

		FOR BHF USE			

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**Supportive Living Facility**

**2014  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2014)**

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

<p><b>I. Facility ID Number:</b> <u>1000103</u></p> <p><b>Facility Name:</b> <u>Courtyard Estates Sullivan</u></p> <p><b>Address:</b> <u>20 Courtyard Blvd</u> <u>Sullivan</u> <u>61951</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Moultrie</u></p> <p><b>Telephone Number:</b> ( <u>217</u> ) <u>728-4300</u> Fax # <u>(217) 728-2165</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>9/30/08</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Mike Kocher</u> <b>Telephone Number:</b> <u>(309)691-8113</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2014</u> to <u>12/31/2014</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;"> <b>Officer or Administrator of Provider</b> </td> <td>                 (Signed) _____                  (Type or Print Name) <u>Mark Petersen</u>                  (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="vertical-align: top;"> <b>Paid Preparer</b> </td> <td>                 (Signed) _____                  (Print Name and Title) _____                  (Firm Name &amp; Address) _____                  (Telephone) ( <u>    </u> ) _____ Fax # ( <u>    </u> ) _____             </td> </tr> </table> <p align="right">                 MAIL TO: BUREAU OF HEALTH FINANCE                  IL DEPT OF HEALTHCARE AND FAMILY SERVICES                  201 S. Grand Avenue East                  Springfield, IL 62763-0001 Phone # (217) 782-1630             </p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>Mark Petersen</u> (Title) <u>Chief Executive Officer</u>	<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( <u>    </u> ) _____ Fax # ( <u>    </u> ) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Facility Name Courtyard Estates SullivanReport Period Beginning: 1/1/2014 Ending: 12/31/2014

## III. STATISTICAL DATA

## A. Certified units; enter number of units and unit days

Date of change in certified units

N/A

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	50	Single Unit Apartment	50	18,250	1
2		Double Unit Apartment			2
3		Other			3
4	50	TOTALS	50	18,250	4

## B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
5	Single Unit	7,092	9,719		16,811	5
6	Double Unit					6
7	Other					7
8	TOTALS	7,092	9,719		16,811	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 92.12%

D. Indicate the number of paid bed-hold days the SLF had during this year

None

Also, indicate the number of unpaid bed-hold days the SLF

had during this year. None (Do not include bed-hold days in Section B.)

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES  NO 

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES  NO 

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

N/A

## H. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* I. Is your fiscal year identical to your tax year?  YES  NOTax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? No If yes, did the facility make all of the required payments of interest and principle? \_\_\_\_\_  
If no, explain. \_\_\_\_\_K. Does the facility have any loans from the Federal Home Loan Bank outstanding? No If yes, did the facility make all of the required payments of interest and principle? \_\_\_\_\_  
If no, explain. \_\_\_\_\_L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? No If yes, did the facility make all of the required payments of interest and principle? \_\_\_\_\_  
If no, explain. \_\_\_\_\_

Facility Name: Courtyard Estates Sullivan

Report Period Beginning:

1/1/2014

Ending: 12/31/2014

## IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
<b>A. General Services</b>								
1	Dietary and Food Purchase	113,540	97,765		211,305	(1,968)	209,337	1
2	Housekeeping, Laundry and Maintenance	59,444	20,878	16,271	96,593		96,593	2
3	Heat and Other Utilities			67,135	67,135		67,135	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	172,984	118,643	83,406	375,033	(1,968)	373,065	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	216,517	348		216,865		216,865	6
7	Activities and Social Services	7,128	100	18,154	25,382		25,382	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	223,645	448	18,154	242,247		242,247	9
<b>C. General Administration</b>								
10	Administrative and Clerical	24,001	1,097	158,469	183,567	(82,351)	101,216	10
11	Marketing Materials, Promotions and Advertising		2,748	28,260	31,008	(31,008)		11
12	Employee Benefits and Payroll Taxes			92,181	92,181		92,181	12
13	Insurance-Property, Liability and Malpractice			7,340	7,340		7,340	13
14	Other (specify):			15,719	15,719	(15,719)		14
15	<b>TOTAL General Administration</b>	24,001	3,845	301,969	329,815	(129,078)	200,737	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	420,630	122,936	403,529	947,095	(131,046)	816,049	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			213,536	213,536		213,536	17
18	Interest			145,599	145,599		145,599	18
19	Real Estate Taxes			127,446	127,446		127,446	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			7,560	7,560		7,560	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			494,141	494,141		494,141	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	420,630	122,936	897,670	1,441,236	(131,046)	1,310,190	24

Facility Name: Courtyard Estates Sullivan

Report Period Beginning 1/1/2014 Ending: 12/31/2014

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 19.61	1
2	Licensed Practical Nurses	1	19.33	2
3	Certified Nurse Assistants	7	10.44	3
4	Activity Director & Assistants	0	10.22	4
5	Social Service Workers			5
6	Head Cook	1	12.50	6
7	Cook Helpers/Assistants	5	9.32	7
8	Dishwashers			8
9	Maintenance Workers	1	14.33	9
10	Housekeepers	1	9.63	10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical	1	11.78	14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>18</b>	<b>\$ 117</b>	<b>17</b>

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1	N/A			\$	1
2					2
3					3
4					4
5					5
<b>Total</b>				<b>\$</b>	<b>6</b>

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	N/A	\$ 1
2		2
<b>Total</b>		<b>\$ 3</b>

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES

Name	1	City	2
See Attached Schedule 4A			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES  NO

Name of related entity: Petersen Health Care, Inc. & Petersen Health Care M If yes, what is the value of those services? \$ 140,500

(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES  NO

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

Facility Name: Courtyard Estates Sullivan

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

VIII. OWNERSHIP COSTS

A. Purchase price of land 315,335 Year land was acquired 2004

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar. \*Total units on this schedule must agree with page 2.

	1 Units*	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	
1	50			2008	6,418,133	164,567	39	164,568	\$ 1	\$ 1,069,692	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Painting & Remodeling in water damaged areas		2014	15,348	853	15	853		853	6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14		Transportation									14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 6,433,481	\$ 165,420		\$ 165,421	\$ 1	\$ 1,070,545	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 336,812	\$ 48,116	\$ 48,116	-	7 yrs.	\$ 233,057	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 336,812	\$ 48,116	\$ 48,116	\$		\$ 233,057	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: Courtyard Estates Sullivan

Report Period Beginning: 1/1/2014

Ending: 2/31/2014

**IX. RENTAL COSTS**

**A. Building and Fixed Equipment**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES  NO

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

8. Is movable equipment rental included in building rental?

YES  NO

9. Rental amount for movable equipment \$ -

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

**X. INTEREST EXPENSE**

	1	2	3	4	6	7	8	9		
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
		YES	NO			Original	Balance			
	<b>A. Directly Facility Related</b>									
	<b>Long-Term</b>									
1	Ist Merit		X	Mortgage	2/1/12	\$ 3,704,700	3,404,730	1/31/17	Varies	\$ 145,599
2					/ /			/ /		
3					/ /			/ /		
	<b>Working Capital</b>									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	<b>TOTAL Facility Related</b>					\$ 3,704,700	\$ 3,404,730			\$ 145,599
	<b>B. Non-Facility Related</b>									
8					/ /			/ /		
9					/ /			/ /		
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 3,704,700	\$ 3,404,730			\$ 145,599

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

\*\* If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

Facility Name: Courtyard Estates Sullivan

Report Period Beginning: 1/1/2014

Ending:

12/31/2014

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (3,310,802)	\$ (3,310,802)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	170,996	170,996	3
4	Supply Inventory (priced : <u>Cost</u> )	2,414	2,414	4
5	Short-Term Investments			5
6	Prepaid Insurance	17,484 #	17,484	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(50,751)	(50,751)	8
9	Other(specify): <u>Security Deposits</u>	225	225	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (3,170,434)	\$ (3,170,434)	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		#	12
13	Land	315,335	315,335	13
14	Buildings, at Historical Cost	6,418,133	6,418,133	14
15	Leasehold Improvements, at Historical Cost	15,348	15,348	15
16	Equipment, at Historical Cost	336,812	336,812	16
17	Accumulated Depreciation (book methods)	(1,322,973)	(1,302,749)	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 ( <u>Loan Costs</u> )	369,854	369,854	22
23	Other(specify): <u>Prepaid Management Fees</u>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 6,132,509	\$ 6,152,733	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,962,075	\$ 2,982,299	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 48,237	\$ 48,237	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	21,630	21,630	30
31	Accrued Taxes Payable	133,611	133,611	31
32	Accrued Interest Payable	12,577	12,577	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	<u>Payroll Withholdings</u>	33,756	33,756	35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 249,811	\$ 249,811	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	3,404,730	3,404,730	39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42		17,400	17,400	42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 3,422,130	\$ 3,422,130	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 3,671,941	\$ 3,671,941	45
46	<b>TOTAL EQUITY</b>	\$ (709,866)	\$ (689,642)	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 2,962,075	\$ 2,982,299	47

\*(See instructions.)

Facility Name: Courtyard Estates Sullivan

Report Period Beginning: 1/1/2014

Ending:

12/31/2014

## XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 1,429,089	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 1,429,089</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals	1,968	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 1,968</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income		13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	Cable Television Revenue	6,600	15
16	Miscellaneous Revenue	1,998	16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 8,598</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 1,439,655</b>	<b>18</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	375,033	19
20	Health Care/ Personal Care	242,247	20
21	General Administration	329,815	21
<b>B. Capital Expense</b>			
22	Ownership	494,141	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 1,441,236</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ (1,581)</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ (1,581)</b>	<b>31</b>

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Total
1. Dietary	113,540	8,554	0	122,094	0	122,094	0	122,094
2. Food Purchase	0	89,211	0	89,211	0	89,211	-1,968	87,243
3. Housekeeping	29,780	8,596	0	38,376	0	38,376	0	38,376
4. Laundry	0	3,338	0	3,338	0	3,338	0	3,338
5. Heat and Other Utilities	0	0	67,135	67,135	0	67,135	0	67,135
6. Maintenance	29,664	8,944	16,271	54,879	0	54,879	0	54,879
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	172,984	118,643	83,406	375,033	0	375,033	-1,968	373,065
9. Medical Director	0	0	0	0	0	0	0	0
10. Nursing & Medical Records	216,517	348	0	216,865	0	216,865	0	216,865
10a. Therapy	0	0	0	0	0	0	0	0
11. Activities	7,128	100	18,154	25,382	0	25,382	0	25,382
12. Social Services	0	0	0	0	0	0	0	0
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	223,645	448	18,154	242,247	0	242,247	0	242,247
17. Administrative	0	0	140,500	140,500	0	140,500	-82,333	58,167
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	4,493	4,493	0	4,493	0	4,493
20. Fees, Subscriptions & Promotion	0	0	3,929	3,929	0	3,929	0	3,929
21. Clerical & General Office	24,001	1,097	6,376	31,474	0	31,474	-18	31,456
22. Employee Benefits & Payroll	0	0	92,181	92,181	0	92,181	0	92,181
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	0	0	0	0	0	0
25. Other Admin. Staff Trans	0	0	3,171	3,171	0	3,171	0	3,171
26. Insurance-Prop.Liab.Malpractice	0	0	7,340	7,340	0	7,340	0	7,340
27. Other (specify)*	0	2,748	43,979	46,727	0	46,727	-46,727	0
28. Total General Adminis	24,001	3,845	301,969	329,815	0	329,815	-129,078	200,737
29. Total General Administrative	420,630	122,936	403,529	947,095	0	947,095	-131,046	816,049

30. Depreciation	0	0	213,536	213,536	0	213,536	0	213,536
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	145,599	145,599	0	145,599	0	145,599
33. Real Estate	0	0	127,446	127,446	0	127,446	0	127,446
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	7,560	7,560	0	7,560	0	7,560
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	494,141	494,141	0	494,141	0	494,141
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Other (specify):*	0	0	0	0	0	0	0	0
43. Total Special Cost Ce	0	0	0	0	0	0	0	0
44. Grand Total	420,630	122,936	897,670	1,441,236	0	1,441,236	-131,046	1,310,190

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-3,310,802	-3,310,802
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	170,996	170,996
4. Supply Inventory	2,414	2,414
5. Short-Term Investments	0	0
6. Prepaid Insurance	17,484	17,484
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	-50,751	-50,751
9. Other (specify):	225	225
10. Total current assets	-3,170,434	-3,170,434
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	315,335	315,335
14. Buildings, at Historical Cost	6,418,133	6,418,133
15. Leasehold Improvements, Historical Cost	15,348	15,348
16. Equipment, at Historical Cost	336,812	336,812
17. Accumulated Depreciation (book methods)	-1,322,973	-1,302,749
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	369,854	369,854
23. other (specify):	0	0
24. Total Long-Term Assets	6,132,509	6,152,733
25. Total Assets	2,962,075	2,982,299
CURRENT LIABILITIES		
26. Accounts Payable	48,237	48,237
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	21,630	21,630
31. Accrued Taxes Payable	5,271	5,271

32. Accrued Real Estate Taxes	128,340	128,340
33. Accrued Interest Payable	12,577	12,577
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	33,756	33,756
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	249,811	249,811
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	3,404,730	3,404,730
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	17,400	17,400
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	3,422,130	3,422,130
46.Total Liabilities	3,671,941	3,671,941
47.Total Equity	-709,866	-689,642
48.Total Liabilities and Equity	2,962,075	2,982,299

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,429,089
2. Discounts and Allowances for all Level	0
Subtotal - Inpatient Care	1,429,089
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,968
15. Telephone, Television, and Radio	6,600
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	8,568
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	0
28. Other Revenue (specify):	1,998
Subtotal - Other Revenue	1,998

30. Total Revenue	1,439,655
31. General Services	343,113
32. Health Care	224,126
33. General Administration	324,124
34. Ownership	495,573
35. Special Cost Centers	0
35. Provider Participation Fee	0
37. Other	0
40. Total Expenses	1,386,936
41. Income Before Income Taxes	52,719
42. Income Taxes	0
43. Net Income or Loss for the Year	52,719



