	811	5	811		907	67
68								811	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 881,627	\$ 63,759		\$ 63,759	\$	\$ 613,870	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: 01/01/07 Ending: 12/31/07

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	\$ 515,329	\$ 44,480	\$ 44,480	\$	5-20	\$ 318,838	71
72	Current Year Purchases	22,172	899	899		5-15	899	72
73	Fully Depreciated Assets	237,071					237,071	73
74	home office allocation		7,561	7,561				74
75	TOTALS	\$ 774,572	\$ 52,940	\$ 52,940	\$		\$ 556,808	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)	\$	1,706,095	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	116,699	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	116,699	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)	\$	1,220,574	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>341,766</u>	<u>20</u>	<u>20</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		181		\$ 341,766			7

10. Effective dates of current rental agreement:

Beginning 8/01/2007

Ending 7/31/2012

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

Fiscal Year Ending Annual Rent

12. /2008 \$ varies with Prime Rate

13. /2009 \$ varies with Prime Rate

14. /2010 \$ 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: \$ 1,303 Description: 253 office/1050 clinitron beds

(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			<u>N/A</u>		19
20					20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A col 3	hrs	\$	826	\$ 51,388	\$ 59	826	\$ 51,447	1
2	Licensed Speech and Language Development Therapist	10A col 3	hrs		111	9,411		111	9,411	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A col 3	hrs		983	58,259	382	983	58,641	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39	# of prescrpts				73,751		73,751	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	1,920	\$ 119,058	\$ 74,192	1,920	\$ 193,250	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: 01/01/07

Ending:

12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 90,715	\$	1
2	Cash-Patient Deposits	20,872		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,866,419		3
4	Supply Inventory (priced at <u>cost</u>)	34,638		4
5	Short-Term Investments			5
6	Prepaid Insurance	48,183		6
7	Other Prepaid Expenses	7,756		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,068,583	\$	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	879,970		15
16	Equipment, at Historical Cost	826,125		16
17	Accumulated Depreciation (book methods)	(1,220,573)		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)	\$ 485,522	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,554,105	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 474,808	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,872		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	81,547		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,016		31
32	Accrued Real Estate Taxes(Sch.IX-B)	57,712		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Intercompany</u>	209,968		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 854,923	\$	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)	\$ 854,923	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,699,182	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,554,105	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,816,926	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,816,926	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(117,744)	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)	\$ (117,744)	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)	\$ 1,699,182	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Eldercare of Alton

0023317

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,601,796	1
2	Discounts and Allowances for all Levels	(317,447)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,284,349	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	483,294	6
7	Oxygen	53,323	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 536,617	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	14,861	12
13	Barber and Beauty Care	2,380	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	136,440	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,338	19
20	Radiology and X-Ray	855	20
21	Other Medical Services	142,942	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 320,816	23
D. Non-Operating Revenue			
24	Contributions	2,552	24
25	Interest and Other Investment Income***	12,327	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,879	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Garnishment fees	1,009	28
28a	Misc Income	656	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,665	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,158,326	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,062,472	31
32	Health Care	2,373,934	32
33	General Administration	1,147,461	33
B. Capital Expense			
34	Ownership	516,530	34
C. Ancillary Expense			
35	Special Cost Centers	76,575	35
36	Provider Participation Fee	99,098	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,276,070	40
41	Income before Income Taxes (line 30 minus line 40)**	(117,744)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (117,744)	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: 01/01/07

Ending:

12/31/07

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,099	2,219	\$ 60,362	\$ 27.20	1
2	Assistant Director of Nursing	1,849	1,909	44,890	23.51	2
3	Registered Nurses	4,563	4,825	115,554	23.95	3
4	Licensed Practical Nurses	26,776	28,938	572,982	19.80	4
5	CNAs & Orderlies	74,860	80,128	899,843	11.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,710	8,030	88,974	11.08	8
9	Activity Director					9
10	Activity Assistants	5,441	5,881	53,117	9.03	10
11	Social Service Workers	6,193	6,500	77,807	11.97	11
12	Dietician					12
13	Food Service Supervisor	1,928	1,968	27,120	13.78	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,091	21,483	167,994	7.82	15
16	Dishwashers					16
17	Maintenance Workers	5,810	6,239	67,381	10.80	17
18	Housekeepers	26,879	28,466	213,778	7.51	18
19	Laundry	11,679	12,388	92,439	7.46	19
20	Administrator	2,000	2,080	80,146	38.53	20
21	Assistant Administrator					21
22	Other Administrative	1,040	1,040	86,095	82.78	22
23	Office Manager					23
24	Clerical	18,698	19,872	348,337	17.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Inservice</u>	4,119	4,407	98,183	22.28	33
34	TOTAL (lines 1 - 33)	221,735	236,373	\$ 3,095,002 *	\$ 13.09	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	275	\$ 9,804	1-3	35
36	Medical Director	monthly	24,000	9-3	36
37	Medical Records Consultant	78	3,090	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	21	840	10-3	39
40	Physical Therapy Consultant	242	13,599	10-3	40
41	Occupational Therapy Consultant	98	6,590	10-3	41
42	Respiratory Therapy Consultant	15	1,000	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	64	3,977	11-3	44
45	Social Service Consultant	67	4,197	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	860	\$ 67,097		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	42	\$ 1,774	10-3	50
51	Licensed Practical Nurses	1,340	38,044	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,382	\$ 39,818		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? 5-7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 202 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. \$ 99,098
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. \$ N/A
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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.