FOR BHF USE

LL1

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

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.

I. IDPH License ID Number: 0023317

Facility Name: Eldercare of Alton

Address: 3523 Wickenhauser (Number) Alton (City) 62002 (Zip Code)

County: Madison

Telephone Number: 618-465-8887 **Fax #** 618-465-1811

HFS ID Number:

Date of Initial License for Current Owners: 4/1/1977

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steven C. Wolf **Telephone Number:** 618-234-2273
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) Steven C Wolf
(Title) Executive Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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 Eldercare of Alton # 0023317 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	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,202	1,229	2,703	6,134	8
9	SNF/PED					9
10	ICF	34,495	3,687		38,182	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,697	4,916	2,703	44,316	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.08%

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 [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 04/01/1977

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 2,703

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] 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: 01/01/2010 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	241,445	23,294	11,775	276,514	475	276,989		276,989			1
2	Food Purchase		256,690		256,690	(15,372)	241,318	(141)	241,177			2
3	Housekeeping	268,874	46,483		315,357		315,357		315,357			3
4	Laundry	106,269	22,598		128,867		128,867		128,867			4
5	Heat and Other Utilities			157,070	157,070		157,070	1,913	158,983			5
6	Maintenance	73,660	10,896	68,791	153,347		153,347	3,419	156,766			6
7	Other (specify):*											7
8	TOTAL General Services	690,248	359,961	237,636	1,287,845	(14,897)	1,272,948	5,191	1,278,139			8
	B. Health Care and Programs											
9	Medical Director			30,600	30,600		30,600		30,600			9
10	Nursing and Medical Records	1,932,803	93,695	252,714	2,279,212	(148,134)	2,131,078		2,131,078			10
10a	Therapy					136,479	136,479		136,479			10a
11	Activities	64,230	8,184	2,080	74,494		74,494		74,494			11
12	Social Services	82,706		4,026	86,732		86,732		86,732			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,079,739	101,879	289,420	2,471,038	(11,655)	2,459,383		2,459,383			16
	C. General Administration											
17	Administrative	234,412		81,630	316,042		316,042	(81,630)	234,412			17
18	Directors Fees											18
19	Professional Services			1,754	1,754		1,754	4,691	6,445			19
20	Dues, Fees, Subscriptions & Promotions			42,708	42,708		42,708	(15,571)	27,137			20
21	Clerical & General Office Expenses	389,140	15,345	56,095	460,580	1,100	461,680	9,463	471,143			21
22	Employee Benefits & Payroll Taxes			378,616	378,616	12,997	391,613	36,398	428,011			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,611	7,611		7,611	1,302	8,913			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			79,041	79,041		79,041	731	79,772			26
27	Other (specify):*											27
28	TOTAL General Administration	623,552	15,345	647,455	1,286,352	14,097	1,300,449	(44,616)	1,255,833			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,393,539	477,185	1,174,511	5,045,235	(12,455)	5,032,780	(39,425)	4,993,355			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: 01/01/2010 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			104,300	104,300		104,300	2,630	106,930			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			65,296	65,296		65,296		65,296			33
34	Rent-Facility & Grounds			338,918	338,918		338,918	20,061	358,979			34
35	Rent-Equipment & Vehicles			368	368		368		368			35
36	Other (specify):*											36
37	TOTAL Ownership			508,882	508,882		508,882	22,691	531,573			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		122,917		122,917	12,455	135,372		135,372			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		9,411		9,411		9,411		9,411			41
42	Provider Participation Fee			99,098	99,098		99,098		99,098			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		132,328	99,098	231,426	12,455	243,881		243,881			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,393,539	609,513	1,782,491	5,785,543		5,785,543	(16,734)	5,768,809			45

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

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 01/01/2010 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	(141)	2		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	(5,850)	20		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	(200)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(10,174)	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)**	$ (16,365)		$	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)	(169)	var	34
35	Other- Attach Schedule	(200)	20	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (369)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (16,734)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		13,519	39	42
43	Prescription Drugs	X		114,562		43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 128,081		47

Eldercare of Alton

ID# 0023317

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	lobbying Exp	$ (200)	20	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**	(200)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eldercare of Alton # 0023317 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(141)	0	0	0	0	0	0	0	0	0	0	(141)	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	1,913	0	0	0	0	0	0	0	0	1,913	5
6	Maintenance	0	0	3,419	0	0	0	0	0	0	0	0	3,419	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(141)	0	5,332	0	0	0	0	0	0	0	0	5,191	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	(81,630)	0	0	0	0	0	0	0	0	(81,630)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(200)	0	4,891	0	0	0	0	0	0	0	0	4,691	19
20	Fees, Subscriptions & Promotions	(16,424)	0	653	0	0	0	0	0	0	0	0	(15,771)	20
21	Clerical & General Office Expenses	0	0	9,463	0	0	0	0	0	0	0	0	9,463	21
22	Employee Benefits & Payroll Taxes	0	0	36,398	0	0	0	0	0	0	0	0	36,398	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,302	0	0	0	0	0	0	0	0	1,302	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	731	0	0	0	0	0	0	0	0	731	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(16,624)	0	(28,192)	0	0	0	0	0	0	0	0	(44,816)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(16,765)	0	(22,860)	0	0	0	0	0	0	0	0	(39,625)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eldercare of Alton # 0023317 **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 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	2,630	0	0	0	0	0	0	0	0	2,630	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	20,061	0	0	0	0	0	0	0	0	20,061	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	22,691	0	0	0	0	0	0	0	0	22,691	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)**	(16,765)	0	(169)	0	0	0	0	0	0	0	0	(16,934)	45

Facility Name & ID Number Eldercare of Alton # 0023317 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
Steven C Wolf	30	Eldercare of Alton	Alton	Eldercare Inc	Belleville, IL	Mgmt Co.
Steven C Wolf	50	Columbia Conv Ctr	Columbia			

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. [X] 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	17-1	Home Office Adm Wages	$ 120,992	Eldercare Inc	0.00%	$ 120,992	$	1
2	V	21-1	Home Office Wages	182,362	Eldercare Inc	0.00%	182,362		2
3	V	21-3	Home Office Expenses	81,630	Eldercare Inc	0.00%	81,461	(169)	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			$ 384,984			$ 384,815	$ * (169)	14

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

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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)	
15	V	5	Utilities	$	Eldercare Inc	0.00%	$ 1,913	$ 1,913	15
16	V	6	Maintenance		Eldercare Inc	0.00%	3,419	3,419	16
17	V	17	Officer Salary	120,992	Eldercare Inc	0.00%	120,992		17
18	V	19	Legal & Acctg		Eldercare Inc	0.00%	4,891	4,891	18
19	V	20	Dues & Licenses		Eldercare Inc	0.00%	653	653	19
20	V	21	Home Office Wages	182,362	Eldercare Inc	0.00%	182,362		20
21	V	21	Admin/office expenses		Eldercare Inc	0.00%	9,463	9,463	21
22	V	22	Payroll Taxes/benefits		Eldercare Inc	0.00%	36,398	36,398	22
23	V	24	Travel		Eldercare Inc	0.00%	1,302	1,302	23
24	V	26	Liability and Property insurance		Eldercare Inc	0.00%	731	731	24
25	V	30	Depreciation		Eldercare Inc	0.00%	2,630	2,630	25
26	V	34	Building Lease		Eldercare Inc	0.00%	20,061	20,061	26
27	V	17	Home Office Expenses	81,630	Eldercare Inc	0.00%		(81,630)	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			$ 384,984			$ 384,815	$ * (169)	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: 01/01/2010 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 Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Steve Wolf	President	Exec Admin	30.00	A 38249	20	40.00	Salary	$ 120,992	17-1	1
2					B 127256						2
3											3
4											4
5		A- Columbia Conv Ctr									5
6		B Calvin Johnson Care Center									6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 120,992		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: 01/01/2010 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 [X] NO [ ]

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

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

	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	5	Utilities	Patient Days	90,926	2	$ 3,926	$	44,316	$ 1,913	1
2	6	Maintenance	Patient Days	90,926	2	7,014		44,316	3,419	2
3	17	Home Office Adm Wages	Patient Days	90,926	2	248,248	248,248	44,316	120,992	3
4	19	Legal & Acctg	Patient Days	90,926	2	10,035		44,316	4,891	4
5	20	Dues & Licenses	Patient Days	90,926	2	1,340		44,316	653	5
6	21	Home Office Wages	Patient Days	90,926	2	374,163	374,163	44,316	182,362	6
7	21	Administrative expenses	Patient Days	90,926	2	19,415		44,316	9,463	7
8	22	Payroll Taxes/benefits	Patient Days	90,926	2	74,681		44,316	36,398	8
9	24	Travel	Patient Days	90,926	2	2,672		44,316	1,302	9
10	26	Liability and Property insur	Patient Days	90,926	2	1,499		44,316	731	10
11	30	Depreciation	Patient Days	90,926	2	5,397		44,316	2,630	11
12	34	Building Lease	Patient Days	90,926	2	41,160		44,316	20,061	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					$ 789,550	$ 622,411		$ 384,815	25

Facility Name & ID Number Eldercare of Alton # 0023317 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							$	$			$	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:** 01/01/2010 **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.**	$ 78,828	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.)		$ 78,808	2
3. Under or (over) accrual (line 2 minus line 1).		$ (20)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 65,316	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.		$ 65,296	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	60,539	8
2006	57,029	9
2007	59,583	10
2008	61,586	11
2009	63,412	12

$ 15,396 pd Jan 2010 for last install of 2008 tax bill. $63412 pd in 2010 for 2009 taxes.

	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 Eldercare of Alton COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0023317

CONTACT PERSON REGARDING THIS REPORT Steve Wolf

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

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

Enter the tax index number and real estate tax assessed for 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.	23-1-08-17-10-105-027	Nursing Home & 4.42 Acres	$ 63,412.16	$ 63,412.16
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 63,412.16	$ 63,412.16

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 Eldercare of Alton # 0023317 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Eldercare of Alton # 0023317 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					$	$		$	$	$	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		8,873	15
16	Nurse Station Remodeling			1991	60,801		15			60,801	16
17							5				17
18	Asphalet Sealer			1992	2,900		12			2,900	18
19	Remodeling			1992	77,249		15			77,248	19
20	Roof & Remodeling			1993	68,700		15			68,700	20
21	Remodel Hall & Offices			1994	20,445		15			20,445	21
22	Concrete			1994	1,677		15			1,677	22
23	Roof Repairs & Asphalt			1995	2,150		12			2,150	23
24	Waste Line Renovations			1996	15,112	756	20	756		10,956	24
25	New Therapy Room			1996	3,782	252	15	252		3,719	25
26	Sidewalks & Parking Lot Seal			1996	8,930	524	5-15y	524		8,668	26
27	Landscape			1996	7,436		10			7,436	27
28	Concrete Walls & Signs			1997	14,479	965	15	965		13,031	28
29	Hall Renovations			1998	3,516		10			3,516	29
30	Laundry Boiler			1998	1,241	83	15	83		1,076	30
31	Parking Lot			1998	14,062	586	12	586		14,062	31
32	Landscape			1998	1,383		10			1,383	32
33	Drywall,Wall Carpet,Stained Glass Door,Lighting Chapel			1999	20,560		10			20,560	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 Eldercare of Alton # 0023317 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	Tubesheets & Copper Tubes in Water Heater	1999	$ 6,904	$	7	$	$	$ 6,904	37
38	Drywall,Wall Carpet,Electric Work,and Flooring	2000	23,534	1,177	10	1,177		23,534	38
39	Duro-last Roofing System	2000	162,940	12,158	10	12,158		162,940	39
40	Roof-top HVAC Unit & 2 HVAC/Heat Unit-DR&Kitchen	2000	60,000		8			60,000	40
41	Foutain, Brick & Keystone install, Bush removal	2000	1,178	59	10	59		1,178	41
42	Asphalt Parking Lot	2001	7,745	645	12	645		6,131	42
43	Sidewalk entrance	2001	11,061	737	15	737		7,005	43
44	PA System	2001	573		5			573	44
45	Rooftop A/C	2001	4,133		8			4,133	45
46	Fireplace Dining Room/Awning	2001	3,917	392	10	392		3,722	46
47	New lighting-all wings/handrails	2001	49,081	3,272	15	3,272		31,085	47
48	New lighting	2002	5,788	386	15	386		3,473	48
49	Concrete pads	2002	1,882	94	20	94		847	49
50	Electrical rewiring kitchen	2003	7,770	388	20	388		3,108	50
51	Boiler room door, bathroom renovations	2003	4,564	456	10	456		3,423	51
52									52
53	Generator, wiring, cable	2004	20,678	1,034	20	1,034		7,237	53
54	Handrails and installation	2004	13,980	932	15	932		6,524	54
55	Smoke detectors, emergency lighting, fire doors	2004	28,610	2,861	10	2,861		18,596	55
56	Carpeting, HVAC upgrades	2004	6,904		5			6,904	56
57	Electrical panel	2005	6,342	317	20	317		1,744	57
58	Fire alarm system upgrades	2005	19,966	1,997	10	1,997		10,981	58
59	Boiler repairs, heating, A/C	2005	2,788	279	5	279		2,788	59
60	Exterior drainage	2005	1,495	149	10	149		822	60
61	Electrical wiring	2006	970	48	20	48		242	61
62	Fire system repairs, lighting,new doors	2006	24,896	2,490	10	2,490		12,365	62
63	Awning, air conditioning	2006	3,719	744	5	744		3,347	63
64	Sidewalk	2006	2,400	240	10	240		1,200	64
65	Concrete steps and railings	2007	11,200	560	20	560		2,240	65
66	New awnings, boiler	2007	18,142	1,814	10	1,814		6,350	66
67	Heating/AC units	2007	8,114	1,623	5	1,623		5,680	67
68	2004 retirement								68
69									69
70	TOTAL (lines 4 thru 69)		$ 879,590	$ 38,467		$ 38,467	$	$ 757,184	70

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

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 01/01/2010 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	
1	Totals from Page 12A, Carried Forward		$ 879,590	$ 38,467		$ 38,467	$	$ 757,184	1
2	Copper fin boiler and water heater storage tank	2008	29,025	1,451	20	1,451		3,631	2
3	DVR Indoor security cameras	2008	10,103	1,010	10	1,010		2,154	3
4	Heating/AC upgrades	2008	8,526	1,705	5	1,705		5,116	4
5	Concrete walk ramps and railings,exit ramps	2008	18,104	1,207	15	1,207		3,621	5
6	Ambulance door	2008	1,190	59	20	59		147	6
7	sewer clean out riser and storm drain	2008	1,800	90	20	90		224	7
8	low voltage pathway lighting	2008	1,400	140	10	140		350	8
9	fire escape repairs	2008	500	50	10	50		125	9
10	Replaced damaged awning	2008	917	92	10	92		230	10
11	new tile flooring rooms 204, 211	2008	1,566	157	10	157		392	11
12	New drain line in kitchen	2008	2,450	245	10	245		612	12
13	2 new valve tampers for backflow preventer on sprinklers	2009	8,098	810	10	810		1,588	13
14	repair concrete walls with cracks	2009	1,250	125	10	125		187	14
15	covebase in 7 bathrooms	2009	822	82	10	82		123	15
16	carpeting and cove for nurse stations, office, care plans	2009	7,198	1,440	5	1,440		2,695	16
17	4 heating/ air conditioning units	2009	2,164	433	5	433		649	17
18	New igniter for water heater	2009	610	122	5	122		183	18
19	replaced block heater	2009	735	147	5	147		220	19
20									20
21									21
22									22
23									23
24	New Door fire rated	2009	1,382	92	15	92		184	24
25	Ground Fault outlets	2009	5,400	270	20	270		540	25
26	New Tile flooring	2010	75,148	2,505	15	2,505		2,505	26
27	New doors	2010	9,061	906	10	906		906	27
28	Heating/AC units	2010	22,135	2,214	5	2,214		2,214	28
29	New flower and mulch beds	2010	3,025	605	5	605		605	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,092,199	$ 54,424		$ 54,424	$	$ 786,385	34

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

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 01/01/2010 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	$ 483,798	$ 43,126	$ 43,126	$		$ 338,187	71
72	Current Year Purchases	34,671	5,702	5,702		5-10 yrs	5,702	72
73	Fully Depreciated Assets	301,933					301,933	73
74	Home Office allocation		2,630	2,630				74
75	TOTALS	$ 820,402	$ 51,458	$ 51,458	$		$ 645,822	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	1,048	1,048		4	1,571	77
78										78
79										79
80	TOTALS			$ 44,045	$ 1,048	$ 1,048	$		$ 41,426	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)	$ 1,956,646	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 106,930	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 106,930	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)	$ 1,473,633	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Eldercare of Alton # 0023317 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: 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. [X] 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	$ 338,918	20	15	3
4	Additions							4
5								5
6								6
7	TOTAL		181		$ 338,918 **			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 [X] NO Terms: *

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.	/2011	$ varies with profitability
13.	/2012	$ varies with profitability
14.	/2013	$ varies with profitability

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: $ 368 Description: office equip
(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 Eldercare of Alton # 0023317 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 Eldercare of Alton

STATE OF ILLINOIS
0023317 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A col 3	hrs	$	795	$ 55,741	$	795	$ 55,741	1
2	Licensed Speech and Language Development Therapist	10A col 3	hrs		129	10,800		129	10,800	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A col 3	hrs		1,148	69,948		1,148	69,948	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				114,562		114,562	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab	L 39					13,519		13,519	12
13	Other (specify): Radiology	L 39					489		489	13
14	TOTAL			$	2,072	$ 136,489	$ 128,570	2,072	$ 265,059	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 Eldercare of Alton # 0023317 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	$ 102,266	$	1
2	Cash-Patient Deposits	17,782		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	782,309		3
4	Supply Inventory (priced at cost)	38,534		4
5	Short-Term Investments			5
6	Prepaid Insurance	43,542		6
7	Other Prepaid Expenses	10,676		7
8	Accounts Receivable (owners or related parties)	213,209		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,208,318	$	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	1,090,543		15
16	Equipment, at Historical Cost	866,103		16
17	Accumulated Depreciation (book methods)	(1,473,633)		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)**	$ 483,013	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,691,331	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 269,556	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,782		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	148,312		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,847		31
32	Accrued Real Estate Taxes(Sch.IX-B)	65,316		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)**	$ 510,813	$	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)**	$ 510,813	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,180,518	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,691,331	$	48

*(See instructions.)

Facility Name & ID Number Eldercare of Alton # 0023317 **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**	$ 1,546,897	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,546,897	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(366,379)	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)**	$ (366,379)	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)**	$ 1,180,518	24 *

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

Facility Name & ID Number Eldercare of Alton # 0023317 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	$ 4,903,671	1
2	Discounts and Allowances for all Levels	(583,555)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,320,116	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	555,154	6
7	Oxygen	47,482	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 602,636	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	13,981	12
13	Barber and Beauty Care	2,580	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	211,940	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,010	19
20	Radiology and X-Ray	905	20
21	Other Medical Services	74,212	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 328,628	23
	D. Non-Operating Revenue		
24	Contributions	500	24
25	Interest and Other Investment Income***	1,961	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,461	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc	2,099	28
28a	Insurance	163,224	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 165,323	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,419,164	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,287,845	31
32	Health Care	2,471,038	32
33	General Administration	1,286,352	33
	B. Capital Expense		
34	Ownership	508,882	34
	C. Ancillary Expense		
35	Special Cost Centers	132,328	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)***	$ 5,785,543	40
41	**Income before Income Taxes (line 30 minus line 40)****	(366,379)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (366,379)	43

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

return not complete

** **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 Eldercare of Alton # 0023317 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	2,000	2,080	$ 69,488	$ 33.41	1
2	Assistant Director of Nursing	1,670	1,750	48,219	27.55	2
3	Registered Nurses	4,212	4,380	109,363	24.97	3
4	Licensed Practical Nurses	24,336	26,324	573,338	21.78	4
5	CNAs & Orderlies	74,003	79,749	935,458	11.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,979	8,159	95,139	11.66	8
9	Activity Director					9
10	Activity Assistants	5,731	6,206	64,230	10.35	10
11	Social Service Workers	6,012	6,497	82,706	12.73	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	40,084	19.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,945	23,333	201,361	8.63	15
16	Dishwashers					16
17	Maintenance Workers	5,890	6,290	73,660	11.71	17
18	Housekeepers	29,457	31,669	268,874	8.49	18
19	Laundry	11,681	12,357	106,269	8.60	19
20	Administrator	2,000	2,080	113,420	54.53	20
21	Assistant Administrator					21
22	Other Administrative	1,000	1,040	120,992	116.34	22
23	Office Manager					23
24	Clerical	20,379	21,559	389,140	18.05	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)	4,035	4,215	101,798	24.15	32
33	Other(specify) Inserv/careplans					33
34	TOTAL (lines 1 - 33)	224,330	239,768	$ 3,393,539 *	$ 14.15	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	243	$ 11,775	1-3	35
36	Medical Director	monthly	30,600	9-3	36
37	Medical Records Consultant	59	2,376	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	6,103	10-3	39
40	Physical Therapy Consultant	174	9,495	10-3	40
41	Occupational Therapy Consultant	72	4,906	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	29	1,933	10-3	43
44	Activity Consultant	35	2,080	11-3	44
45	Social Service Consultant	67	4,026	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	679	$ 73,294		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	885	$ 37,474	10-3	50
51	Licensed Practical Nurses	1,127	38,252	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,012	$ 75,726		53

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Deborah Cutright	Administrator	0	$ 113,420
Steven C. Wolf	Executive Admin	30	120,992
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 234,412

B. Administrative - Other

Description	Amount
Eldercare Inc-home office allocation	$ 81,630
TOTAL (agree to Schedule V, line 17, col. 3)	$ 81,630
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Wessels & Sherman	legal	$ 200
Moore Renner & Simonin	accounting	138
Hepler, Broom	legal	612
P. Michael Read	legal	192
Evans & Green	legal	612
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 1,754

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,244
Unemployment Compensation Insurance	39,843
FICA Taxes	230,255
Employee Health Insurance	34,344
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other emplyee benefits	7,555
Home office	36,398
Employee meals	15,372
TOTAL (agree to Schedule V, line 22, col.8)	$ 428,011

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

Description	Line #	Amount
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	20,340
Health Care Worker Background Check	740
(Indicate # of checks performed 134)	
Patient Background Checks 88	1,100
Various licenses/fees	1,028
Various subs	1,286
Home Office	653
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,137

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,611
Home Office allocation	1,302
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,913

**See instructions.

Facility Name & ID Number Eldercare of Alton # 0023317 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						N/A							
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Eldercare of Alton **#** 0023317 **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? **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. $ **0** 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. $ **15,372** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **2,080**

(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.