FOR BHF USE

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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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0045609

Facility Name: ALHAMBRA CARE CENTER

Address: 417 EAST MAIN, BOX 310 (Number) ALHAMBRA (City) 62001 (Zip Code)

County: MADISON

Telephone Number: (618) 488-3565 **Fax #** (618) 488-2517

HFS ID Number:

Date of Initial License for Current Owners: 02/08/02

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: MARK J. KORTE **Telephone Number:** (618) 654-9895
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) DEMARIS A. WEDER
(Title) ADMINISTRATOR

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) MARK J. KORTE, CPA, PRINCIPAL
(Firm Name & Address) SCHEFFEL & COMPANY, P.C., P.O. BOX 374, HIGHLAND, IL 62249
(Telephone) (618) 654-9895 Fax # (618) 654-9898

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,694	1,694	8
9	SNF/PED					9
10	ICF	11,651	6,117		17,768	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,651	6,117	1,694	19,462	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.48%

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 [X]

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

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 [X] Date 12/14/01 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 11 and days of care provided 1,694

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE INSURANCE CORP

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	101,132	6,637	4,392	112,161		112,161		112,161			1
2	Food Purchase		124,755		124,755		124,755		124,755			2
3	Housekeeping	111,174	31,166		142,340		142,340		142,340			3
4	Laundry	20,795	7,904		28,699		28,699		28,699			4
5	Heat and Other Utilities			94,558	94,558		94,558		94,558			5
6	Maintenance	13,970	46,659		60,629		60,629		60,629			6
7	Other (specify):* UNIFORMS			1,255	1,255		1,255		1,255			7
8	TOTAL General Services	247,071	217,121	100,205	564,397		564,397		564,397			8
	B. Health Care and Programs											
9	Medical Director	52,980		15,825	68,805		68,805		68,805			9
10	Nursing and Medical Records	720,913	143,993	1,272	866,178		866,178		866,178			10
10a	Therapy			117,067	117,067		117,067		117,067			10a
11	Activities	40,665	9,888	1,309	51,862		51,862		51,862			11
12	Social Services	35,978		1,310	37,288		37,288		37,288			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	850,536	153,881	136,783	1,141,200		1,141,200		1,141,200			16
	C. General Administration											
17	Administrative	22,602			22,602		22,602		22,602			17
18	Directors Fees											18
19	Professional Services			11,525	11,525		11,525		11,525			19
20	Dues, Fees, Subscriptions & Promotions			24,965	24,965		24,965	(21,713)	3,252			20
21	Clerical & General Office Expenses	51,443	21,993	4,159	77,595		77,595	(2,105)	75,490			21
22	Employee Benefits & Payroll Taxes			190,759	190,759		190,759		190,759			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,771	12,771		12,771		12,771			24
25	Other Admin. Staff Transportation			15	15		15		15			25
26	Insurance-Prop.Liab.Malpractice			46,581	46,581		46,581		46,581			26
27	Other (specify):* LIFE INSURANCE			930	930		930	(930)				27
28	TOTAL General Administration	74,045	21,993	291,705	387,743		387,743	(24,748)	362,995			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,171,652	392,995	528,693	2,093,340		2,093,340	(24,748)	2,068,592			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 ALHAMBRA CARE CENTER #0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			38,828	38,828		38,828	28,307	67,135			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,273	3,273		3,273	37,039	40,312			32
33	Real Estate Taxes			15,056	15,056		15,056		15,056			33
34	Rent-Facility & Grounds			201,191	201,191		201,191	(201,191)				34
35	Rent-Equipment & Vehicles			1,275	1,275		1,275		1,275			35
36	Other (specify):*											36
37	**TOTAL Ownership**			259,623	259,623		259,623	(135,845)	123,778			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			1,249	1,249		1,249		1,249			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,990	45,990		45,990		45,990			42
43	Other (specify):* **BAD DEBT EXP**			32,145	32,145		32,145		32,145			43
44	**TOTAL Special Cost Centers**			79,384	79,384		79,384		79,384			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,171,652	392,995	867,700	2,432,347		2,432,347	(160,593)	2,271,754			45

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

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(4,828)	30		17
18	Fines and Penalties	(1,160)	21		18
19	Entertainment				19
20	Contributions	(945)	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	(19,284)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,429)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (29,576)		$	30

BHF USE ONLY								
48		49		50		51		52	

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 Amount	2 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)	(131,017)	30,32,34	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (131,017)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (160,593)		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 Yes	2 No	3 Amount	4 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	**TOTAL (C): (sum of lines 38-46)**			$		47

ALHAMBRA CARE CENTER

ID# 0045609

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number ALHAMBRA CARE CENTER **#** 0045609 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(21,713)	0	0	0	0	0	0	0	0	0	0	(21,713)	20
21	Clerical & General Office Expenses	(2,105)	0	0	0	0	0	0	0	0	0	0	(2,105)	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	**TOTAL General Administration**	(24,748)	0	0	0	0	0	0	0	0	0	0	(24,748)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(24,748)	0	0	0	0	0	0	0	0	0	0	(24,748)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(4,828)	33,135	0	0	0	0	0	0	0	0	0	28,307	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	37,039	0	0	0	0	0	0	0	0	0	37,039	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(201,191)	0	0	0	0	0	0	0	0	0	(201,191)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,828)	(131,017)	0	0	0	0	0	0	0	0	0	(135,845)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(29,576)	(131,017)	0	0	0	0	0	0	0	0	0	(160,593)	45

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT - FACILITY & EQ	$	DEMARIS & CHARLES WEDER	100.00%	$	$ (201,191)	1
2	V	30	DEPRECIATION		DEMARIS & CHARLES WEDER	100.00%	33,135	33,135	2
3	V	32	INTEREST		DEMARIS & CHARLES WEDER		37,039	37,039	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			$			$ 70,174	$ * (131,017)	14

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

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DEMARIS A WEDER	ADMINISTRATOR	ADMIN	50.00		40	100.00	SALARY	$ 22,602	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	52,980	9-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 75,582		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 ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	DEMARIS & CHARLES WED	X		BUILDING & EQUIPMENT	$4,827.18	12/14/01	$ 695,000	$ 517,558	10/14/2013	6.0000	$ 31,909	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CHARLES WEDER	X		OPERATING CASH	$775.82	8/02/05	196,798	83,206	10/14/2013	6.0000	5,130	6
7	BANK OF EDWARDSVILLE		X	OPERATING CASH	INTEREST	12/23/08	200,000	124,000	4/1/11	4.0000	3,273	7
8												8
9	TOTAL Facility Related				$5,603.00		$ 1,091,798	$ 724,764			$ 40,312	9
	B. Non-Facility Related*											
10	ALLY		X	NON-CARE VEHICLE	$534.88	8/13/10	32,093	29,418	8/13/15			10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$534.88		$ 32,093	$ 29,418			$	14
15	TOTALS (line 9+line14)						$ 1,123,891	$ 754,182			$ 40,312	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 ALHAMBRA CARE CENTER **#** 0045609 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 19,024	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 14,772	2
3. Under or (over) accrual (line 2 minus line 1).		$ (4,252)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 19,308	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 15,056	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	16,141	8
	2006	17,527	9
	2007	18,449	10
	2008	19,024	11
	2009	19,598	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ALHAMBRA CARE CENTER COUNTY MADISON

FACILITY IDPH LICENSE NUMBER 0045609

CONTACT PERSON REGARDING THIS REPORT MARK KORTE, CPA

TELEPHONE (618) 654-9895 FAX #: (618) 654-9898

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

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-2-11-11-20-401-027	PEARCE W W ADD	$ 19,308.40	$ 19,308.40
2.	-07-2-11-11-20-402-025	PEARCE W W ADD	$ 290.04	$ 290.04
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 19,598.44	$ 19,598.44

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 [X] (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 [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	84 BEDS	15,183	2001	$ 14,592	1
2	STORAGE LOTS		2008	25,000	2
3	TOTALS	15,183		$ 39,592	3

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	6		2001	1971	$ 23,856	$ 596	40	$ 596	$	$ 5,318	4
5	18		2001	1973	71,520	1,788	40	1,788		15,943	5
6	24		2001	1976	119,424	2,986	40	2,986		26,622	6
7	24		2001	1979	94,512	2,362	40	2,362		21,068	7
8	12		2001	1983	144,096	3,602	40	3,602		32,121	8
	Improvement Type**										
9	LEASED EQUIPMENT FROM RELATED PARTIES			2001	215,000	21,500	10	21,500		191,708	9
10	OFFICE			1971	12,000	300	40	300		2,675	10
11	AWNING			2002	755	50	15	50		424	11
12	FENCE			2002	600		5			600	12
13	TILE FLOORING			2004	2,643	132	20	132		859	13
14	ROOF			2006	8,050	201	40	201		989	14
15	KITCHEN CABINETS			2006	12,738	1,274	10	1,274		5,944	15
16	DOORS/WINDOWS			2006	15,768	394	40	394		1,807	16
17	ELECTRICAL UPGRADE			2006	1,828	46	40	46		209	17
18	FLOORING CARPET			2006	580	58	10	58		280	18
19	TILE FLOORING			2006	3,117	312	10	312		1,455	19
20	EXTERIOR DOORS			2008	7,400	740	10	740		2,097	20
21	PORCH & ELECTRICAL WIRING			2008	9,384	235	40	235		606	21
22	PORCH			2010	4,625	89	39	89		89	22
23	ROOF			2010	10,249	88	39	88		88	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

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 758,145	$ 36,753		$ 36,753	$	$ 310,902	70

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

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 231,253	$ 26,056	$ 26,056	$	5	$ 132,712	71
72	Current Year Purchases	28,040	1,826	1,826		5	1,826	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 259,293	$ 27,882	$ 27,882	$		$ 134,538	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	$ 18,125	76
77										77
78										78
79										79
80	TOTALS			$ 25,000	$ 2,500	$ 2,500	$		$ 18,125	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)	$ 1,082,030	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 67,135	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 67,135	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)	$ 463,565	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	$ 1,907	$ 19,887	86
87	MAINT VEHICLE 97 DODGE DAKOTA	10,500	1,050	3,238	87
88	TOWN & COUNTRY - NON PATIENT C	44,897	1,871	1,871	88
89					89
90					90
91	TOTALS	$ 88,089	$ 4,828	$ 24,996	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.

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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.

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	
	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 prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

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

STATE OF ILLINOIS

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (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	$ 2,284	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	75,538		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,716		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 85,538	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	6,436		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	77,736		15
16	Equipment, at Historical Cost	339,690		16
17	Accumulated Depreciation (book methods)	(173,217)		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)**	$ 250,645	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 336,183	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 29,830	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	4,383		29
30	Accrued Salaries Payable	43,054		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,553		31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,308		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)**	$ 102,128	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	231,922		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)**	$ 231,922	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 334,050	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,133	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 336,183	$	48

***(See instructions.)**

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 137,908	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 137,908	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(135,775)	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)**	$ (135,775)	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)**	$ 2,133	24	*

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

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,296,465	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,296,465	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	MISC INCOME	107	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 107	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,296,572	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	564,397	31
32	Health Care	1,141,200	32
33	General Administration	387,743	33
	B. Capital Expense		
34	Ownership	259,623	34
	C. Ancillary Expense		
35	Special Cost Centers	79,384	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,432,347	40
41	**Income before Income Taxes (line 30 minus line 40)****	(135,775)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (135,775)	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.**

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

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,965	2,100	$ 52,980	$ 25.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,647	4,700	103,399	22.00	3
4	Licensed Practical Nurses	13,405	14,126	268,404	19.00	4
5	CNAs & Orderlies	37,584	39,740	349,110	8.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,804	4,100	40,665	9.91	9
10	Activity Assistants					10
11	Social Service Workers	2,033	2,079	35,978	17.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,573	10,764	101,132	9.40	15
16	Dishwashers					16
17	Maintenance Workers	1,285	1,300	13,970	11.00	17
18	Housekeepers	11,755	12,358	111,174	9.40	18
19	Laundry	2,051	2,188	20,795	9.50	19
20	Administrator	2,080	2,080	22,602	10.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,786	4,160	51,443	12.36	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)	94,968	99,695	$ 1,171,652 *	$ 11.75	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	98	$ 4,392	L1 & C3	35
36	Medical Director	77	12,000	L9 & C3	36
37	Medical Records Consultant	28	1,272	L9 & C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	848	50,904	L10A & C3	40
41	Occupational Therapy Consultant	626	37,545	L10A & C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	477	28,618	L10A & C3	43
44	Activity Consultant	32	1,309	L11 & C3	44
45	Social Service Consultant	33	1,310	L12 & C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,218	$ 137,350		49

C. CONTRACT NURSES

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

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DEMARIS WEDER	ADMIN	50	$ 22,602
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 22,602

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
THE SCHEFFEL COMPANIES	ACCOUNTING	$ 11,525
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 11,525

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,204
Unemployment Compensation Insurance	38,291
FICA Taxes	87,322
Employee Health Insurance	24,861
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
SIMPLE RETIREMENT PLAN	8,801
FRINGE BENEFITS	280
TOTAL (agree to Schedule V, line 22, col.8)	$ 190,759

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,308
Health Care Worker Background Check	1,350
(Indicate # of checks performed 49)	
RESIDENT BACKGROUND CH 42	
ADVERTISING	21,713
NEWS SUBSCRIPTIONS	330
DUES	264
Less: Public Relations Expense	( )
Non-allowable advertising	(19,284)
Yellow page advertising	(2,429)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,252

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ALHAMBRA CARE CENTER # 0045609 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. $ 11,526 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. $ 45,990
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. $ N/A Has any meal income been offset against related costs? Indicate the amount. $ NO EMPLOYEE MEALS

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 20%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES FOR VAN & TRUCK - NO FOR THE DURANGO & TOWN & COUNTRY
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 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.

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)	(135,775)
Adjustments to Taxable Income (Cash Basis)	
Record 12/09 Accounts Receivable	103,985
	7,067
Record 12/09 Accounts Payable	(41,565)
Record 12/09 Unemployment Taxes	(3,388)
Record 12/09 Accrued Real Estate Taxes Payable	(19,024)
Record 12/09 Accrued Wages	(38,432)
Reverse 12/09 Accounts Receivable	(72,936)
Reverse 12/10 Prepaid Insurance	(7,716)
Reverse 12/10 Accounts Payable	29,291
Reverse 12/10 Unemployment Taxes	5,553
Reverse 12/10 Accrued Real Estate Taxes Payable	19,308
Reverse 12/10 Accrued Wages	43,054
Tax Depreciation Adjustment	(8,965)
Taxable Income (Loss)	(119,543)

SEE ACCOUNTANT'S COMPILATION REPORT

ALHAMBRA CARE CENTER
IDPH# 000045609
PAGE # 5 Schedule
Non-allowable Expenses

Adjustments

Interest on Non-Care Vehicle - Page 9	0
Depreciation on Non-Care Assets - Page 13	4,828
Fines, Penalties, and Nondeductible Expenses - Account 9430	1,160
Meals & Entertainment - Account 7045	0
Contributions - Account 7070	945
Non-allowable Advertising - Page 21	19,284
Yellow Page Advertising - Page 21	2,429
Life Insurance - Account 6147	930
Taxable Income (Loss)	29,576