

		FOR BHF USE					

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**2009**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2009)**

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

<p><b>I. IDPH License ID Number:</b> <u>0045609</u></p> <p><b>Facility Name:</b> <u>ALHAMBRA CARE CENTER</u></p> <p><b>Address:</b> <u>417 EAST MAIN, BOX 310</u> <u>ALHAMBRA</u> <u>62001</u>          Number City Zip Code</p> <p><b>County:</b> <u>MADISON</u></p> <p><b>Telephone Number:</b> <u>(618) 488-3565</u> <b>Fax #</b> <u>(618) 488-2517</u></p> <p><b>HFS ID Number:</b> <u>37-1415755</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>02/08/02</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>MARK J. KORTE, CPA</u> <b>Telephone Number:</b> <u>(618) 654-9895</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2009</u> to <u>12/31/2009</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>DEMARIS A. WEDER</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>ADMINISTRATOR</u></td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) <u>MARK J. KORTE, CPA / RONALD C. SCHNEIDER, CPA</u> <u>PRINCIPAL</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>SCHEFFEL &amp; COMPANY, P.C.</u> <u>P.O. BOX 374, HIGHLAND, IL 62249</u></td> </tr> <tr> <td>(Telephone) <u>(618) 654-9895</u> Fax # <u>(618) 654-9898</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>      201 S. Grand Avenue East      Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>DEMARIS A. WEDER</u> (Date) _____		(Title) <u>ADMINISTRATOR</u>	<b>Paid Preparer</b>	(Signed) _____	(Print Name and Title) <u>MARK J. KORTE, CPA / RONALD C. SCHNEIDER, CPA</u> <u>PRINCIPAL</u>	(Firm Name & Address) <u>SCHEFFEL &amp; COMPANY, P.C.</u> <u>P.O. BOX 374, HIGHLAND, IL 62249</u>	(Telephone) <u>(618) 654-9895</u> Fax # <u>(618) 654-9898</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ALHAMBRA CARE CENTER

# 0045609 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	11	Skilled (SNF)	11	4,015	1
2		Skilled Pediatric (SNF/PED)			2
3	73	Intermediate (ICF)	73	26,645	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF			1,535	1,535		8
9	SNF/PED						9
10	ICF	10,087	5,152		15,239		10
11	ICF/DD						11
12	SC						12
13	DD 16 OR LESS						13
14	TOTALS	10,087	5,152	1,535	16,774		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.71%

D. How many bed-hold days during this year were paid by the Department? NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
N/A

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 02/08/02

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 12/14/01 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 11 and days of care provided 1,535

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE INSURANCE CORP

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

**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	96,818	5,019	4,417	106,254		106,254		106,254		1
2	Food Purchase		102,770		102,770		102,770		102,770		2
3	Housekeeping	85,515	23,539		109,054		109,054		109,054		3
4	Laundry	23,846	8,809		32,655		32,655		32,655		4
5	Heat and Other Utilities			88,559	88,559		88,559		88,559		5
6	Maintenance	16,072	26,997		43,069		43,069		43,069		6
7	Other (specify):* <b>UNIFORMS</b>			1,082	1,082		1,082		1,082		7
8	<b>TOTAL General Services</b>	222,251	167,134	94,058	483,443		483,443		483,443		8
	<b>B. Health Care and Programs</b>										
9	Medical Director	43,945		11,633	55,578		55,578		55,578		9
10	Nursing and Medical Records	670,158	109,299	7,622	787,079		787,079		787,079		10
10a	Therapy			159,959	159,959		159,959		159,959		10a
11	Activities	36,798	7,315	1,288	45,401		45,401		45,401		11
12	Social Services	29,044		1,288	30,332		30,332		30,332		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	779,945	116,614	181,790	1,078,349		1,078,349		1,078,349		16
	<b>C. General Administration</b>										
17	Administrative	16,243			16,243		16,243		16,243		17
18	Directors Fees										18
19	Professional Services			13,020	13,020		13,020		13,020		19
20	Dues, Fees, Subscriptions & Promotions			32,749	32,749		32,749	(26,642)	6,107		20
21	Clerical & General Office Expenses	56,522	16,262	3,376	76,160		76,160	(937)	75,223		21
22	Employee Benefits & Payroll Taxes			143,049	143,049		143,049		143,049		22
23	Inservice Training & Education										23
24	Travel and Seminar			15,598	15,598		15,598		15,598		24
25	Other Admin. Staff Transportation			184	184		184		184		25
26	Insurance-Prop.Liab.Malpractice			50,019	50,019		50,019		50,019		26
27	Other (specify):* <b>LIFE INSURANCE</b>			930	930		930	(930)			27
28	<b>TOTAL General Administration</b>	72,765	16,262	258,925	347,952		347,952	(28,509)	319,443		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,074,961	300,010	534,773	1,909,744		1,909,744	(28,509)	1,881,235		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number ALHAMBRA CARE CENTER

#0045609

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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			34,506	34,506		34,506	28,816	63,322			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,736	3,736		3,736	39,032	42,768			32
33	Real Estate Taxes			19,599	19,599		19,599		19,599			33
34	Rent-Facility & Grounds			127,100	127,100		127,100	(127,100)				34
35	Rent-Equipment & Vehicles			376	376		376		376			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			185,317	185,317		185,317	(59,252)	126,065			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			1,268	1,268		1,268		1,268			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			46,557	46,557		46,557		46,557			42
43	Other (specify):* <b>BAD DEBT EXP</b>			36,774	36,774		36,774		36,774			43
44	<b>TOTAL Special Cost Centers</b>			84,599	84,599		84,599		84,599			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,074,961	300,010	804,689	2,179,660		2,179,660	(87,761)	2,091,899			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number ALHAMBRA CARE CENTER

# 0045609

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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				13
14	Non-Care Related Interest	(40)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(4,319)	30		17
18	Fines and Penalties	(750)	21		18
19	Entertainment	(50)	21		19
20	Contributions	(137)	21		20
21	Owner or Key-Man Insurance	(930)	27		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(24,647)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,995)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (32,868)		\$	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)	(54,893)	30,32,34	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (54,893)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (87,761)		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	

SEE ACCOUNTANTS' COMPILATION REPORT

ALHAMBRA CARE CENTER

ID# 0045609

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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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>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number ALHAMBRA CARE CENTER# 0045609

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</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>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	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	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(26,642)	0	0	0	0	0	0	0	0	0	0	(26,642)	20
21	Clerical & General Office Expenses	(937)	0	0	0	0	0	0	0	0	0	0	(937)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(930)	0	0	0	0	0	0	0	0	0	0	(930)	27
28	<b>TOTAL General Administration</b>	<b>(28,509)</b>	<b>0</b>	<b>(28,509)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(28,509)</b>	<b>0</b>	<b>(28,509)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALHAMBRA CARE CENTER# 0045609

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

## 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	(4,319)	33,135	0	0	0	0	0	0	0	0	0	28,816	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(40)	39,072	0	0	0	0	0	0	0	0	0	39,032	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(127,100)	0	0	0	0	0	0	0	0	0	(127,100)	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>(4,359)</b>	<b>(54,893)</b>	<b>0</b>	<b>(59,252)</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>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(32,868)	(54,893)	0	0	0	0	0	0	0	0	0	(87,761)	45

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DEMARIS & CHARLES WEDER	100	N/A				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT - FACILITY & EQ	\$ 128,325	DEMARIS & CHARLES WEDER	100.00%	\$	(127,100)	1
2	V	30 DEPRECIATION		DEMARIS & CHARLES WEDER	100.00%	33,135	33,135	2
3	V	32 INTEREST		DEMARIS & CHARLES WEDER	100.00%	39,072	39,072	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		\$ 128,325			\$ 72,207	\$ * (54,893)	14

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

Facility Name &amp; ID Number

ALHAMBRA CARE CENTER

#

0045609

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	DEMARS A WEDER	ADMINISTRATOR	ADMIN	50.00		40	100.00	SALARY	\$ 16,243	17-1	1
2	CHARLES WEDER	SPOUSE	N/A	50.00				NONE		N/A	2
3	STACEY KESSLER	DIR OF NURSING	DIR OF NURS			40	100.00	SALARY	41,002	9-1	3
4	ANGELA D SCOGGINS	DIR OF NURSING	DIR OF NURS			40	100.00	SALARY	2,943	9-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 60,188		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ALHAMBRA CARE CENTER

# 0045609

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

ALHAMBRA CARE CENTER

# 0045609

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	DEMARIS & CHARLES WED	X		BUILDING AND EQUIPMENT	\$4,827.18	12/14/01	\$ 695,000	\$ 547,773	10/14/2013	6.0000	\$ 33,662	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	CHARLES WEDER	X		OPERATING CASH	\$775.82	8/02/05	196,798	88,026	10/14/2013	6.0000	5,410	6								
7	BANK OF EDWARDSVILLE		X	OPERATING CASH	INTEREST ON	12/23/08	200,000		5/1/2009	4.0000	3,696	7								
8												8								
9	<b>TOTAL Facility Related</b>				\$5,603.00		\$ 1,091,798	\$ 635,799			\$ 42,768	9								
<b>B. Non-Facility Related*</b>																				
10	CHRYSLER FINANCIAL		X	NON-CARE VEHICLE	\$432.28		25,937		6/29/09	4.5000	40	10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>				\$432.28		\$ 25,937	\$			\$ 40	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 1,117,735	\$ 635,799			\$ 42,808	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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





Facility Name & ID Number ALHAMBRA CARE CENTER

# 0045609

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>84 BEDS</u>	<u>15,183</u>	<u>2001</u>	\$ <u>14,592</u>	<u>1</u>
2	<u>STORAGE LOT</u>		<u>2008</u>	<u>25,000</u>	<u>2</u>
3	TOTALS	15,183		\$ 39,592	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	6	2001	1971	\$ 23,856	\$ 597	40	\$ 597		\$ 4,722	4
5	18	2001	1973	71,520	1,788	40	1,788		14,155	5
6	24	2001	1976	119,424	2,986	40	2,986		23,636	6
7	24	2001	1979	94,512	2,363	40	2,363		18,706	7
8	12	2001	1983	144,096	3,602	40	3,602		28,519	8
<b>Improvement Type**</b>										
9	LEASED EQUIPMENT FROM RELATED PARTY		2001	215,000	21,500	10	21,500		170,208	9
10	OFFICE		1971	12,000	300	40	300		2,375	10
11	AWNING		2002	755	50	15	50		373	11
12	FENCE		2002	600		5			600	12
13	TITLE FLOORING		2004	2,643	132	20	132		727	13
14	ROOF		2006	8,050	201	40	201		788	14
15	KITCHEN CABINETS		2006	12,738	1,274	10	1,274		4,671	15
16	DOORS/WINDOWS		2006	15,768	394	40	394		1,412	16
17	ELECTRICAL UPGRADE		2006	1,828	46	40	46		164	17
18	FLOORING CARPET		2006	580	58	10	58		222	18
19	TITLE FLOORING		2006	3,117	312	10	312		1,143	19
20	EXTERIOR DOORS		2008	7,400	740	10	740		1,357	20
21	PORCH & ELECTRICAL WIRING		2008	9,384	235	40	235		372	21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	743,271	\$	36,578	\$	36,578	\$	274,150	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	\$ 198,551	\$ 21,099	\$ 21,099	\$	5	\$ 103,511	71
72	Current Year Purchases	32,702	3,145	3,145		5	3,145	72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$ 231,253	\$ 24,244	\$ 24,244	\$		\$ 106,656	75

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PATIENT CARE VEHICLE	2000 GMC SAVANA TRAN	2003	\$ 25,000	\$ 2,500	\$ 2,500	\$	10	\$ 15,625	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$ 25,000	\$ 2,500	\$ 2,500	\$		\$ 15,625	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)	\$ 1,039,116	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 63,322	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 63,322	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)	\$ 396,431	85

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	DURANGO - NON PATIENT CARE	\$ 32,692	\$ 3,269	\$ 17,980	86
87	MAINT VEHICLE 97 DODGE DAKOTA	10,500	1,050	2,188	87
88					88
89					89
90					90
91	<b>TOTALS</b>	\$ 43,192	\$ 4,319	\$ 20,168	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

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

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

**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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2009**

(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	\$ 579	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	106,646		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,067		6
7	Other Prepaid Expenses			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>	\$ 114,292	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable	6,436		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	62,862		15
16	Equipment, at Historical Cost	299,444		16
17	Accumulated Depreciation (book methods)	(154,279)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 214,463	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 328,755	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 42,812	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	38,432		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,508		31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,024		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 103,776	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	87,071		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>	\$ 87,071	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 190,847	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 137,908	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 328,755	\$	48

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>143,784</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>143,784</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(5,876)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(5,876)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>137,908</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number ALHAMBRA CARE CENTER

# 0045609

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	\$ 2,171,797	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,171,797	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<b>MISC INCOME</b>	1,987	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,987	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,173,784	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	483,443	31
32	Health Care	1,078,349	32
33	General Administration	347,952	33
<b>B. Capital Expense</b>			
34	Ownership	185,317	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	84,599	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,179,660	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(5,876)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (5,876)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

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

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

Facility Name & ID Number **ALHAMBRA CARE CENTER**

# **0045609**

Report Period Beginning: **01/01/2009**

Ending:

**12/31/2009**

**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	1,638	1,758	\$ 43,945	\$ 25.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,268	3,321	79,721	24.01	3
4	Licensed Practical Nurses	13,949	14,672	271,435	18.50	4
5	CNAs & Orderlies	27,087	29,000	319,002	11.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,639	3,860	36,798	9.53	9
10	Activity Assistants					10
11	Social Service Workers	1,819	2,080	29,044	13.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,188	10,295	96,818	9.40	15
16	Dishwashers					16
17	Maintenance Workers	1,427	1,530	16,072	10.50	17
18	Housekeepers	8,985	9,501	85,515	9.00	18
19	Laundry	2,552	2,650	23,846	9.00	19
20	Administrator	2,087	2,087	16,243	7.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,747	4,000	56,522	14.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	80,386	84,754	\$ 1,074,961 *	\$ 12.68	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	98	\$ 4,417	L1 & C3	35
36	Medical Director	128	6,629	L9 & C3	36
37	Medical Records Consultant	110	4,404	L9 & C3	37
38	Nurse Consultant	34	1,359	L10 & C3	38
39	Pharmacist Consultant	12	600	L9 & C3	39
40	Physical Therapy Consultant	2,265	57,083	L10A & C3	40
41	Occupational Therapy Consultant	2,234	56,298	L10A & C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,774	46,578	L10A & C3	43
44	Activity Consultant	32	1,288	L11 & CS	44
45	Social Service Consultant	32	1,288	L12 & CS	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	6,719	\$ 179,944		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	251	6,263	L10 & C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	251	\$ 6,263		53

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Demaris A. Weder	Administrative	50	\$ 16,243	Workers' Compensation Insurance	\$ 22,423	IDPH License Fee	\$	
				Unemployment Compensation Insurance	16,946	Advertising: Employee Recruitment	4,026	
				FICA Taxes	80,017	Health Care Worker Background Check	880	
				Employee Health Insurance	18,619	(Indicate # of checks performed <u>54</u> )		
				Employee Meals	0	Resident Background Check	40	
				Illinois Municipal Retirement Fund (IMRF)*	0	Advertising	26,642	
				<b>SIMPLE Retirement Plan</b>	5,044	News Subscriptions	787	
						Dues	414	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 16,243			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	(24,647)	
Description			Amount			Yellow page advertising	(1,995)	
			\$			TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 6,107	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 143,049	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
The Scheffel Companies	Accounting		\$ 13,020				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 13,020	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

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

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name &amp; ID Number ALHAMBRA CARE CENTER

# 0045609

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. INHA \$100.00
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,551 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 46,557  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ NO EMPLOYEE MEAL
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 20%  
d. Have vehicle usage logs been maintained? YES  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES FOR VAN & TRUCK - NO FOR THE DURANGO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: N/A
- (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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

**Alhambra Care Center, Inc.**

IDPH# 000045609

Page #15

EXPLANATION OF TRAINING PROGRAM

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

**SEE ACCOUNTANTS' COMPILATION REPORT**

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

Income Per Books (Accrual Basis)	(5,876)
Adjustments to Taxable Income (Cash Basis)	
Record 12/08 Accounts Receivable	309,975
Record 12/08 Prepaid Insurance	28,250
Record 12/08 Accounts Payable	(68,218)
Record 12/08 Unemployment Taxes	(2,227)
Record 12/08 Accrued Real Estate Taxes Payable	(18,449)
Record 12/08 Accrued Wages	(35,379)
Reverse 12/09 Accounts Receivable	(103,985)
Reverse 12/09 Prepaid Insurance	(7,067)
Reverse 12/09 Accounts Payable	41,565
Reverse 12/09 Unemployment Taxes	3,388
Reverse 12/09 Accrued Real Estate Taxes Payable	19,024
Reverse 12/09 Accrued Wages	38,432
Tax Depreciation Adjustment	(15,155)
Taxable Income (Loss)	<u>184,278</u>

**SEE ACCOUNTANT'S COMPILATION REPORT**