



Facility Name & ID Number Calvin Johnson Care Center# 0023309 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>132</u>	Skilled (SNF)	<u>132</u>	<u>48,312</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>48</u>	Intermediate (ICF)	<u>48</u>	<u>17,568</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>180</u>	TOTALS	<u>180</u>	<u>65,880</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,572</u>	<u>377</u>	<u>6,116</u>	<u>11,065</u>	8
9	SNF/PED					9
10	ICF	<u>33,838</u>	<u>1,334</u>	<u>933</u>	<u>36,105</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>38,410</u>	<u>1,711</u>	<u>7,049</u>	<u>47,170</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.60%

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

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

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

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

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

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

YES  NO 

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

YES  NO 

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

Date started 04/01/1977

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

YES  Date \_\_\_\_\_ NO 

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

YES  NO  If YES, enter number of beds certified 48 and days of care provided 1,581Medicare Intermediary WPS

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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
	<b>A. General Services</b>										
1	Dietary	230,828	20,827	9,594	261,249	400	261,649		261,649		1
2	Food Purchase		211,465		211,465		211,465		211,465		2
3	Housekeeping	192,537	28,010		220,547		220,547		220,547		3
4	Laundry	100,418	16,742		117,160		117,160		117,160		4
5	Heat and Other Utilities			244,267	244,267		244,267	1,951	246,218		5
6	Maintenance	107,192	4,857	45,835	157,884		157,884	2,892	160,776		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>630,975</b>	<b>281,901</b>	<b>299,696</b>	<b>1,212,572</b>	<b>400</b>	<b>1,212,972</b>	<b>4,843</b>	<b>1,217,815</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			23,500	23,500		23,500		23,500		9
10	Nursing and Medical Records	2,509,833	440,381	53,301	3,003,515	(150,335)	2,853,180		2,853,180		10
10a	Therapy					30,439	30,439		30,439		10a
11	Activities	64,152	10,345	1,106	75,603	350	75,953		75,953		11
12	Social Services	82,575		2,736	85,311	450	85,761		85,761		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,656,560</b>	<b>450,726</b>	<b>80,643</b>	<b>3,187,929</b>	<b>(119,096)</b>	<b>3,068,833</b>		<b>3,068,833</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	178,657		80,188	258,845		258,845	(80,188)	178,657		17
18	Directors Fees										18
19	Professional Services			910	910		910	1,772	2,682		19
20	Dues, Fees, Subscriptions & Promotions			46,259	46,259		46,259	(31,679)	14,580		20
21	Clerical & General Office Expenses	360,128	12,917	49,410	422,455	2,050	424,505	11,192	435,697		21
22	Employee Benefits & Payroll Taxes			431,980	431,980	(3,750)	428,230	28,794	457,024		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,810	9,810		9,810	(1,441)	8,369		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			100,193	100,193		100,193	1,132	101,325		26
27	Other (specify):* <b>taxes, contributions</b>			159,232	159,232		159,232	(159,232)			27
28	<b>TOTAL General Administration</b>	<b>538,785</b>	<b>12,917</b>	<b>877,982</b>	<b>1,429,684</b>	<b>(1,700)</b>	<b>1,427,984</b>	<b>(229,650)</b>	<b>1,198,334</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,826,320</b>	<b>745,544</b>	<b>1,258,321</b>	<b>5,830,185</b>	<b>(120,396)</b>	<b>5,709,789</b>	<b>(224,807)</b>	<b>5,484,982</b>		<b>29</b>

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

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

Facility Name & ID Number Calvin Johnson Care Center

#0023309

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## 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	
	<b>D. Ownership</b>											
30	Depreciation			84,474	84,474		84,474	11,929	96,403			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,919	28,919		28,919	(12,410)	16,509			32
33	Real Estate Taxes			58,095	58,095		58,095		58,095			33
34	Rent-Facility & Grounds			444,913	444,913		444,913	14,844	459,757			34
35	Rent-Equipment & Vehicles			19,901	19,901		19,901		19,901			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			636,302	636,302		636,302	14,363	650,665			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			195	195	120,396	120,591		120,591			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		13,875		13,875		13,875		13,875			41
42	Provider Participation Fee			98,820	98,820		98,820		98,820			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		13,875	99,015	112,890	120,396	233,286		233,286			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,826,320	759,419	1,993,638	6,579,377		6,579,377	(210,444)	6,368,933			45

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

Facility Name & ID Number Calvin Johnson Care Center

# 0023309

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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	(12,410)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(35)	21		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	(22,188)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(6,241)	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	(9,420)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(152,991)	27		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule see sch 5A	(6,495)	var		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (209,780)		\$	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)	(664)	var	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (664)		36
(sum of SUBTOTALS				
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (210,444)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Calvin Johnson Care Center

ID# 0023309

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Lobbying Expense	\$ (300)	20	1
2	Cost of Tee Shirts sold to employees	(2,564)	22	2
3	Chamber of Commerce	(500)	20	3
4	Out of state travel	(3,131)	24	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(6,495)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Calvin Johnson Care Center

# 0023309

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,951	0	0	0	0	0	0	0	0	1,951	5
6	Maintenance	0	0	2,892	0	0	0	0	0	0	0	0	2,892	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	4,843	0	0	0	0	0	0	0	0	4,843	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	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	0	0	1,772	0	0	0	0	0	0	0	0	1,772	19
20	Fees, Subscriptions & Promotions	(32,408)	0	729	0	0	0	0	0	0	0	0	(31,679)	20
21	Clerical & General Office Expenses	(35)	0	11,227	0	0	0	0	0	0	0	0	11,192	21
22	Employee Benefits & Payroll Taxes	(2,564)	0	31,358	0	0	0	0	0	0	0	0	28,794	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,131)	0	1,690	0	0	0	0	0	0	0	0	(1,441)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,132	0	0	0	0	0	0	0	0	1,132	26
27	Other (specify):*	(159,232)	0	0	0	0	0	0	0	0	0	0	(159,232)	27
28	<b>TOTAL General Administration</b>	(197,370)	0	47,908	0	0	0	0	0	0	0	0	(149,462)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(197,370)	0	52,751	0	0	0	0	0	0	0	0	(144,619)	29

STATE OF ILLINOIS

Facility Name & ID Number Calvin Johnson Care Center

# 0023309

Report Period Beginning:

01/01/2008 Ending:

Summary B

12/31/2008

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	11,929	0	0	0	0	0	0	0	0	11,929	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,410)	0	0	0	0	0	0	0	0	0	0	(12,410)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	14,844	0	0	0	0	0	0	0	0	14,844	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(12,410)</b>	<b>0</b>	<b>26,773</b>	<b>0</b>	<b>14,363</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(209,780)</b>	<b>0</b>	<b>79,524</b>	<b>0</b>	<b>(130,256)</b>	<b>45</b>							

Facility Name & ID Number Calvin Johnson Care Center

# 0023309

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

**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
		See Attached				

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	\$ 86,503	Eldercare Inc	0.00%	\$ 86,503	\$	1
2	V	21-1 Home Office Wages	163,079	Eldercare Inc	0.00%	163,079		2
3	V	17-3 Home Office Adm expenses	80,188	Eldercare Inc	0.00%	79,524	(664)	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		\$ 329,770			\$ 329,106	\$ * (664)	14

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

Facility Name & ID Number Calvin Johnson Care Center# 0023309Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## 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%	\$ 1,951	\$ 1,951	15
16	V	6 Maintenance		Eldercare Inc	0.00%	2,892	2,892	16
17	V	17 Administrative Wages	86,503	Eldercare Inc	0.00%	86,503		17
18	V	19 Professional Services		Eldercare Inc	0.00%	1,772	1,772	18
19	V	20 Fees,Subscriptions		Eldercare Inc	0.00%	729	729	19
20	V	21 Clerical and office wages	163,079	Eldercare Inc	0.00%	163,079		20
21	V	21 Admin &General Office		Eldercare Inc	0.00%	11,227	11,227	21
22	V	22 Employee Benefits		Eldercare Inc	0.00%	31,358	31,358	22
23	V	24 Travel&Seminars		Eldercare Inc	0.00%	1,690	1,690	23
24	V	26 Ins. Prop		Eldercare Inc	0.00%	1,132	1,132	24
25	V	30 Depreciation		Eldercare Inc	0.00%	11,929	11,929	25
26	V	34 Rent Facility		Eldercare Inc	0.00%	14,844	14,844	26
27	V	17 Home Office Admin expenses		Eldercare Inc	0.00%			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		\$ 249,582			\$ 329,106	\$ * 79,524	39

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

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## 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		SEE ATTACHED									3
4											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 Calvin Johnson Care Center

# 0023309

Report Period Beginning: 01/01/2008

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Census	92,662	2	\$ 3,833	\$ 47,170	\$ 1,951	1
2	6	Maintenance	Census	92,662	2	5,682	47,170	2,892	2
3	17	Administrative	Census	92,662	2	169,928	169,928	86,503	3
4	19	Professional Services	Census	92,662	2	3,481	47,170	1,772	4
5	20	Fees,Subscriptions	Census	92,662	2	1,432	47,170	729	5
6	21	Clerical and office wages	Census	92,662	2	320,356	320,356	163,079	6
7	21	Admin &General Office	Census	92,662	2	22,055	47,170	11,227	7
8	22	Employee Benefits	Census	92,662	2	61,602	47,170	31,359	8
9	24	Travel&Seminars	Census	92,662	2	3,319	47,170	1,690	9
10	26	Ins. Prop	Census	92,662	2	2,223	47,170	1,132	10
11	30	Depreciation	Census	92,662	2	23,434	47,170	11,929	11
12	34	Rent Facility	Census	92,662	2	29,160	47,170	14,844	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					\$ 646,505	\$ 490,284	\$ 329,107	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6	The Bank of Edwardsville		X	Working Capital	Demand	6/7/07	2,000,000	772,307	3/9/09	varies	28,919	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 2,000,000	\$ 772,307			\$ 28,919	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 2,000,000	\$ 772,307			\$ 28,919	15								

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2007 report.	\$	<b>56,100</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<b>55,995</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(105)</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>58,200</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>58,095</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<b>42,305</b>	<b>8</b>
	2004	<b>46,776</b>	<b>9</b>
	2005	<b>50,327</b>	<b>10</b>
	2006	<b>53,944</b>	<b>11</b>
	2007	<b>55,995</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Calvin Johnson Care Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0023309

CONTACT PERSON REGARDING THIS REPORT David Read

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

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-20.0-211-030</u>	<u>Nursing Home 4.18 Acres</u>	<u>\$ 55,995.00</u>	<u>\$ 55,995.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	<b>\$ 55,995.00</b>	<b>\$ 55,995.00</b>

**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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number Calvin Johnson Care Center

# 0023309 Report Period Beginning:

01/01/2008 Ending:

12/31/2008

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

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

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

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

Facility Name &amp; ID Number Calvin Johnson Care Center

# 0023309

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Bldg Imp			1982	600		10			600	9
10	1983 Audit			1983	4,085		10				10
11	Bldg Imp			1983	39,106		10			39,106	11
12	Black Top			1983	1,033		12			1,033	12
13	Remodeling			1984	7,160		20			7,160	13
14	Landscaping			1984	3,604		10			3,604	14
15	Windows			1985	1,454		10			1,454	15
16	A/C System			1985	1,983		8			1,983	16
17											17
18	Sidewalks			1985	7,800		15			7,800	18
19	Driveway Sealer			1985	810		5			810	19
20	Parking Stripes			1986	524		5			524	20
21	Renovate Halls			1988	21,660		10			21,660	21
22	Renovate Baths			1989	14,042		10			14,042	22
23	Roof Remodeling			1990	42,560		10-15y			42,560	23
24	Remodeling (less retirement in 2008 1621)			1991	46,957	506	5-10y	506		45,693	24
25	Remodeling			1992	107,939		5-15y			107,939	25
26	Remodeling (less retirement in 2008 9905)			1993	74,695	2,438	5-15y	2,438		74,695	26
27	Hall Monitor System			1994	3,208	204	15-20y	204		3,005	27
28	Improvements			1995	24,740	250	5-15y	250		24,365	28
29	Elevator			1996	4,929	329	15	329		4,108	29
30	rounding				3						30
31	Rooftop			1996	10,643		8			10,643	31
32											32
33	A/C Work & Carpeting			1997	6,164	269	5-15y	269		5,357	33
34	Fence			1998	1,250		8			1,250	34
35	Interior Renovation			1998	11,308	569	5-15y	569		10,974	35
36	Interior Renovation			1999	53,624	4,555	5-15y	4,555		49,440	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Calvin Johnson Care Center

# 0023309

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Cubicle Tracks	2000	\$ 14,481	\$ 965	15	\$ 965	\$	\$ 8,206	37
38	Renovations Interior	2000	12,015	1,202	10	1,202		10,213	38
39	Renovations Interior	2000	4,776		5			4,776	39
40	Landscaping	2000	21,213	2,121	10	2,121		17,501	40
41	Renovations Interior	2001	8,725	1,552	10	1,552		4,844	41
42	Renovations Interior	2001	45,895	3,060	15	3,060		23,712	42
43	Kitchen hood- stainless steel	2002	21,235	1,416	15	1,416		8,848	43
44	Fire alarm control panel	2002	5,857	164	10	164		1,064	44
45	insurance proceeds for control panel	2003	(4,221)						45
46	Fire Alarm panel	2003	1,120	112	10	112		672	46
47	Bldg generator	2003	19,164	958	20	958		5,749	47
48	HVAC units	2003	6,158	616	10	616		6,158	48
49	Wiring Hall 400, new door	2004	3,361	168	20	168		840	49
50	guardrails, exhaust fan	2004	2,671	178	15	178		801	50
51	Fire alarm pulls, dampers, wiring	2004	4,749	475	10	475		2,374	51
52	Carpeting, vinyl base	2004	4,875	975	5	975		4,387	52
53	Roof, door locks, wall coverings	2005	39,288	3,929	10	3,929		13,751	53
54	Entrance Canopy	2005	10,641	2,338	5	2,338		8,303	54
55	Roof,ductwork, doors, plumbing	2006	57,665	5,766	10	5,766		14,416	55
56	Air conditioning	2006	7,999	1,598	5	1,598		3,999	56
57	lighting, sidewalks, patio	2006	31,149	2,077	15	2,077		5,192	57
58	New decking	2006	37,555	3,754	10	3,754		9,389	58
59	Heating/AC units, new carpeting	2007	13,017	2,603	5	2,603		3,905	59
60	New awnings, canopy, laundry	2007	11,508	1,151	10	1,151		1,726	60
61	Handrails, electrical work	2007	4,203	280	15	280		560	61
62	Boiler, Steel fire doors	2008	9,115	456	20	456		456	62
63	New wood doors and frames	2008	5,045	84	15	84		84	63
64	Windows w/ marble sills, elevator doors, fire alarm	2008	13,720	1,029	10	1,029		1,029	64
65	Carpeting, heating/AC,sewer line	2008	6,384	638	5	638		638	65
66	Landscape paver stones	2008	1,457	146	10	146		146	66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 912,701	\$ 48,931		\$ 48,931	\$	\$ 643,544	70

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

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	\$ 341,796	\$ 31,000	\$ 31,000	\$	5-20 yr	\$ 251,636	71
72	Current Year Purchases	50,241	3,339	3,339		3-20 yr	3,339	72
73	Fully Depreciated Assets	249,055					240,955	73
74	Home Office allocation		11,929	11,929				74
75	TOTALS	\$ 641,092	\$ 46,268	\$ 46,268	\$		\$ 495,930	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	1971 Bus & lift	1977	\$ 8,638	\$	\$	\$		\$ 8,638	76
77	Patient Transport	2- 1997 Ford Buses w/ lifts	2004	8,269					8,269	77
78	Facility Use	1999 Dodge Caravan	2005	7,214	1,204	1,204		3	7,214	78
79										79
80	TOTALS			\$ 24,121	\$ 1,204	\$ 1,204	\$		\$ 24,121	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)		\$ 1,577,914	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 96,403	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 96,403	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)		\$ 1,163,595	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.



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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L 10A	hrs	\$	54	\$ 5,129	\$ 28	54	\$ 5,157	1
2	Licensed Speech and Language Development Therapist	L 10A	hrs		34	2,878		34	2,878	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A	hrs		307	22,322	81	307	22,403	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab</u>	L39				11,712			11,712	12
13	Other (specify): <u>X-Ray</u>	L39				818			818	13
14	TOTAL			\$	396	\$ 42,859	\$ 109	396	\$ 42,968	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.

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## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 45,969	\$	1
2	Cash-Patient Deposits	58,283		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,942,284		3
4	Supply Inventory (priced at <u>cost</u> )	77,373		4
5	Short-Term Investments			5
6	Prepaid Insurance	46,026		6
7	Other Prepaid Expenses	36,346		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,206,281	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable	33,057		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	908,616		15
16	Equipment, at Historical Cost	665,213		16
17	Accumulated Depreciation (book methods)	(1,163,595)		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): <u>Alton</u>	681,287		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,124,578	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,330,859	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 704,021	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	58,283		28
29	Short-Term Notes Payable	772,307		29
30	Accrued Salaries Payable	134,932		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,250		31
32	Accrued Real Estate Taxes(Sch.IX-B)	58,200		32
33	Accrued Interest Payable	1,562		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	78,844		35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,821,399	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,821,399	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,509,460	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,330,859	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,250,145	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,250,145	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	259,315	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)	\$ 259,315	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,509,460	24 *

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

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

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,475,660	1
2	Discounts and Allowances for all Levels	(838,141)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,637,519</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	55,158	6
7	Oxygen	206,704	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 261,862</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	21,761	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	162,463	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,816	19
20	Radiology and X-Ray	1,514	20
21	Other Medical Services	710,441	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 917,995</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	12,410	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 12,410</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	T shirts 3254/sell scrap 600/Late pay fees 2811	6,665	28
28a	Garnish fees 1215/Fund raiser 382/misc 644	2,241	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 8,906</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 6,838,692</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,212,572	31
32	Health Care	3,187,929	32
33	General Administration	1,429,684	33
<b>B. Capital Expense</b>			
34	Ownership	636,302	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	14,070	35
36	Provider Participation Fee	98,820	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 6,579,377</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>259,315</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 259,315</b>	<b>43</b>

\* 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.

return extended

\*\*\* 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.

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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	1,900	1,900	\$ 51,187	\$ 26.94	1
2	Assistant Director of Nursing	2,156	2,156	46,205	21.43	2
3	Registered Nurses	8,270	8,937	225,828	25.27	3
4	Licensed Practical Nurses	34,827	37,285	763,220	20.47	4
5	CNAs & Orderlies	86,451	92,707	1,007,726	10.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,966	2,046	21,622	10.57	8
9	Activity Director	2,080	2,080	29,332	14.10	9
10	Activity Assistants	4,123	4,363	34,820	7.98	10
11	Social Service Workers	5,952	6,344	82,575	13.02	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	35,052	16.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,991	22,451	195,776	8.72	15
16	Dishwashers					16
17	Maintenance Workers	7,715	8,224	107,192	13.03	17
18	Housekeepers	20,526	21,918	192,537	8.78	18
19	Laundry	10,849	11,622	100,418	8.64	19
20	Administrator	2,080	2,080	92,154	44.30	20
21	Assistant Administrator					21
22	Other Administrative	1,040	1,040	86,503	83.18	22
23	Office Manager					23
24	Clerical	18,435	19,649	360,128	18.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care: Respiratory	13,727	14,460	315,816	21.84	32
33	Other(specify) Inservice	3,499	3,692	78,229	21.19	33
34	TOTAL (lines 1 - 33)	248,587	265,034	\$ 3,826,320 *	\$ 14.44	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	200	\$ 9,594	1-3	35
36	Medical Director	varies	23,500	9-3	36
37	Medical Records Consultant	12	436	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,125	10-3	39
40	Physical Therapy Consultant	49	2,742	10-3	40
41	Occupational Therapy Consultant	6	405	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	118	10-3	43
44	Activity Consultant	27	961	11-3	44
45	Social Service Consultant	78	2,882	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	386	\$ 41,763		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		N/A	52
53	TOTAL (lines 50 - 52)		\$	53

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**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Debra Ford	Administrator	0	\$ 92,154	Workers' Compensation Insurance	\$ 69,138	IDPH License Fee	\$ 995	
Steven Wolf	Owner/Exec Admin	30	86,503	Unemployment Compensation Insurance	42,470	Advertising: Employee Recruitment	10,363	
				FICA Taxes	268,837	Health Care Worker Background Check	640	
				Employee Health Insurance	31,778	(Indicate # of checks performed <u>64</u> )		
				Employee Meals		Patient Background Checks	96	
				Illinois Municipal Retirement Fund (IMRF)*		Group purchasing	175	
				Other benefits	13,443	Misc dues and subs	483	
				Home Office allocation	31,358	CLIA Lab Fee	150	
						Secretary of State stickers	85	
TOTAL (agree to Schedule V, line 17, col. 1)						Home Office allocation	729	
(List each licensed administrator separately.)			\$ 178,657			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	( )	
Description			Amount			Yellow page advertising	( )	
Home Office allocation			\$ 80,188					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 80,188					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Wessels & Pautsch	Labor attorney		\$ 150				Out-of-State Travel	\$
Greensfelder, Hemke	Legal		660					
Moore Renner & Simonin	accountants		100				In-State Travel	2,208
					N/A			
							Seminar Expense	4,471
							Home Office allocation	1,690
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 910				TOTAL	\$ 8,369

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Calvin Johnson Care Center

**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? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? 5-10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 116 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 98,820  
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? Yes -adjusted out  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? 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. \$ 0**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ 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? n/a  
Attach invoices and a summary of services for all architect and appraisal fees.