



Facility Name & ID Number Eldercare of Alton

# 0023317 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	132	Skilled (SNF)	132	48,312	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,934	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	181	TOTALS	181	66,246	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,354	862	1,188	3,404	8
9	SNF/PED					9
10	ICF	37,505	4,583		42,088	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,859	5,445	1,188	45,492	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.67%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 04/01/1977

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 40 and days of care provided 1,188

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_

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

Facility Name & ID Number Eldercare of Alton # 0023317 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	214,425	20,552	16,274	251,251	450	251,701	(136)	251,565		1
2	Food Purchase		241,902		241,902		241,902		241,902		2
3	Housekeeping	248,582	31,836		280,418		280,418		280,418		3
4	Laundry	99,189	16,293		115,482		115,482		115,482		4
5	Heat and Other Utilities			148,249	148,249		148,249	1,882	150,131		5
6	Maintenance	68,848	10,607	45,300	124,755		124,755	2,790	127,545		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>631,044</b>	<b>321,190</b>	<b>209,823</b>	<b>1,162,057</b>	<b>450</b>	<b>1,162,507</b>	<b>4,536</b>	<b>1,167,043</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,883,007	94,942	161,582	2,139,531	(90,427)	2,049,104		2,049,104		10
10a	Therapy					76,479	76,479		76,479		10a
11	Activities	57,008	13,335	4,647	74,990		74,990		74,990		11
12	Social Services	75,866	34	3,052	78,952		78,952		78,952		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,015,881</b>	<b>108,311</b>	<b>193,281</b>	<b>2,317,473</b>	<b>(13,948)</b>	<b>2,303,525</b>		<b>2,303,525</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	165,524		77,980	243,504		243,504	(77,980)	165,524		17
18	Directors Fees										18
19	Professional Services			13,888	13,888		13,888	(11,900)	1,988		19
20	Dues, Fees, Subscriptions & Promotions			32,744	32,744		32,744	(7,825)	24,919		20
21	Clerical & General Office Expenses	358,724	12,267	62,680	433,671	1,825	435,496	10,828	446,324		21
22	Employee Benefits & Payroll Taxes			352,562	352,562	(3,525)	349,037	30,244	379,281		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,800	5,800		5,800	1,629	7,429		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			99,871	99,871		99,871	1,091	100,962		26
27	Other (specify):*			150	150		150	(150)			27
28	<b>TOTAL General Administration</b>	<b>524,248</b>	<b>12,267</b>	<b>645,675</b>	<b>1,182,190</b>	<b>(1,700)</b>	<b>1,180,490</b>	<b>(54,063)</b>	<b>1,126,427</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,171,173</b>	<b>441,768</b>	<b>1,048,779</b>	<b>4,661,720</b>	<b>(15,198)</b>	<b>4,646,522</b>	<b>(49,527)</b>	<b>4,596,995</b>		<b>29</b>

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

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

Facility Name & ID Number Eldercare of Alton #0023317 Report Period Beginning: 01/01/2008 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			109,517	109,517		109,517	11,505	121,022			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			63,811	63,811		63,811		63,811			33
34	Rent-Facility & Grounds			339,123	339,123		339,123	14,316	353,439			34
35	Rent-Equipment & Vehicles			310	310		310		310			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			512,761	512,761		512,761	25,821	538,582			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		44,249		44,249	15,198	59,447		59,447			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		8,646		8,646		8,646		8,646			41
42	Provider Participation Fee			99,370	99,370		99,370		99,370			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		52,895	99,370	152,265	15,198	167,463		167,463			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,171,173	494,663	1,660,910	5,326,746		5,326,746	(23,706)	5,303,040			45

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

Facility Name & ID Number Eldercare of Alton

# 0023317

Report Period Beginning: 01/01/2008

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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(136)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(150)	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	(8,528)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (8,814)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,283)	var	34
35	Other- Attach Schedule	(13,609)	var	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (14,892)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (23,706)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Eldercare of Alton

ID# 0023317

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Non-allowable legal	\$ (13,609)	19
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	(13,609)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Eldercare of Alton

# 0023317

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	(136)	0	0	0	0	0	0	0	0	0	0	(136)	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	1,882	0	0	0	0	0	0	0	0	1,882	5
6	Maintenance	0	0	2,790	0	0	0	0	0	0	0	0	2,790	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(136)</b>	<b>0</b>	<b>4,672</b>	<b>0</b>	<b>4,536</b>	<b>8</b>							
	<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>	<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>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	(77,980)	0	0	0	0	0	0	0	0	(77,980)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,609)	0	1,709	0	0	0	0	0	0	0	0	(11,900)	19
20	Fees, Subscriptions & Promotions	(8,528)	0	703	0	0	0	0	0	0	0	0	(7,825)	20
21	Clerical & General Office Expenses	0	0	10,828	0	0	0	0	0	0	0	0	10,828	21
22	Employee Benefits & Payroll Taxes	0	0	30,244	0	0	0	0	0	0	0	0	30,244	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,629	0	0	0	0	0	0	0	0	1,629	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	1,091	0	0	0	0	0	0	0	0	1,091	26
27	Other (specify):*	(150)	0	0	0	0	0	0	0	0	0	0	(150)	27
28	<b>TOTAL General Administration</b>	<b>(22,287)</b>	<b>0</b>	<b>(31,776)</b>	<b>0</b>	<b>(54,063)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(22,423)</b>	<b>0</b>	<b>(27,104)</b>	<b>0</b>	<b>(49,527)</b>	<b>29</b>							

## STATE OF ILLINOIS

Facility Name & ID Number Eldercare of Alton# 0023317 Report Period Beginning:

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

Summary B

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	11,505	0	0	0	0	0	0	0	0	11,505	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	14,316	0	0	0	0	0	0	0	0	14,316	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>25,821</b>	<b>0</b>	<b>25,821</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 (sum of lines 29, 37 &amp; 44)</b>	<b>(22,423)</b>	<b>0</b>	<b>(1,283)</b>	<b>0</b>	<b>(23,706)</b>	<b>45</b>							

Facility Name & ID Number Eldercare of Alton

# 0023317

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	\$ 83,425	Eldercare Inc	0.00%	\$ 83,425	\$
2	V	21-1 Home Office Wages	157,277	Eldercare Inc	0.00%	157,277	
3	V	21-3 Home Office Expenses	77,980	Eldercare Inc	0.00%	76,697	(1,283)
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 318,682			\$ 317,399	\$ * (1,283)

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

Facility Name & ID Number Eldercare of Alton# 0023317Report Period Beginning: 01/01/2008 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%	\$ 1,882	\$ 1,882	15
16	V	6 Maintenance		Eldercare Inc	0.00%	2,790	2,790	16
17	V	17 Officer Salary	83,425	Eldercare Inc	0.00%	83,425		17
18	V	19 Legal & Acctg		Eldercare Inc	0.00%	1,709	1,709	18
19	V	20 Dues & Licenses		Eldercare Inc	0.00%	703	703	19
20	V	21 Home Office Wages	157,277	Eldercare Inc	0.00%	157,277		20
21	V	21 Admin/office expenses		Eldercare Inc	0.00%	10,828	10,828	21
22	V	22 Payroll Taxes/benefits		Eldercare Inc	0.00%	30,244	30,244	22
23	V	24 Travel		Eldercare Inc	0.00%	1,629	1,629	23
24	V	26 Liability and Property insurance		Eldercare Inc	0.00%	1,091	1,091	24
25	V	30 Depreciation		Eldercare Inc	0.00%	11,505	11,505	25
26	V	34 Building Lease		Eldercare Inc	0.00%	14,316	14,316	26
27	V	17 Home Office Expenses	77,980	Eldercare Inc	0.00%		(77,980)	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		\$ 318,682			\$ 317,399	\$ * (1,283)	39

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

Facility Name &amp; ID Number

Eldercare of Alton

#

0023317

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										3
4		SEE ATTACHED								4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Eldercare of Alton

# 0023317 Report Period Beginning: 01/01/2008

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	92,662	2	\$ 3,833	\$ 45,492	\$ 1,882	1
2	6	Maintenance	Patient Days	92,662	2	5,682	45,492	2,790	2
3	17	Home Office Adm Wages	Patient Days	92,662	2	169,928	45,492	83,425	3
4	19	Legal & Acctg	Patient Days	92,662	2	3,481	45,492	1,709	4
5	20	Dues & Licenses	Patient Days	92,662	2	1,432	45,492	703	5
6	21	Home Office Wages	Patient Days	92,662	2	320,356	45,492	157,277	6
7	21	Administrative expenses	Patient Days	92,662	2	22,055	45,492	10,828	7
8	22	Payroll Taxes/benefits	Patient Days	92,662	2	61,602	45,492	30,243	8
9	24	Travel	Patient Days	92,662	2	3,319	45,492	1,629	9
10	26	Liability and Property insur	Patient Days	92,662	2	2,223	45,492	1,091	10
11	30	Depreciation	Patient Days	92,662	2	23,434	45,492	11,505	11
12	34	Building Lease	Patient Days	92,662	2	29,160	45,492	14,316	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	\$	\$ 317,398	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										6										
7						N/A				7										
8										8										
9	<b>TOTAL Facility Related</b>									9										
<b>B. Non-Facility Related*</b>																				
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Non-Facility Related</b>									14										
15	<b>TOTALS (line 9+line14)</b>									15										

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

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

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

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

B. Real Estate Taxes

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2007 report.		\$ 58,140	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.)		\$ 59,583	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 1,443	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 61,368	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>		\$ 1,000	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.		\$ 63,811	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	90,696	8
	2004	96,590	9
	2005	60,539	10
	2006	57,029	11
	2007	59,583	12
	<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:

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
- 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 Eldercare of Alton COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0023317

CONTACT PERSON REGARDING THIS REPORT David Read

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

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

Enter the tax index number and real estate tax assessed for 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>23-1-08-17-10-105-027</u>	<u>Nursing Home &amp; 4.42 Acres</u>	<u>\$ 59,583.00</u>	<u>\$ 59,583.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	<b>\$ 59,583.00</b>	<b>\$ 59,583.00</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 X NO

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

**C. Tax Bills**

Attach a copy of the original 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 Eldercare of Alton

# 0023317 Report Period Beginning:

01/01/2008 Ending:

12/31/2008

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 45,621 B. General Construction Type: Exterior Brick Frame concrete/steel Number of Stories 2

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

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

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

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

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

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Improvements		1982	2,080		10			2,080	9
10		Improvements		1983	1,825		10			1,825	10
11		Improvements		1985	3,728		7			3,728	11
12		Improvements		1985	10,578		20			10,578	12
13		Improvements		1986	5,506		10			5,506	13
14		Heat Range		1988	1,190		10			1,190	14
15		Door Alarm		1991	8,986	449	20	449		7,975	15
16		Nurse Station Remodeling		1991	60,801		15			60,801	16
17		Carpet		1991	1,482		5			1,482	17
18		Asphalet Sealer		1992	2,900		12			2,900	18
19		Remodeling		1992	77,249		15			77,249	19
20		Roof & Remodeling		1993	68,700	3,435	15	3,435		68,700	20
21		Remodel Hall & Offices		1994	20,445	1,363	15	1,363		20,370	21
22		Concrete		1994	1,677	112	15	112		1,593	22
23		Roof Repairs & Asphalt		1995	2,150		12			2,150	23
24		Waste Line Renovations		1996	15,112	756	20	756		9,445	24
25		New Therapy Room		1996	3,782	252	15	252		3,215	25
26		Sidewalks & Parking Lot Seal		1996	8,930	524	5-15y	524		7,620	26
27		Landscape		1996	7,436		10			7,436	27
28		Concrete Walls & Signs		1997	14,479	965	15	965		11,101	28
29		Hall Renovations		1998	3,516	176	10	176		3,516	29
30		Laundry Boiler		1998	1,241	83	15	83		910	30
31		Parking Lot		1998	14,062	1,172	12	1,172		12,304	31
32		Landscape		1998	1,383		10			1,383	32
33		Drywall,Wall Carpet,Stained Glass Door,Lighting Chapel		1999	20,560	2,056	10	2,056		19,018	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Eldercare of Alton

# 0023317

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	Tubesheets & Copper Tubes in Water Heater	1999	\$ 6,904	\$	7	\$	\$	\$ 6,904	37
38	Drywall,Wall Carpet,Electric Work,and Flooring	2000	23,534	2,353	10	2,353		20,004	38
39	Duro-last Roofing System	2000	165,440	16,294	10	16,294		134,488	39
40	Roof-top HVAC Unit & 2 HVAC/Heat Unit-DR&Kitchen	2000	60,000	5,625	8	5,625		60,000	40
41	Foutain, Brick & Keystone install, Bush removal	2000	1,178	118	10	118		1,001	41
42	Asphalt Parking Lot	2001	7,745	645	12	645		4,841	42
43	Sidewalk entrance	2001	11,061	737	15	737		5,530	43
44	PA System	2001	573		5			573	44
45	Rooftop A/C	2001	4,133	517	8	517		3,874	45
46	Fireplace Dining Room/Awning	2001	3,917	392	10	392		2,938	46
47	New lighting-all wings/handrails	2001	49,081	3,272	15	3,272		24,541	47
48	New lighting	2002	5,788	386	15	386		2,701	48
49	Concrete pads	2002	1,882	94	20	94		659	49
50	Electrical rewiring kitchen	2003	7,770	388	20	388		2,331	50
51	Boiler room door, bathroom renovations	2003	4,564	456	10	456		2,510	51
52	Insurance proceeds on roofing system from 2000	2000	(2,500)						52
53	Generator, wiring, cable	2004	20,678	1,034	20	1,034		5,169	53
54	Handrails and installation	2004	13,980	932	15	932		4,660	54
55	Smoke detectors, emergency lighting, fire doors	2004	28,610	2,861	10	2,861		12,874	55
56	Carpeting, HVAC upgrades	2004	7,459	1,492	5	1,492		6,713	56
57	Electrical panel	2005	6,342	317	20	317		1,110	57
58	Fire alarm system upgrades	2005	19,966	1,997	10	1,997		6,988	58
59	Boiler repairs, heating, A/C	2005	2,788	558	5	558		1,952	59
60	Exterior drainage	2005	1,495	149	10	149		523	60
61	Electrical wiring	2006	970	48	20	48		145	61
62	Fire system repairs, lighting,new doors	2006	24,896	2,490	10	2,490		7,386	62
63	Awning, air conditioning	2006	3,719	744	5	744		1,859	63
64	Sidewalk	2006	2,400	240	10	240		720	64
65	Concrete steps and railings	2007	11,200	560	20	560		1,120	65
66	New awnings, boiler	2007	18,142	1,814	10	1,814		2,721	66
67	Heating/AC units	2007	8,114	1,623	5	1,623		2,434	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 881,627	\$ 59,479		\$ 59,479	\$	\$ 673,344	70

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

Facility Name & ID Number Eldercare of Alton

# 0023317

Report Period Beginning:

01/01/2008 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	
1	Totals from Page 12A, Carried Forward		\$ 881,627	\$ 59,479		\$ 59,479	\$	\$ 673,344	1
2	Hot Water system,lighting,security system	2008	32,015	800	20	800		800	2
3	Fire escapes, kitchen drain lines, tile	2008	16,935	847	10	847		847	3
4	Heating/AC upgrades	2008	8,524	1,705	5	1,705		1,705	4
5	Concrete walk ramps and railings,exit ramps	2008	18,104	1,207	15	1,207		1,207	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	TOTAL (lines 1 thru 33)		\$ 957,205	\$ 64,038		\$ 64,038	\$	\$ 677,903	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 515,797	\$ 43,178	\$ 43,178	\$	5-15	\$ 340,388	71
72	Current Year Purchases	24,705	2,301	2,301		5-15	2,301	72
73	Fully Depreciated Assets	242,187					242,187	73
74	Home Office allocation		11,505	11,505				74
75	TOTALS	\$ 782,689	\$ 56,984	\$ 56,984	\$		\$ 584,876	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1985 Van	1985	\$ 10,041	\$	\$	\$		\$ 10,041	76
77	Patient Transportation	1991 Bus	1991	39,855					39,855	77
78										78
79										79
80	TOTALS			\$ 49,896	\$	\$	\$		\$ 49,896	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	1,789,790	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	121,022	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	121,022	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)	\$	1,312,675	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	10A col 3	hrs	\$	416	\$ 29,639	\$	416	\$ 29,639	1
2	Licensed Speech and Language Development Therapist	10A col 3	hrs		88	7,901		88	7,901	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A col 3	hrs		622	38,949	133	622	39,082	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39	# of prescrpts				86,887		86,887	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab</u>	L 39				6,146			6,146	12
13	Other (specify): <u>Radiology</u>	L 39				1,737			1,737	13
14	TOTAL			\$	1,126	\$ 84,372	\$ 87,020	1,126	\$ 171,392	14

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

Facility Name & ID Number Eldercare of Alton# 0023317Report Period Beginning: 01/01/2008

Ending:

12/31/2008**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	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 162,982	\$	1
2	Cash-Patient Deposits	24,460		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	2,192,320		3
4	Supply Inventory (priced at <u>cost</u> )	34,658		4
5	Short-Term Investments			5
6	Prepaid Insurance	47,456		6
7	Other Prepaid Expenses	10,951		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>due from employees</u>	5,132		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,477,959	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	956,285		15
16	Equipment, at Historical Cost	833,504		16
17	Accumulated Depreciation (book methods)	(1,312,675)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 477,114	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,955,073	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 578,375	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,460		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	93,728		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,540		31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,368		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 768,471	\$	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	<u>Due to Belleville</u>	619,882		43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 619,882	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,388,353	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,566,720	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,955,073	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,699,182	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,699,182	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(132,462)	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)	\$ (132,462)	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)	\$ 1,566,720	24 *

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

Facility Name &amp; ID Number Eldercare of Alton

# 0023317

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,901,690	1
2	Discounts and Allowances for all Levels	(315,867)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 4,585,823</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	341,736	6
7	Oxygen	32,595	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 374,331</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	14,010	12
13	Barber and Beauty Care	2,580	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	86,887	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,371	19
20	Radiology and X-Ray	1,737	20
21	Other Medical Services	108,225	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 224,810</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	465	24
25	Interest and Other Investment Income***	511	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 976</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Collection fees 4564/garnish fees 1653/copies 177	6,394	28
28a	sell old equip 150/Insurance 1800	1,950	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 8,344</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 5,194,284</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,162,057	31
32	Health Care	2,317,473	32
33	General Administration	1,182,190	33
<b>B. Capital Expense</b>			
34	Ownership	512,761	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	52,895	35
36	Provider Participation Fee	99,370	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 5,326,746</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(132,462)</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>\$ (132,462)</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 on extension

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

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

Facility Name & ID Number Eldercare of Alton

# 0023317

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 65,510	\$ 31.50	1
2	Assistant Director of Nursing	2,000	2,080	43,264	20.80	2
3	Registered Nurses	3,059	3,237	82,587	25.51	3
4	Licensed Practical Nurses	26,071	28,156	600,856	21.34	4
5	CNAs & Orderlies	73,450	78,812	903,976	11.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,401	7,880	89,757	11.39	8
9	Activity Director					9
10	Activity Assistants	5,641	6,077	57,008	9.38	10
11	Social Service Workers	5,741	6,153	75,866	12.33	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	37,920	18.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,180	21,631	176,505	8.16	15
16	Dishwashers					16
17	Maintenance Workers	5,944	6,242	68,848	11.03	17
18	Housekeepers	29,122	30,727	248,582	8.09	18
19	Laundry	11,385	12,185	99,189	8.14	19
20	Administrator	2,000	2,080	82,099	39.47	20
21	Assistant Administrator					21
22	Other Administrative	1,000	1,040	83,425	80.22	22
23	Office Manager					23
24	Clerical	18,778	19,980	358,724	17.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Inservice</u>	3,831	4,176	97,057	23.24	33
34	TOTAL (lines 1 - 33)	219,603	234,616	\$ 3,171,173 *	\$ 13.52	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	355	\$ 16,274	1-3	35
36	Medical Director	varies	24,000	9-3	36
37	Medical Records Consultant	76	3,072	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	266	14,744	10-3	40
41	Occupational Therapy Consultant	80	5,432	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	111	7,490	10-3	43
44	Activity Consultant	75	4,647	11-3	44
45	Social Service Consultant	52	3,052	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,015	\$ 78,711		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	9	\$ 360	10-3	50
51	Licensed Practical Nurses	1,151	37,328	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,160	\$ 37,688		53





Facility Name &amp; ID Number Eldercare of Alton

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? 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? 7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,569 Line L 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 99,370  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (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.