

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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.

<p>I. IDPH License ID Number: <u>0045609</u></p> <p>Facility Name: <u>ALHAMBRA CARE CENTER</u></p> <p>Address: <u>417 EAST MAIN, BOX 310</u> <u>ALHAMBRA</u> <u>62001</u> Number City Zip Code</p> <p>County: <u>MADISON</u></p> <p>Telephone Number: <u>(618) 488-3565</u> Fax # <u>(618) 488-2517</u></p> <p>HFS ID Number: <u>37-1415755</u></p> <p>Date of Initial License for Current Owners: <u>02/08/02</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>MARK J. KORTE, CPA</u> Telephone Number: <u>(618) 654-9895</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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 type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/08</u> to <u>12/31/08</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>DEMARIS A. WEDER</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>ADMINISTRATOR</u></td> <td></td> </tr> <tr> <td rowspan="5" style="width: 20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>MARK J. KORTE, CPA</u> <u>PRINCIPAL</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>SCHEFFEL & COMPANY, P.C.</u> <u>P.O. BOX 374, HIGHLAND, IL 62249</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(618) 654-9895</u> Fax # <u>(618) 654-9898</u></td> <td></td> </tr> <tr> <td>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</td> <td></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>DEMARIS A. WEDER</u>			(Title) <u>ADMINISTRATOR</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>MARK J. KORTE, CPA</u> <u>PRINCIPAL</u>		(Firm Name & Address) <u>SCHEFFEL & COMPANY, P.C.</u> <u>P.O. BOX 374, HIGHLAND, IL 62249</u>		(Telephone) <u>(618) 654-9895</u> Fax # <u>(618) 654-9898</u>		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	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ALHAMBRA CARE CENTER

0045609 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	11	Skilled (SNF)	11	4,015	1
2		Skilled Pediatric (SNF/PED)			2
3	73	Intermediate (ICF)	73	26,645	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	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			1,397	1,397	8
9	SNF/PED					9
10	ICF	10,866	5,225		16,091	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,866	5,225	1,397	17,488	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.04%

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

NONE (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)

N/A

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 02/08/02

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

YES Date 12/14/01 NO

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

YES NO If YES, enter number of beds certified 11 and days of care provided 1,397

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE INSURANCE CORP

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number

ALHAMBRA CARE CENTER

0045609

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	86,480	2,744	4,338	93,562		93,562		93,562		1
2	Food Purchase		97,252		97,252		97,252		97,252		2
3	Housekeeping	72,244	21,216		93,460		93,460		93,460		3
4	Laundry	20,965	5,484		26,449		26,449		26,449		4
5	Heat and Other Utilities			78,880	78,880		78,880		78,880		5
6	Maintenance	21,363	24,386		45,749		45,749		45,749		6
7	Other (specify):* UNIFORMS			1,142	1,142		1,142		1,142		7
8	TOTAL General Services	201,052	151,082	84,360	436,494		436,494		436,494		8
	B. Health Care and Programs										
9	Medical Director	68,531		5,926	74,457		74,457		74,457		9
10	Nursing and Medical Records	658,938	107,256	674	766,868		766,868		766,868		10
10a	Therapy			128,873	128,873		128,873		128,873		10a
11	Activities	28,918	7,460		36,378		36,378		36,378		11
12	Social Services	24,488		2,806	27,294		27,294		27,294		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	780,875	114,716	138,279	1,033,870		1,033,870		1,033,870		16
	C. General Administration										
17	Administrative	16,055			16,055		16,055		16,055		17
18	Directors Fees										18
19	Professional Services			16,634	16,634		16,634	(2,089)	14,545		19
20	Dues, Fees, Subscriptions & Promotions			30,433	30,433		30,433	(23,060)	7,373		20
21	Clerical & General Office Expenses	55,017	16,587	9,455	81,059		81,059	(5,922)	75,137		21
22	Employee Benefits & Payroll Taxes			146,560	146,560		146,560		146,560		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,225	8,225		8,225		8,225		24
25	Other Admin. Staff Transportation			128	128		128		128		25
26	Insurance-Prop.Liab.Malpractice			47,961	47,961		47,961		47,961		26
27	Other (specify):* LIFE INSURANCE			930	930		930		930		27
28	TOTAL General Administration	71,072	16,587	260,326	347,985		347,985	(31,071)	316,914		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,052,999	282,385	482,965	1,818,349		1,818,349	(31,071)	1,787,278		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number ALHAMBRA CARE CENTER

#0045609

Report Period Beginning:

01/01/08

Ending:

12/31/08

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			30,015	30,015		30,015	28,816	58,831			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,549	15,549		15,549	31,482	47,031			32
33	Real Estate Taxes			19,370	19,370		19,370		19,370			33
34	Rent-Facility & Grounds			159,554	159,554		159,554	(159,554)				34
35	Rent-Equipment & Vehicles			265	265		265		265			35
36	Other (specify):*											36
37	TOTAL Ownership			224,753	224,753		224,753	(99,256)	125,497			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			1,214	1,214		1,214		1,214			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			46,557	46,557		46,557		46,557			42
43	Other (specify):* BAD DEBT EXP			13,717	13,717		13,717		13,717			43
44	TOTAL Special Cost Centers			61,488	61,488		61,488		61,488			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,052,999	282,385	769,206	2,104,590		2,104,590	(130,327)	1,974,263			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

ALHAMBRA CARE CENTER

ID# 0045609

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 ALHAMBRA CARE CENTER# 0045609

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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 Program	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,089)	0	0	0	0	0	0	0	0	0	0	(2,089)	19
20	Fees, Subscriptions & Promotions	(23,060)	0	0	0	0	0	0	0	0	0	0	(23,060)	20
21	Clerical & General Office Expenses	(5,922)	0	0	0	0	0	0	0	0	0	0	(5,922)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(31,071)	0	0	0	0	0	0	0	0	0	0	(31,071)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(31,071)	0	0	0	0	0	0	0	0	0	0	(31,071)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALHAMBRA CARE CENTER

0045609

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(4,319)	33,135	0	0	0	0	0	0	0	0	0	28,816	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(282)	31,764	0	0	0	0	0	0	0	0	0	31,482	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(159,554)	0	0	0	0	0	0	0	0	0	(159,554)	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	(4,601)	(94,655)	0	(99,256)	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)	(35,672)	(94,655)	0	(130,327)	45								

Facility Name & ID Number ALHAMBRA CARE CENTER

0045609

Report Period Beginning: 01/01/08 Ending: 12/31/08

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
DEMARIS A & CHARLES WEDER	100	N/A				

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	34 RENT-FACILITY & EQ	\$ 159,554	DEMARIS A. & CHARLES WEDER	100.00%	\$	\$ (159,554)	1
2	V	30 DEPRECIATION		DEMARIS A. & CHARLES WEDER	100.00%	33,135	33,135	2
3	V	32 INTEREST		DEMARIS A. & CHARLES WEDER	100.00%	31,764	31,764	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		\$ 159,554			\$ 64,899	\$ * (94,655)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

ALHAMBRA CARE CENTER

#

0045609

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	DEMARIS A WEDER	ADMINISTRATOR	ADMIN	50.00		40	100.00	SALARY	\$ 16,055	17-1	1
2	CHARLES WEDER	SPOUSE	N/A	50.00				NONE		N/A	2
3	MARILYN K EYEMAN	DIR OF NURSING	DIR OF NURS			40	100.00	SALARY	68,131	9-1	3
4	ANGELA D SCOGGINS	DIR OF NURSING	DIR OF NURS			40	100.00	SALARY	400	9-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 84,586		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ALHAMBRA CARE CENTER

0045609

Report Period Beginning:

01/01/08

Ending: 12/31/08

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	Demaris & Charles Weder	x		Building & Equipment	\$5,225.00	12/14/01	\$ 695,000	\$ 572,038	10/14/08	6.5000	\$ 31,764	1				
2												2				
3												3				
4												4				
5												5				
Working Capital																
6	Bank of Edwardsville		x	Operating Cash	Interest Only	12/24/03	150,000		12/23/08	prime+.75	5,904	6				
7	Charles Weder	x		Operating Cash	\$3,500.00	08/02/05	196,798	91,938	02/15/09	6.5000	5,852	7				
8	Bank of Edwardsville		x	Operating Cash	Interest Only	12/23/08	200,000	197,870	5/1/09	4.0000		8				
9	TOTAL Facility Related				\$8,725.00		\$ 1,241,798	\$ 861,845			\$ 43,521	9				
B. Non-Facility Related*																
10	Chrysler Financial		x	Non-Care Vehicle	\$432.28		25,937	2,553	6/29/09	4.5000	282	10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related				\$432.28		\$ 25,937	\$ 2,553			\$ 282	14				
15	TOTALS (line 9+line14)						\$ 1,267,735	\$ 864,399			\$ 43,803	15				

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

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

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

Facility Name & ID Number ALHAMBRA CARE CENTER

0045609

Report Period Beginning:

01/01/08

Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,454 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>48 BEDS</u>	<u>11,027</u>	<u>2001</u>	<u>\$ 4,656</u>	<u>1</u>
2	<u>36 BEDS</u>	<u>4,156</u>	<u>2001</u>	<u>9,936</u>	<u>2</u>
3	TOTALS	15,183		\$ 14,592	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	6		2001	1971	\$ 23,856	\$ 597	40	\$ 597		\$ 4,125	4
5	18		2001	1973	71,520	1,788	40	1,788		12,367	5
6	24		2001	1976	119,424	2,986	40	2,986		20,650	6
7	24		2001	1979	94,512	2,363	40	2,363		16,343	7
8	12		2001	1983	144,096	3,602	40	3,602		24,917	8
	Improvement Type**										
9	LEASED EQUIPMENT FROM RELATE PARTY			2001	215,000	21,500	10	21,500		148,708	9
10	OFFICE			1971	12,000	300	40	300		2,075	10
11	AWNING			2002	755	50	15	50		323	11
12	FENCE			2002	600		5			600	12
13	TILE FLOORING			2004	2,643	132	20	132		595	13
14	ROOF			2006	8,050	201	40	201		587	14
15	KITCHEN CABINETS			2006	12,738	1,274	10	1,274		3,397	15
16	DOORS/WINDOWS			2006	15,768	394	40	394		1,018	16
17	ELECTRICAL UPGRADE			2006	1,828	46	40	46		118	17
18	FLOORING CARPET			2006	580	58	10	58		164	18
19	TILE FLOORING			2006	3,117	312	10	312		831	19
20	EXTERIOR DOORS			2008	7,400	617	10	617		617	20
21	PORCH & ELECTRICAL WIRING			2008	9,384	137	40	137		137	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

*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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 743,271	\$ 36,357		\$ 36,357	\$	\$ 237,572	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number ALHAMBRA CARE CENTER

0045609

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	\$ 164,153	\$ 17,499	\$ 17,499	\$	Life 5	\$ 79,939	71
72	Current Year Purchases	34,398	2,475	2,475		Life 5	2,475	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 198,551	\$ 19,974	\$ 19,974	\$		\$ 82,414	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 CARE VEHICLE	2000 GMC SAVANA TRAN	2003	\$ 25,000	\$ 2,500	\$ 2,500	\$	10	\$ 13,125	76
77										77
78										78
79										79
80	TOTALS			\$ 25,000	\$ 2,500	\$ 2,500	\$		\$ 13,125	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 981,414	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 58,831	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 58,831	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 333,111	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	DURANGO - NON PATIENT CARE	\$ 32,692	\$ 3,269	\$ 14,711	86
87	MAINT VEHICLE 97 DODGE DAKOTA	10,500	1,050	1,138	87
88					88
89					89
90					90
91	TOTALS	\$ 43,192	\$ 4,319	\$ 15,849	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: _____

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

If NO, see instructions.

YES NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

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

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)							
					Units	Cost										
1	Licensed Occupational Therapist		hrs	\$				\$								1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):															13
14	TOTAL			\$				\$		\$				\$		14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **ALHAMBRA CARE CENTER**# **0045609**Report Period Beginning: **01/01/08**Ending: **12/31/08**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/08**

(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	\$ 4,417	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	312,971		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,250		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 345,637	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	6,436		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	62,862		15
16	Equipment, at Historical Cost	266,743		16
17	Accumulated Depreciation (book methods)	(119,773)		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)	\$ 216,268	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 561,906	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 69,705	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	237,557		29
30	Accrued Salaries Payable	35,380		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,227		31
32	Accrued Real Estate Taxes(Sch.IX-B)	18,449		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 363,318	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	54,804		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)	\$ 54,804	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 418,122	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 143,784	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 561,906	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 168,329	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 168,329	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(24,545)	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)	\$ (24,545)	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)	\$ 143,784	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ALHAMBRA CARE CENTER

0045609

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	\$ 2,075,641	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,075,641	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>MISC INCOME</u>	4,404	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,404	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,080,045	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	436,494	31
32	Health Care	1,033,870	32
33	General Administration	347,985	33
B. Capital Expense			
34	Ownership	224,753	34
C. Ancillary Expense			
35	Special Cost Centers	61,488	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,104,590	40
41	Income before Income Taxes (line 30 minus line 40)**	(24,545)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (24,545)	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.

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

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

Facility Name & ID Number ALHAMBRA CARE CENTER

0045609

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	1,944	2,060	\$ 54,432	\$ 24.66	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,410	2,482	54,100	21.79	3
4	Licensed Practical Nurses	15,549	16,047	304,150	18.75	4
5	CNAs & Orderlies	31,342	32,980	314,787	9.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,227	3,402	28,919	8.50	9
10	Activity Assistants					10
11	Social Service Workers	1,721	1,884	24,488	13.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,119	9,461	86,480	9.13	15
16	Dishwashers					16
17	Maintenance Workers	1,935	2,000	21,469	10.73	17
18	Housekeepers	8,134	8,539	72,244	8.46	18
19	Laundry	2,519	2,691	20,859	7.75	19
20	Administrator	2,065	2,080	16,055	8.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,307	4,584	55,016	12.00	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)					33
34	TOTAL (lines 1 - 33)	84,272	88,210	\$ 1,052,999 *	\$ 11.94	34

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	108	\$ 4,338	L1 & C3	35
36	Medical Director	174	5,926	L9 & C3	36
37	Medical Records Consultant	9	319	L9 & C3	37
38	Nurse Consultant	10	355	L10 & C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	1,835	45,879	L10a & C3	40
41	Occupational Therapy Consultant	2,024	50,592	L10a & C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,296	32,402	L10a & C3	43
44	Activity Consultant				44
45	Social Service Consultant	51	2,806	L12 & C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	5,507	\$ 142,617		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number ALHAMBRA CARE CENTER

0045609

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	
Demaris A. Weder	Administrative	50	\$ 16,055	Workers' Compensation Insurance	\$ 27,221	IDPH License Fee	\$	
				Unemployment Compensation Insurance	16,630	Advertising: Employee Recruitment	5,430	
				FICA Taxes	78,477	Health Care Worker Background Check	1,090	
				Employee Health Insurance	20,439	(Indicate # of checks performed <u>86</u>)		
				Employee Meals	0	Resident Background Check	41	
				Illinois Municipal Retirement Fund (IMRF)*	0	Advertising	23,060	
				SIMPLE Retirement Plan	3,793	News Subscriptions	197	
						Dues	656	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 16,055			Less: Public Relations Expense	()	
(List each licensed administrator separately.)						Non-allowable advertising	(21,036)	
						Yellow page advertising	(2,024)	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 7,373	
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
The Scheffel Companies	Accounting		\$ 14,270			\$	Out-of-State Travel	\$
Elvidge Kelly Law	Legal		1,489					
Stephen Wilfong	Accounting		275				In-State Travel	
Larsen, Feist & Hess	Legal		600					
							Seminar Expense	
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 16,634	TOTAL		\$	TOTAL	\$
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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? YES
If YES, give association name and amount. INHA \$100.00
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,985 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. \$ 46,557
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? YES/TIME CA If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ No Employee Meals
- (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? 20%
 - 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 FOR VAN & TRUCK - NO FOR THE DURANGO
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
 - 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: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Alhambra Care Center, Inc.

IDPH# 000045609

Page #15

EXPLANATION OF TRAINING PROGRAM

ALL NURSES AIDES WERE TRAINED AND
CERTIFIED PRIOR TO BEGINNING EMPLOYMENT
WITH THE ALHAMBRA CARE CENTER, INC.

SEE ACCOUNTANTS' COMPILATION REPORT

ALHAMBRA CARE CENTER
IDPH# 000045609
PAGE # 19 Schedule
Taxable Income Reconciliation

Income Per Books (Accrual Basis)	(24,545)
Adjustments to Taxable Income (Cash Basis)	
Record 12/07 Accounts Receivable	270,405
Record 12/07 Prepaid Insurance	17,407
Record 12/07 Accounts Payable	(101,527)
Record 12/07 Unemployment Taxes	(5,237)
Record 12/07 Accrued Real Estate Taxes Payable	(17,527)
Record 12/07 Accrued Wages	(27,024)
Reverse 12/08 Accounts Receivable	(309,975)
Reverse 12/08 Prepaid Insurance	(28,250)
Reverse 12/08 Accounts Payable	68,218
Reverse 12/08 Unemployment Taxes	2,227
Reverse 12/08 Accrued Real Estate Taxes Payable	18,449
Reverse 12/08 Accrued Wages	35,379
Tax Depreciation Adjustment	(7,261)
Taxable Income (Loss)	<u>(109,261)</u>

SEE ACCOUNTANT'S COMPILATION REPORT