

Facility Name & ID Number Eldercare of Alton

0023317 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	132	Skilled (SNF)	132	48,180	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	181	TOTALS	181	66,065	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,249	1,452	1,506	5,207	8
9	SNF/PED					9
10	ICF	32,841	4,374		37,215	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,090	5,826	1,506	42,422	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.21%

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 1,506

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 01/01/2009 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
	A. General Services										
1	Dietary	218,705	21,489	13,259	253,453	475	253,928	(164)	253,764		1
2	Food Purchase		240,980		240,980	(17,590)	223,390	(1,482)	221,908		2
3	Housekeeping	248,937	41,045		289,982		289,982		289,982		3
4	Laundry	98,288	7,419		105,707		105,707		105,707		4
5	Heat and Other Utilities			136,561	136,561		136,561	1,874	138,435		5
6	Maintenance	69,044	7,410	46,300	122,754		122,754	2,976	125,730		6
7	Other (specify):*										7
8	TOTAL General Services	634,974	318,343	196,120	1,149,437	(17,115)	1,132,322	3,204	1,135,526		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,770,589	99,173	171,251	2,041,013	(111,733)	1,929,280		1,929,280		10
10a	Therapy					85,180	85,180		85,180		10a
11	Activities	54,752	10,488	2,613	67,853		67,853		67,853		11
12	Social Services	75,161		4,233	79,394		79,394		79,394		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,900,502	109,661	202,097	2,212,260	(26,553)	2,185,707		2,185,707		16
	C. General Administration										
17	Administrative	167,220		76,842	244,062		244,062	(76,842)	167,220		17
18	Directors Fees										18
19	Professional Services			9,394	9,394		9,394	(3,998)	5,396		19
20	Dues, Fees, Subscriptions & Promotions			34,115	34,115		34,115	(8,595)	25,520		20
21	Clerical & General Office Expenses	356,497	16,059	56,531	429,087	1,875	430,962	12,009	442,971		21
22	Employee Benefits & Payroll Taxes			358,497	358,497	14,440	372,937	32,645	405,582		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,399	5,399		5,399	1,213	6,612		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			93,233	93,233		93,233	591	93,824		26
27	Other (specify):*										27
28	TOTAL General Administration	523,717	16,059	634,011	1,173,787	16,315	1,190,102	(42,977)	1,147,125		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,059,193	444,063	1,032,228	4,535,484	(27,353)	4,508,131	(39,773)	4,468,358		29

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

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

Facility Name & ID Number

Eldercare of Alton

#0023317

Report Period Beginning:

01/01/2009

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	
	D. Ownership											
30	Depreciation			101,809	101,809		101,809	6,203	108,012			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			63,650	63,650		63,650		63,650			33
34	Rent-Facility & Grounds			339,106	339,106		339,106	14,280	353,386			34
35	Rent-Equipment & Vehicles			5,064	5,064		5,064		5,064			35
36	Other (specify):*											36
37	TOTAL Ownership			509,629	509,629		509,629	20,483	530,112			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation		50,866		50,866		50,866		50,866			38
39	Ancillary Service Centers					27,353	27,353		27,353			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		8,918		8,918		8,918		8,918			41
42	Provider Participation Fee			99,098	99,098		99,098		99,098			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		59,784	99,098	158,882	27,353	186,235		186,235			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,059,193	503,847	1,640,955	5,203,995		5,203,995	(19,290)	5,184,705			45

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

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	(1,482)	2		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	(164)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,310)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (10,956)		\$	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)	15	var	34
35	Other- Attach Schedule	(8,349)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (8,334)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (19,290)		37

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		x	\$	38
39					39
40	Gift and Coffee Shops		x		40
41	Barber and Beauty Shops		x		41
42	Laboratory and Radiology	x		8,614	39 42
43	Prescription Drugs	x		62,482	39 43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$ 71,096	47

BHF USE ONLY							
48		49		50		51	52

Eldercare of Alton

ID# 0023317

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Lobbying Exp	\$ (200)	20	1
2	Legal relating to collections	(8,149)	19	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(8,349)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eldercare of Alton# 0023317

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	(164)	0	0	0	0	0	0	0	0	0	0	(164)	1
2	Food Purchase	(1,482)	0	0	0	0	0	0	0	0	0	0	(1,482)	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	1,874	0	0	0	0	0	0	0	0	1,874	5
6	Maintenance	0	0	2,976	0	0	0	0	0	0	0	0	2,976	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,646)	0	4,850	0	3,204	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(76,842)	0	0	0	0	0	0	0	0	(76,842)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,149)	0	4,151	0	0	0	0	0	0	0	0	(3,998)	19
20	Fees, Subscriptions & Promotions	(9,510)	0	915	0	0	0	0	0	0	0	0	(8,595)	20
21	Clerical & General Office Expenses	0	0	12,009	0	0	0	0	0	0	0	0	12,009	21
22	Employee Benefits & Payroll Taxes	0	0	32,645	0	0	0	0	0	0	0	0	32,645	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,213	0	0	0	0	0	0	0	0	1,213	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	591	0	0	0	0	0	0	0	0	591	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(17,659)	0	(25,318)	0	(42,977)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(19,305)	0	(20,468)	0	(39,773)	29							

STATE OF ILLINOIS

Facility Name & ID Number Eldercare of Alton# 0023317

Report Period Beginning:

01/01/2009 Ending:

Summary B

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)	
	D. Ownership													
30	Depreciation	0	0	6,203	0	0	0	0	0	0	0	0	6,203	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	14,280	0	0	0	0	0	0	0	0	14,280	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	20,483	0	20,483	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(19,305)	0	15	0	0	0	0	0	0	0	0	(19,290)	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
		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	\$ 82,989	Eldercare Inc	0.00%	\$ 82,989	\$	1	
2	V	21-1 Home Office Wages	158,194	Eldercare Inc	0.00%	158,194		2	
3	V	21-3 Home Office Expenses	76,842	Eldercare Inc	0.00%		(76,842)	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		\$ 318,025			\$ 241,183	\$ *	(76,842)	14

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

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%	\$ 1,874	\$	1,874	15
16	V	6 Maintenance		Eldercare Inc	0.00%	2,976		2,976	16
17	V	17 Officer Salary	82,989	Eldercare Inc	0.00%	82,989			17
18	V	19 Legal & Acctg		Eldercare Inc	0.00%	4,151		4,151	18
19	V	20 Dues & Licenses		Eldercare Inc	0.00%	915		915	19
20	V	21 Home Office Wages	158,194	Eldercare Inc	0.00%	158,194			20
21	V	21 Admin/office expenses		Eldercare Inc	0.00%	12,009		12,009	21
22	V	22 Payroll Taxes/benefits		Eldercare Inc	0.00%	32,645		32,645	22
23	V	24 Travel		Eldercare Inc	0.00%	1,213		1,213	23
24	V	26 Liability and Property insurance		Eldercare Inc	0.00%	591		591	24
25	V	30 Depreciation		Eldercare Inc	0.00%	6,203		6,203	25
26	V	34 Building Lease		Eldercare Inc	0.00%	14,280		14,280	26
27	V	17 Home Office Expenses	76,842	Eldercare Inc	0.00%			(76,842)	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		\$ 318,025			\$ 318,040	\$ *	15	39

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

Facility Name & ID Number

Eldercare of Alton

0023317

Report Period Beginning:

01/01/2009

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									\$		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: 01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	86,626	2	\$ 3,826	\$ 42,422	\$ 1,874	1
2	6	Maintenance	Patient Days	86,626	2	6,076	42,422	2,976	2
3	17	Home Office Adm Wages	Patient Days	86,626	2	169,464	169,464	82,989	3
4	19	Legal & Acctg	Patient Days	86,626	2	8,477	42,422	4,151	4
5	20	Dues & Licenses	Patient Days	86,626	2	1,869	42,422	915	5
6	21	Home Office Wages	Patient Days	86,626	2	323,033	323,033	158,194	6
7	21	Administrative expenses	Patient Days	86,626	2	24,522	42,422	12,009	7
8	22	Payroll Taxes/benefits	Patient Days	86,626	2	66,662	42,422	32,645	8
9	24	Travel	Patient Days	86,626	2	2,477	42,422	1,213	9
10	26	Liability and Property insur	Patient Days	86,626	2	1,207	42,422	591	10
11	30	Depreciation	Patient Days	86,626	2	12,667	42,422	6,203	11
12	34	Building Lease	Patient Days	86,626	2	29,160	42,422	14,280	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					\$ 649,440	\$ 492,497	\$ 318,040	25

Facility Name & ID Number

Eldercare of Alton

0023317

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

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

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

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

Facility Name & ID Number Eldercare of Alton

0023317

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Eldercare of Alton

0023317

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements		1982		2,080		10			2,080	9
10	Improvements		1983		1,825		10			1,825	10
11	Improvements		1985		3,728		7			3,728	11
12	Improvements		1985		10,578		20			10,578	12
13	Improvements		1986		5,506		10			5,506	13
14	Heat Range		1988		1,190		10			1,190	14
15	Fire Alarm		1991		8,986	449	20	449		8,424	15
16	Nurse Station Remodeling		1991		60,801		15			60,801	16
17	Carpet		1991		1,482		5			1,482	17
18	Asphalt Sealer		1992		2,900		12			2,900	18
19	Remodeling		1992		77,249		15			77,249	19
20	Roof & Remodeling		1993		68,700		15			68,700	20
21	Remodel Hall & Offices		1994		20,445	76	15	76		20,445	21
22	Concrete		1994		1,677	83	15	83		1,677	22
23	Roof Repairs & Asphalt		1995		2,150		12			2,150	23
24	Waste Line Renovations		1996		15,112	756	20	756		10,201	24
25	New Therapy Room		1996		3,782	252	15	252		3,467	25
26	Sidewalks & Parking Lot Seal		1996		8,930	524	5-15y	524		8,144	26
27	Landscape		1996		7,436		10			7,436	27
28	Concrete Walls & Signs		1997		14,479	965	15	965		12,066	28
29	Hall Renovations		1998		3,516		10			3,516	29
30	Laundry Boiler		1998		1,241	83	15	83		993	30
31	Parking Lot		1998		14,062	1,172	12	1,172		13,476	31
32	Landscape		1998		1,383		10			1,383	32
33	Drywall,Wall Carpet,Stained Glass Door,Lighting Chapel		1999		20,560	1,542	10	1,542		20,560	33
34											34
35	Retirement		1991		(1,482)					(1,482)	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Eldercare of Alton

0023317

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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	2,354	10	2,354		22,357	38
39	Duro-last Roofing System	2000	165,440	16,294	10	16,294		150,782	39
40	Roof-top HVAC Unit & 2 HVAC/Heat Unit-DR&Kitchen	2000	60,000		8			60,000	40
41	Fountain, Brick & Keystone install, Bush removal	2000	1,178	118	10	118		1,119	41
42	Asphalt Parking Lot	2001	7,745	645	12	645		5,486	42
43	Sidewalk entrance	2001	11,061	737	15	737		6,267	43
44	PA System	2001	573		5			573	44
45	Rooftop A/C	2001	4,133	258	8	258		4,133	45
46	Fireplace Dining Room/Awning	2001	3,917	392	10	392		3,330	46
47	New lighting-all wings/handrails	2001	49,081	3,272	15	3,272		27,813	47
48	New lighting	2002	5,788	386	15	386		3,087	48
49	Concrete pads	2002	1,882	94	20	94		753	49
50	Electrical rewiring kitchen	2003	7,770	389	20	389		2,719	50
51	Boiler room door, bathroom renovations	2003	4,564	456	10	456		2,967	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		6,203	53
54	Handrails and installation	2004	13,980	932	15	932		5,592	54
55	Smoke detectors, emergency lighting, fire doors	2004	28,610	2,861	10	2,861		15,735	55
56	Carpeting, HVAC upgrades	2004	7,459	746	5	746		7,459	56
57	Electrical panel	2005	6,342	317	20	317		1,427	57
58	Fire alarm system upgrades	2005	19,966	1,997	10	1,997		8,985	58
59	Boiler repairs, heating, A/C	2005	2,788	558	5	558		2,509	59
60	Exterior drainage	2005	1,495	149	10	149		673	60
61	Electrical wiring	2006	970	48	20	48		194	61
62	Fire system repairs, lighting,new doors	2006	24,896	2,490	10	2,490		9,875	62
63	Awning, air conditioning	2006	3,719	744	5	744		2,603	63
64	Sidewalk	2006	2,400	240	10	240		960	64
65	Concrete steps and railings	2007	11,200	560	20	560		1,680	65
66	New awnings, boiler	2007	18,142	1,814	10	1,814		4,535	66
67	Heating/AC units	2007	8,114	1,623	5	1,623		4,057	67
68	2004 retirement		(555)					(555)	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 879,590	\$ 47,410		\$ 47,410	\$	\$ 718,717	70

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

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		\$ 879,590	\$ 47,410		\$ 47,410	\$	\$ 718,717	1
2	Hot Water system,lighting,security system	2008	32,015	1,601	20	1,601		2,401	2
3	Fire escapes, kitchen drain lines, tile	2008	16,935	1,694	10	1,694		2,540	3
4	Heating/AC upgrades	2008	8,526	1,705	5	1,705		3,410	4
5	Concrete walk ramps and railings,exit ramps	2008	18,104	1,207	15	1,207		2,414	5
6	Ground Fault outlets	2009	5,400	270	20	270		270	6
7	New Door fire rated	2009	1,382	92	15	92		92	7
8	Sprinkler upgrades/flooring	2009	10,171	509	10	509		509	8
9	Heating/AC upgrades/carpeting/	2009	10,707	1,606	5	1,606		1,606	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)		\$ 982,830	\$ 56,094		\$ 56,094	\$	\$ 731,959	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	\$ 452,811	\$ 42,269	\$ 42,269	\$		\$ 298,006	71
72	Current Year Purchases	36,852	2,922	2,922			2,922	72
73	Fully Depreciated Assets	296,067					296,067	73
74								74
75	TOTALS	\$ 785,730	\$ 45,191	\$ 45,191	\$		\$ 596,995	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	1991 Bus	1991	\$ 39,855	\$	\$	\$	4	\$ 39,855	76
77	Patient Transportation	2000 Ford Windstar	2009	4,190	524	524		4	524	77
78										78
79										79
80	TOTALS			\$ 44,045	\$ 524	\$ 524	\$		\$ 40,379	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)	\$ 1,812,605	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 101,809	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,809	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)	\$ 1,369,333	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			N/A		88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93		N/A	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.

Facility Name & ID Number

Eldercare of Alton

0023317

Report Period Beginning:

01/01/2009

Ending: 12/31/2009

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: National Nursing Homes Inc.

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1971	181	4/1/77	\$ 339,106	20	15	3
4	Additions							4
5								5
6								6
7	TOTAL		181		\$ 339,106			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: \$ 5,064 Description: Office equip 333/Therapy beds 4731

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning 08/01/07

Ending 7/31/2012

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

Fiscal Year Ending Annual Rent

12. /2010 \$ varies with profitability

13. /2011 \$ varies with profitability

14. /2012 \$ varies with profitability

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A col 3	hrs	\$	447	\$ 34,937	\$	447	\$ 34,937	1
2	Licensed Speech and Language Development Therapist	10A col 3	hrs		78	7,218		78	7,218	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A col 3	hrs		658	43,025		658	43,025	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				62,482		62,482	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab</u>	L 39				6,877			6,877	12
13	Other (specify): <u>Radiology</u>	L 39				495			495	13
14	TOTAL			\$	1,183	\$ 92,552	\$ 62,482	1,183	\$ 155,034	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**# **0023317**Report Period Beginning: **01/01/2009**Ending: **12/31/2009****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 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 93,490	\$	1
2	Cash-Patient Deposits	24,857		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,486,398		3
4	Supply Inventory (priced at <u>cost</u>)	36,357		4
5	Short-Term Investments			5
6	Prepaid Insurance	46,936		6
7	Other Prepaid Expenses	11,464		7
8	Accounts Receivable (owners or related parties)	30,959		8
9	Other(specify): <u>due from employees</u>	1,756		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,732,217	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	982,830		15
16	Equipment, at Historical Cost	829,775		16
17	Accumulated Depreciation (book methods)	(1,369,333)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 443,272	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,175,489	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 412,562	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,857		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	101,099		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,246		31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,828		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 628,592	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 628,592	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,546,897	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,175,489	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,566,720	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,566,720	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(19,823)	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)	\$ (19,823)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,546,897	24 *

* This must agree with page 17, line 47.

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,751,381	1
2	Discounts and Allowances for all Levels	(263,069)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,488,312	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	364,428	6
7	Oxygen	42,756	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 407,184	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	14,832	12
13	Barber and Beauty Care	2,180	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	115,592	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,723	19
20	Radiology and X-Ray	495	20
21	Other Medical Services	95,654	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 241,476	23
D. Non-Operating Revenue			
24	Contributions	3,392	24
25	Interest and Other Investment Income***	38,997	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 42,389	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>collection fees 3412/garnish fees 1226/copies 82</u>	4,720	28
28a	<u>misc = 2 rounding</u>	91	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,811	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,184,172	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,149,437	31
32	Health Care	2,212,260	32
33	General Administration	1,173,787	33
B. Capital Expense			
34	Ownership	509,629	34
C. Ancillary Expense			
35	Special Cost Centers	59,784	35
36	Provider Participation Fee	99,098	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,203,995	40
41	Income before Income Taxes (line 30 minus line 40)**	(19,823)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (19,823)	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.

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 66,070	\$ 31.76	1
2	Assistant Director of Nursing	1,556	1,596	38,297	24.00	2
3	Registered Nurses	3,771	3,921	97,037	24.75	3
4	Licensed Practical Nurses	23,264	25,164	537,256	21.35	4
5	CNAs & Orderlies	67,997	73,277	842,680	11.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,563	8,037	91,943	11.44	8
9	Activity Director					9
10	Activity Assistants	4,981	5,394	54,752	10.15	10
11	Social Service Workers	5,572	6,022	75,161	12.48	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	39,864	19.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,110	21,382	178,841	8.36	15
16	Dishwashers					16
17	Maintenance Workers	5,666	6,014	69,044	11.48	17
18	Housekeepers	27,829	29,919	248,937	8.32	18
19	Laundry	11,021	11,659	98,288	8.43	19
20	Administrator	2,000	2,080	84,231	40.50	20
21	Assistant Administrator					21
22	Other Administrative	1,000	1,040	82,989	79.80	22
23	Office Manager					23
24	Clerical	19,039	20,141	356,497	17.70	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)	3,869	4,109	97,306	23.68	33
34	TOTAL (lines 1 - 33)	209,238	223,915	\$ 3,059,193 *	\$ 13.66	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	274	\$ 13,258	1-3	35
36	Medical Director	monthly	24,000	9-3	36
37	Medical Records Consultant	74	2,941	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	199	11,374	10-3	40
41	Occupational Therapy Consultant	118	7,833	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	104	7,026	10-3	43
44	Activity Consultant	43	2,613	11-3	44
45	Social Service Consultant	71	4,233	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	883	\$ 73,278		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	419	\$ 17,521	10-3	50
51	Licensed Practical Nurses	700	22,706	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,119	\$ 40,227		53

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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. \$ _____ Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 99,098
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 17,590 Has any meal income been offset against related costs? yes Indicate the amount. \$ 1,482
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.