



Facility Name & ID Number CENTRAL BAPTIST HOME

# 0007435 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	37	Skilled (SNF)	124	45,384	1
2		Skilled Pediatric (SNF/PED)			2
3	87	Intermediate (ICF)			3
4		Intermediate/DD			4
5	29	Sheltered Care (SC)	29	10,614	5
6		ICF/DD 16 or Less			6
7	153	TOTALS	153	55,998	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Public Aid Recipient	Private Pay	Other		
8	SNF	3,927	7,797	967	12,691	8
9	SNF/PED					9
10	ICF	12,039	17,249		29,288	10
11	ICF/DD					11
12	SC	1,647	3,955		5,602	12
13	DD 16 OR LESS					13
14	TOTALS	17,613	29,001	967	47,581	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.97%

D. How many bed-hold days during this year were paid by Public Aid? 68 (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)  
MEALS ON WHEELS

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 11/01/1978

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 11/01/1978 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 11 and days of care provided 967

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number CENTRAL BAPTIST HOME # 0007435 Report Period Beginning: 01/01/00 Ending: 12/31/00

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	464,566	42,700	26,479	533,745		533,745	(81,525)	452,220		1
2	Food Purchase		341,498		341,498		341,498	(187,524)	153,974		2
3	Housekeeping	151,296	35,561	73,686	260,543		260,543	(89,549)	170,994		3
4	Laundry	86,915	15,764	24,964	127,643		127,643	(29,107)	98,536		4
5	Heat and Other Utilities			196,595	196,595		196,595	(67,570)	129,025		5
6	Maintenance	171,343	44,164	197,787	413,294		413,294	(143,121)	270,173		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	874,120	479,687	519,511	1,873,318		1,873,318	(598,396)	1,274,922		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			26,400	26,400		26,400		26,400		9
10	Nursing and Medical Records	1,619,906	83,536	5,977	1,709,419		1,709,419	(10,760)	1,698,659		10
10a	Therapy	46,883		7,054	53,937		53,937		53,937		10a
11	Activities	233,804	35,107	2,427	271,338		271,338	(59,146)	212,192		11
12	Social Services	193,429	3,380	1,770	198,579		198,579	(44,240)	154,339		12
13	Nurse Aide Training										13
14	Program Transportation			1,083	1,083		1,083		1,083		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,094,022	122,023	44,711	2,260,756		2,260,756	(114,146)	2,146,610		16
	<b>C. General Administration</b>										
17	Administrative	131,783			131,783		131,783		131,783		17
18	Directors Fees										18
19	Professional Services			121,652	121,652		121,652	(41,671)	79,981		19
20	Dues, Fees, Subscriptions & Promotions			56,714	56,714		56,714	(7,980)	48,734		20
21	Clerical & General Office Expenses	257,697	50,004	262,146	569,847		569,847	(285,140)	284,707		21
22	Employee Benefits & Payroll Taxes			773,837	773,837		773,837	(81,373)	692,464		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,550	12,550		12,550	(4,798)	7,752		24
25	Other Admin. Staff Transportation			2,710	2,710		2,710	(900)	1,810		25
26	Insurance-Prop.Liab.Malpractice			111,811	111,811		111,811	(43,392)	68,419		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	389,480	50,004	1,341,420	1,780,904		1,780,904	(465,254)	1,315,650		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,357,622	651,714	1,905,642	5,914,978		5,914,978	(1,177,796)	4,737,182		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.

**CENTRAL BAPTIST HOME**  
**0007435**  
**COST REPORT RECLASSIFICATIONS**  
**01/01/00**  
**12/31/00**

SCHEDULE V LINE #
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22	EMPLOYEE BENEFITS	_____
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2	FOOD	_____
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To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	_____
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19	PROFESSIONAL FEES	_____
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To reclass cost of appealing real estate taxes

Facility Name & ID Number **CENTRAL BAPTIST HOME**

#0007435

Report Period Beginning:

01/01/00

Ending:

12/31/00

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership			578,232	578,232		578,232	(66,705)	511,527			30
31	Depreciation											31
32	Amortization of Pre-Op. & Org.											32
33	Interest											33
34	Real Estate Taxes											34
35	Rent-Facility & Grounds											35
36	Rent-Equipment & Vehicles			948	948		948		948			36
37	Other (specify):*			1,707	1,707		1,707		1,707			37
37	<b>TOTAL Ownership</b>			580,887	580,887		580,887	(66,705)	514,182			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		29,735	85,177	114,912		114,912		114,912			39
40	Barber and Beauty Shops			773	773		773	(773)				40
41	Coffee and Gift Shops	112,226	32,891	3,908	149,025		149,025	(32,778)	116,247			41
42	Provider Participation Fee			68,076	68,076		68,076		68,076			42
43	Other (specify):*	121,067	2,157	51,448	174,672		174,672	(174,672)				43
44	<b>TOTAL Special Cost Centers</b>	233,293	64,783	209,382	507,458		507,458	(208,223)	299,235			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,590,915	716,497	2,695,911	7,003,323		7,003,323	(1,452,724)	5,550,599			45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
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	297	30		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				17
18	Fines and Penalties	(950)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(4,963)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(57,555)	21		24
25	Fund Raising, Advertising and Promotional	(1,958)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,387,595)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,452,724)		\$	30

<b>OHF USE ONLY</b>							
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	2	
		<b>Amount</b>	<b>Reference</b>	
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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS)			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (1,452,724)		37

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

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

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0007435

Report Period Beginning: 01/01/00

Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Deferred Maintenance	\$ 6	1
2	IDPA RECOUPMENT (CONTINGENCY)	(10,204)	21 2
3	BOARD EXPENSES OUT OF STATE TRIP	(8,011)	21 3
4	BANK CHARGES	(8,866)	21 4
5	INVESTMENT EXPENSES	(21,810)	21 5
6	NON-RESIDENT MEAL INCOME	(82,768)	2 6
7	BEAUTY SHOP INCOME	(773)	40 7
8	MARKETING EXPENSES	(144,356)	43 8
9	INDEPENDENT LIVING EXPENSES	(28,179)	43 9
10	VENDING INCOME	(10)	41 10
11	GIFT SHOP SALES	(1,296)	41 11
12	ICE CREAM SHOP SALES	(31,472)	41 12
13	TELEPHONE REVENUE	(21,032)	21 13
14	CHAPEL FUND RECEIPTS	(2,874)	21 14
15	MEALS ON WHEELS	(37,933)	2 15
16	REFRESHMENTS FOR MARKETING	(2,157)	43 16
17	REFUND TO BCBS (MGD CARE R)	(10,760)	10 17
18	INDEPENDENT LIVING ALLOCATIONS	(67,570)	5 18
19	INDEPENDENT LIVING ALLOCATIONS	(89,549)	3 19
20	INDEPENDENT LIVING ALLOCATIONS	(131,259)	6 20
21	INDEPENDENT LIVING ALLOCATIONS	(28,592)	4 21
22	INDEPENDENT LIVING ALLOCATIONS	(59,146)	11 22
23	INDEPENDENT LIVING ALLOCATIONS	(44,240)	12 23
24	INDEPENDENT LIVING ALLOCATIONS	(6,022)	20 24
25	INDEPENDENT LIVING ALLOCATIONS	(136,378)	21 25
26	INDEPENDENT LIVING ALLOCATIONS	(41,671)	19 26
27	INDEPENDENT LIVING ALLOCATIONS	(81,525)	1 27
28	INDEPENDENT LIVING ALLOCATIONS	(66,823)	2 28
29	INDEPENDENT LIVING ALLOCATIONS	(38,439)	26 29
30	INDEPENDENT LIVING ALLOCATIONS	(81,373)	22 30
31	NON-CARE ASSET DEPRECIATION	(67,802)	30 31
32	CAPITALIZED REPAIRS AND MAINTENANCE	(11,862)	6 32
33	COPIES INCOME	(144)	21 33
34	GARNISHMENT INCOME	(515)	4 34
35	ENDOWMENT EXPENSE	(4,063)	21 35
36	LATE FEE REVENUE	(13,253)	21 36
37	OUT OF STATE SEMINAR AND EXPENSES	(4,318)	24 37
38	UNSUBSTANTIATED SEMINARS	(480)	24 38
39	UNSUBSTANTIATED TRAVEL	(900)	25 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
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61			61
62			62
63			63
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65			65
66			66
67			67
68			68
69			69
70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	<b>Total</b>	<b>(1,387,595)</b>	<b>90</b>

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number CENTRAL BAPTIST HOME# 0007435 Report Period Beginning:01/01/00

Ending:

12/31/00

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)	
	<b>A. General Services</b>													
1	Dietary	(81,525)											(81,525)	1
2	Food Purchase	(187,524)											(187,524)	2
3	Housekeeping	(89,549)											(89,549)	3
4	Laundry	(29,107)											(29,107)	4
5	Heat and Other Utilities	(67,570)											(67,570)	5
6	Maintenance	(143,121)											(143,121)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(598,396)</b>											<b>(598,396)</b>	8
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(10,760)											(10,760)	10
10a	Therapy													10a
11	Activities	(59,146)											(59,146)	11
12	Social Services	(44,240)											(44,240)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(114,146)</b>											<b>(114,146)</b>	16
	<b>C. General Administration</b>													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(41,671)											(41,671)	19
20	Fees, Subscriptions & Promotions	(7,980)											(7,980)	20
21	Clerical & General Office Expenses	(285,140)											(285,140)	21
22	Employee Benefits & Payroll Taxes	(81,373)											(81,373)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(4,798)											(4,798)	24
25	Other Admin. Staff Transportation	(900)											(900)	25
26	Insurance-Prop.Liab.Malpractice	(43,392)											(43,392)	26
27	Other (specify):*													27
28	<b>TOTAL General Administration</b>	<b>(465,254)</b>											<b>(465,254)</b>	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(1,177,796)</b>											<b>(1,177,796)</b>	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number CENTRAL BAPTIST HOME# 0007435

Report Period Beginning:

01/01/00

Ending:

12/31/00

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(66,705)											(66,705)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest													32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	(66,705)											(66,705)	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(773)											(773)	40
41	Coffee and Gift Shops	(32,778)											(32,778)	41
42	Provider Participation Fee													42
43	Other (specify):*	(174,672)											(174,672)	43
44	<b>TOTAL Special Cost Centers</b>	(208,223)											(208,223)	44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	(1,452,724)											(1,452,724)	45

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							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		\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V						\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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	<b>Total</b>		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V							\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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	<b>Total</b>		\$				\$ 0	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V							\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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	<b>Total</b>		\$				\$ 0	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V		\$				\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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	<b>Total</b>		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V		\$				\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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	<b>Total</b>		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V		\$				\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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	<b>Total</b>		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							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	<b>Total</b>		\$			\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V		\$				\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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	<b>Total</b>		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V		\$				\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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	<b>Total</b>		\$				\$	0 \$ *	39

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

Facility Name & ID Number CENTRAL BAPTIST HOME # 0007435 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number CENTRAL BAPTIST HOME

# 0007435

Report Period Beginning:

01/01/00

Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number CENTRAL BAPTIST HOME

# 0007435

Report Period Beginning:

01/01/00

Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

Facility Name & ID Number CENTRAL BAPTIST HOME

# 0007435

Report Period Beginning:

01/01/00

Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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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 CENTRAL BAPTIST HOME

# 0007435

Report Period Beginning:

01/01/00

Ending: 12/31/00

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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 CENTRAL BAPTIST HOME

# 0007435

Report Period Beginning:

01/01/00

Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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 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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number CENTRAL BAPTIST HOME

# 0007435

Report Period Beginning:

01/01/00

Ending: 12/31/00

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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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number CENTRAL BAPTIST HOME

# 0007435

Report Period Beginning:

01/01/00

Ending: 12/31/00

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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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number CENTRAL BAPTIST HOME

# 0007435

Report Period Beginning:

01/01/00

Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number CENTRAL BAPTIST HOME

# 0007435

Report Period Beginning:

01/01/00

Ending: 12/31/00

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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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number CENTRAL BAPTIST HOME

# 0007435

Report Period Beginning:

01/01/00

Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

	1	2	3	4	5	6		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	1999 A Bond Series		X	Assisted Living Construction		11/01/99	\$ 10,000,000	\$ 10,000,000	11/15/2029	5.5-7.13%	\$ Capitalized	1							
2	1999 B Bond Series		X	Assisted Living Construction		11/01/99	13,300,000	13,300,000	11/15/2029	3.63%	Capitalized	2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6												6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$ 23,300,000	\$ 23,300,000			\$	9							
<b>B. Non-Facility Related*</b>																			
10	Supplemental Schedule											10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 23,300,000	\$ 23,300,000			\$	15							

\* 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

CENTRAL BAPTIST HOME

# 0007435

Report Period Beginning:

01/01/00

Ending:

12/31/00

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	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
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				

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

**B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	N/A	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.)	\$		2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. 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. <b>TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$		7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	8	
	1996	9	
	1997	10	
	1998	11	
	1999	12	
	<b>FOR OFF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 1999 \$	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.**

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 61,531 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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

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

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

Retirement Center

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

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

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1956</u>	\$ <u>55,756</u>	1
2	<u>Facility</u>		<u>2000</u>	<u>22,375</u>	2
3	<b>TOTALS</b>			\$ <b>78,131</b>	3

Facility Name & ID Number CENTRAL BAPTIST HOME# 0007435

Report Period Beginning:

01/01/00

Ending:

12/31/00

## XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	152		1984	1978	\$ 1,700,300	\$ 48,580	35	\$ 48,580	\$	\$ 781,328	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various			1978	741,182	18,529	40	18,529		410,739	9	
10	Various			1980	169,392	5,646	30	5,646		112,927	10	
11	Various			1981	11,565	298	30-39	298		6,907	11	
12	Various			1982	253,573	8,676	20-36	8,676		166,939	12	
13	Various			1983	128,501	2,899	5-30	2,899		36,018	13	
14	Various			1984	41,935	1,648	10-20	1,648		35,315	14	
15	Various			1985	7,156	10	10-20	10		7,110	15	
16	Various			1986	5,544	146	10-20	146		4,741	16	
17	Various			1988	20,524		5-10			20,524	17	
18	Various			1989	897,986	29,157	5-10	29,157		346,432	18	
19	Various			1990	2,062,025	71,757	5-30	71,757		772,564	19	
20	Various			1991	113,650	2,885	5-27	2,885		28,711	20	
21	Various			1992	201,338	11,636	10-26	11,636		99,572	21	
22	Various			1993	139,141	8,655	7-25	8,655		67,837	22	
23	Various			1994	115,592	10,974	5-24	10,974		79,269	23	
24	Various			1995	292,495	21,457	5-23	21,457		114,514	24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32	PAGE 12D TOTALS					2,872			72	72	72	32
33	PAGE 12C TOTALS					573,488	26,063		26,287	225	37,559	33
34	PAGE 12B TOTALS					1,451,636	66,393		66,393		126,742	34
35	PAGE 12A TOTALS					154,624	15,666		15,666		49,923	35
36	TOTAL (lines 4 thru 35)					\$ 9,084,519	\$ 351,075		\$ 351,371	\$ 297	\$ 3,305,743	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.

Facility Name & ID Number CENTRAL BAPTIST HOME# 0007435

Report Period Beginning:

01/01/00

Ending:

12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		<b>Patio Improvements</b>		1996	4,614	461	10	461		2,114	9
10		<b>Parking Bumpers</b>		1996	593	27	22	27		130	10
11		<b>Exit Lighting</b>		1996	850	39	22	39		175	11
12		<b>Computer Wiring</b>		1996	7,001	700	10	700		2,858	12
13		<b>Elevator Ventilation</b>		1996	736	73	10	73		344	13
14		<b>Gate Alarm System</b>		1996	2,430	511	5	511		2,046	14
15		<b>Automatic Exit Door</b>		1996	1,775	81	22	81		364	15
16											16
17		<b>Landscaping</b>		1997	3,026	303	10	303		1,060	17
18		<b>Landscaping</b>		1997	12,700	1,270	10	1,270		4,445	18
19		<b>Parking Lot asphalt and sealing</b>		1997	20,504	2,050	10	2,050		6,834	19
20		<b>Ejector Pumps</b>		1997	4,750	475	10	475		1,544	20
21		<b>Carpeting</b>		1997	5,298	1,060	5	1,060		3,444	21
22		<b>Entryway heater</b>		1997	1,965	94	21	94		360	22
23		<b>Door Hardware</b>		1997	637	30	21	30		115	23
24		<b>Insulation</b>		1997	1,323	63	21	63		226	24
25		<b>HVAC</b>		1997	2,623	262	10	262		917	25
26		<b>Elevator Renovation</b>		1997	10,918	1,092	10	1,092		3,640	26
27		<b>Automatic Doors</b>		1997	5,840	278	21	278		904	27
28		<b>Pump</b>		1997	4,845	903	5	903		3,113	28
29		<b>Exhaust Fans</b>		1998	3,450	345	10	345		978	29
30		<b>Parking Lot</b>		1998	20,610	2,061	10	2,061		4,809	30
31		<b>Ceiling Tile</b>		1998	528	26	20	26		54	31
32		<b>Tuckpointing</b>		1998	1,100	55	20	55		124	32
33		<b>Carpeting</b>		1998	31,383	3,138	10	3,138		8,630	33
34		<b>Door/Frame</b>		1998	1,700	85	20	85		220	34
35		<b>Door Edge Guards</b>		1998	3,425	184	20	184		475	35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 154,624	\$ 15,666		\$ 15,666	\$	\$ 49,923	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.

Facility Name & ID Number CENTRAL BAPTIST HOME# 0007435

Report Period Beginning:

01/01/00 Ending:12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		<b>Fire Damper</b>		1998	32,115	1,606	20	1,606		3,480	9
10		<b>NP Electrical Upgrade</b>		1998	2,758	138	20	138		287	10
11		<b>Resident Room re-painted</b>		1998	22,345	1,117	20	1,117		2,327	11
12		<b>Med Room Remodeling-Cabinets</b>		1998	3,215	161	20	161		335	12
13		<b>Elevator Upgrades</b>		1998	11,617	581	20	581		1,210	13
14		<b>Board Room Redecorated</b>		1998	2,561	128	20	128		267	14
15		<b>NP Dining Room</b>		1998	1,153,898	28,787	20	28,787		62,382	15
16		<b>Compressor</b>		1998	2,100	105	20	105		245	16
17		<b>Fire Alarm System</b>		1998	5,065	253	20	253		527	17
18		<b>Sprinklers</b>		1998	2,275	114	20	114		266	18
19		<b>Circulator Pump</b>		1998	566	57	10	57		123	19
20		<b>Storm Windows</b>		1998	28,876	1,686	20	1,686		4,637	20
21		<b>Dock Stairs/Railing</b>		1998	3,090	309	10	309		670	21
22		<b>Chiller</b>		1998	6,783	848	2	848		6,783	22
23		<b>Air Compressor</b>		1998	1,540	321	2	321		1,540	23
24		<b>Ejector Pump</b>		1998	2,757	276	10	276		782	24
25		<b>Verticle Blinds</b>		1998	9,142	914	10	914		2,590	25
26		<b>Antenna Repair/Upgrade</b>		1998	2,350	470	5	470		1,332	26
27		<b>Rebuild Doors</b>		1999	700	70	10	70		111	27
28		<b>Electrical Repairs/Code</b>		1999	834	83	10	83		166	28
29		<b>Toilet Safety Rails</b>		1999	2,084	208	10	208		382	29
30		<b>Nurse Call System</b>		1999	59,300	5,930	10	5,930		8,401	30
31		<b>Panel for phones</b>		1999	860	86	10	86		151	31
32		<b>Sprinkler Accelerator System</b>		1999	1,150	115	10	115		201	32
33		<b>Hot Water Tanks</b>		1999	35,892	3,589	10	3,589		5,982	33
34		<b>Gas Pipe/Boiler Room</b>		1999	2,900	153	19	153		229	34
35		<b>Phone System Upgrade</b>		1999	54,863	18,288	3	18,288		21,336	35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 1,451,636	\$ 66,393		\$ 66,393	\$	\$ 126,742	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.

Facility Name & ID Number CENTRAL BAPTIST HOME# 0007435

Report Period Beginning:

01/01/00

Ending:

12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		<b>NP Room Renovation</b>	1999		339,396	8,467	20	8,467		18,348	9
10		<b>NP Dining Room</b>	1999		47,760	1,192	20	1,192		2,582	10
11		<b>Asphalt Repairs</b>	2000		1,750	583	20	583		583	11
12		<b>Asphalt Repairs</b>	2000		1,740	363	20	363		363	12
13		<b>Test Stations</b>	2000		2,770	231	20	231		231	13
14		<b>Door Repairs</b>	2000		826	184	20	184		184	14
15		<b>Door Alarm Replacements</b>	2000		673	131	20	131		131	15
16		<b>Roof Work</b>	2000		2,900	604	20	604		604	16
17		<b>Door Repairs</b>	2000		1,013	84	20	84		84	17
18		<b>Carpet</b>	2000		69,866	6,957	20	6,957		6,957	18
19		<b>Walk In Cooler Compressor</b>	2000		2,564	427	2	427		427	19
20		<b>Walk In Cooler Compressor</b>	2000		19,040	4,760	2	4,760		4,760	20
21		<b>Alarm</b>	2000		4,380	852	3	852		852	21
22		<b>Fire Panel</b>	2000		640	124	3	124		124	22
23		<b>Walk In Cooler Compressor</b>	2000		2,823	549	3	549		549	23
24		<b>IDPH 2000 Survey Corrections</b>	2000		66,657	555	10	555		555	24
25		<b>Circuit Repairs</b>	2000		540		20	14	14	14	25
26		<b>Nurse Call Station</b>	2000		540		20	14	14	14	26
27		<b>Electrical Work</b>	2000		578		20	14	14	14	27
28		<b>Walk In Cooler Repairs</b>	2000		650		20	16	16	16	28
29		<b>Circuit Breakers</b>	2000		655		20	16	16	16	29
30		<b>Plumbing Work</b>	2000		721		20	18	18	18	30
31		<b>Freezer Repairs</b>	2000		790		20	20	20	20	31
32		<b>Painting</b>	2000		790		20	20	20	20	32
33		<b>Freezer Repairs</b>	2000		1,061		20	27	27	27	33
34		<b>Chiller Compressor Repairs</b>	2000		1,166		20	29	29	29	34
35		<b>Freezer Coil Replacement</b>	2000		1,499		20	37	37	37	35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 573,488	\$ 26,063		\$ 26,287	\$ 225	\$ 37,559	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.

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	A/C Repairs		2000		2,141		20	54	54	54	9
10	Floor Replacement		2000		731		20	18	18	18	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	<b>TOTAL (lines 4 thru 35)</b>				\$ 2,872	\$		\$ 72	\$ 72	\$ 72	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.

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

Facility Name & ID Number CENTRAL BAPTIST HOME

# 0007435

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

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	
37	Purchased in Prior Years	\$ 1,202,748	\$ 125,935	\$ 125,935	\$		\$ 877,784	37
38	Current Year Purchases	99,132	21,569	21,569			21,569	38
39	Fully Depreciated Assets	484,223					484,223	39
40								40
41	TOTALS	\$ 1,786,103	\$ 147,504	\$ 147,504	\$		\$ 1,383,576	41

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	
42	Facility	1987 Handicap Bus	1987	\$ 35,380	\$	\$	\$	5	\$ 35,380	42
43	Facility	1995 Ford Van	1995	32,705	2,725	2,725		5	32,705	43
44	Facility	1997 Ford Pickup	1997	26,767	5,353	5,353		5	17,398	44
45	Facility	1998 Mercury Van	1998	22,868	4,574	4,574		5	9,529	45
46	TOTALS			\$ 117,720	\$ 12,652	\$ 12,652	\$		\$ 95,012	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 11,066,473	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 511,231	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 511,527	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 297	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 4,784,331	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Retirement Center	\$ 1,226,001	\$ 40,095	\$ 1,170,715	52
53	Houses	110,673	6,216	72,720	53
54	Vehicle - Administration	46,600	9,010	11,177	54
55	Non-Care Related Equipment	145,839	11,680	129,857	55
56					56
57	TOTALS	\$ 1,529,113	\$ 67,001	\$ 1,384,469	57

G. Construction-in-Progress

	Description	Cost	
58	Independent Living	\$ 11,137,850	58
59			59
60			60
61		\$ 11,137,850	61

\* 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.

CENTRAL BAPTIST HOME  
0007435  
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE  
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
<b>LINE 28: PRIOR YEARS</b>					
Central Baptist Village	1,202,748	125,935	125,935		877,784
<b>TOTALS</b>	1,202,748	125,935	125,935		877,784

<b>LINE 29: CURRENT YEAR</b>					
Central Baptist Village	99,132	21,569	21,569		21,569
<b>TOTALS</b>	99,132	21,569	21,569		21,569

<b>LINE 30: FULLY DEPRECIATED</b>					
Central Baptist Village	484,223				484,223
<b>TOTALS</b>	484,223				484,223

**TOTALS (Should Tie to Totals on Page 13)**

Central Baptist Village	1,786,103	147,504	147,504		1,383,576
<b>TOTALS</b>	1,786,103	147,504	147,504		1,383,576

Facility Name & ID Number CENTRAL BAPTIST HOME

# 0007435

Report Period Beginning:

01/01/00

Ending: 12/31/00

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

\*\*

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

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

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

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

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

YES  NO

16. Rental Amount for movable equipment: \$ 948

Description: Vending Machines

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			\$ _____	\$ _____	18
19			\$ _____	\$ _____	19
20			\$ _____	\$ _____	20
21	<b>TOTAL</b>		\$ _____	\$ <b>0</b>	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. /2001 \$ \_\_\_\_\_

13. /2002 \$ \_\_\_\_\_

14. /2003 \$ \_\_\_\_\_

\* 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.

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

	Facility			
	1	2	3	4
	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 Nurse Aide 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 aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

1	Service	Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or) Allocated	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	46,343	\$		\$	46,343	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				2,094				2,094	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				36,739				36,739	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-2	# of prescripts					28,144			28,144	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	Other (specify): <b>**SEE SUPPLEMENTAL SCHEDULE**</b>	39-2						1,591			1,591	13
14	<b>TOTAL</b>			\$		\$	85,176	\$	29,735	\$	114,911	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 nurse aides, who help with the above activities should not be listed on this schedule.

**SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES**

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1 Medical Supplies	163
2 Laboratory Costs	1,428
3	
4	
5	
6	
7	
8	
9	
10	
	<u>1,591</u>
	<u>1,591</u>
<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
	<u>          </u>
	<u>          </u>

This report must be completed even if financial statements are attached.

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 65,416	\$ 1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,229,277	3
4	Supply Inventory (priced at )		4
5	Short-Term Investments		5
6	Prepaid Insurance	84,248	6
7	Other Prepaid Expenses	40,188	7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify): <a href="#">See supplemental schedule</a>	2,286	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,421,415	\$ 10
<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		11
12	Long-Term Investments	41,183,262	12
13	Land	289,603	13
14	Buildings, at Historical Cost	10,151,268	14
15	Leasehold Improvements, at Historical Cos		15
16	Equipment, at Historical Cost	13,280,507	16
17	Accumulated Depreciation (book methods)	(6,168,503)	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): <a href="#">See supplemental schedule</a>	838,291	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 59,574,428	\$ 24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 60,995,843	\$ 25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 256,186	\$ 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	729,924	28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	296,378	30
31	Accrued Taxes Payable (excluding real estate taxes)	51,554	31
32	Accrued Real Estate Taxes(Sch.IX-B)		32
33	Accrued Interest Payable	133,073	33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See supplemental schedule</a>	1,115	36
37			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,468,230	\$ 38
<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	23,300,000	39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See supplemental schedule</a>		43
44			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 23,300,000	\$ 45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 24,768,230	\$ 46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 36,227,613	\$ #REF! 47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 60,995,843	\$ #REF! 48

\*(See instructions.)

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES

As of 12/31/00

OTHER CURRENT ASSETS:

401K Retirement Withholding  
Staff Fund

Amount	Amount
1,972	
314	
<u>2,286</u>	<u>          </u>

OTHER CURRENT LIABILITIES:

Residents' Bakers Club  
Employee Deposits

Amount	Amount
683	
432	
<u>1,115</u>	<u>          </u>

OTHER NON CURRENT ASSETS:

Bond Issuance Costs (Net of A/A)

838,291	
<u>838,291</u>	<u>          </u>

OTHER NON CURRENT LIABILITIES:

<u>          </u>	<u>          </u>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 35,572,443	1
2	Restatements (describe):		2
3	Depreciation	(3,446)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 35,568,997	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	658,616	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)	\$ 658,616	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 36,227,613	24 *

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

Facility Name & ID Number CENTRAL BAPTIST HOME # 0007435 Report Period Beginning: 01/01/00 Ending: 12/31/00

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Balance per General Ledger 35,568,997

Adjustments:  
-  
-  
-

Depreciation 3,446

Total adjustments 3,446

Balance - Beginning of Year 35,572,443

Equity(Deficit) from Page 17 Col 1 36,227,613

Related Party  
Equity(Deficit) 0  
Income 0

-

Combined Equity - End of Year 36,227,613

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

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

1

Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,492,897	1
2	Discounts and Allowances for all Levels	(515,802)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,977,095	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	152,636	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 152,636	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	32,768	12
13	Barber and Beauty Care	9,870	13
14	Non-Patient Meals	82,768	14
15	Telephone, Television and Radic	21,032	15
16	Rental of Facility Space	3,833	16
17	Sale of Drugs	22,068	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	265,928	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 438,267	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	4,701	24
25	Interest and Other Investment Income***	1,150,809	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,155,510	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See supplemental schedule</u>	(61,569)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (61,569)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,661,939	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,873,318	31
32	Health Care	2,260,756	32
33	General Administration	1,780,904	33
<b>B. Capital Expense</b>			
34	Ownership	580,887	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	439,382	35
36	Provider Participation Fee	68,076	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,003,323	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	658,616	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 658,616	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Available 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.

**SUPPLEMENTAL SCHEDULE OF REVENUES**  
**12/31/00**

<u>DESCRIPTION</u>	<u>AMOUNT</u>
1 Vending Commissions - Adjusted out on Page 5	10
2 Income from Copies - Adjusted out on Page 5	144
3 Sale of Asset	120
4 Banquet Revenue	36
5 Garnishment fee income - Adjusted out on Page 5	515
6 Change in Value of Asset	(65,433)
7 Application Fee Revenue	3,039
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	<u>(61,569)</u>

Facility Name & ID Number CENTRAL BAPTIST HOME

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,884	2,080	\$ 71,763	\$ 34.50	1
2	Assistant Director of Nursing	1,896	2,080	43,146	20.74	2
3	Registered Nurses	10,400	12,467	445,192	35.71	3
4	Licensed Practical Nurses	5,447	7,124	252,281	35.41	4
5	Nurse Aides & Orderlies	33,676	39,776	786,724	19.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,684	4,160	46,883	11.27	8
9	Activity Director	1,968	2,080	32,188	15.48	9
10	Activity Assistants	23,520	23,784	201,616	8.48	10
11	Social Service Workers	11,581	12,395	193,429	15.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	64,251	69,463	464,566	6.69	15
16	Dishwashers					16
17	Maintenance Workers	12,651	13,915	171,343	12.31	17
18	Housekeepers	19,894	21,458	151,296	7.05	18
19	Laundry	9,170	9,948	86,915	8.74	19
20	Administrator	2,024	2,080	87,116	41.88	20
21	Assistant Administrator	1,904	2,080	44,667	21.47	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,946	16,609	257,697	15.52	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	1,901	2,080	20,800	10.00	31
32	Other Health Care(specify)					32
33	Other(specify)	15,413	17,325	233,293	13.47	33
34	TOTAL (lines 1 - 33)	236,210	260,904	\$ 3,590,915 *	\$ 13.76	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 26,400	9-3	36
37	Medical Records Consultant	Monthly 4,353	10-3	37
38	Nurse Consultant	One Time 275	10-3	38
39	Pharmacist Consultant	Monthly 1,350	10-3	39
40	Physical Therapy Consultant	96 4,794	10a-3	40
41	Occupational Therapy Consultant	38 1,886	10a-3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	7 375	10a-3	43
44	Activity Consultant	Monthly 2,427	11-3	44
45	Social Service Consultant	Monthly 1,770	12-3	45
46	Other(specify)			46
47	Dietary - Canteen Management	26,479	1-3	47
48				48
49	TOTAL (lines 35 - 48)	141 \$ 70,109		49

C. CONTRACT NURSES

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

**SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS**

**B. CONSULTANT SERVICES**

	<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
Marketing	5,826	6,292	\$ 101,084	\$ 16.07
Independent Living Svcs	1,631	1,673	19,983	11.94
Canteen Wages	7,956	9,360	112,226	11.99
	<u>15,413</u>	<u>17,325</u>	\$ <u>233,293</u>	\$ <u>13.47</u>





Facility Name & ID Number CENTRAL BAPTIST HOME# 0007435Report Period Beginning: 01/01/00Ending: 12/31/00**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. LSN - \$ 5856.00
- (3) Did the nursing home make political contributions or payments to a political 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. \$ 28,219 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 of Public Aid during this cost report period. \$ 68,076  
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 of Public Aid, 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? Yes 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 benefit on Schedule V. \$ 39,977 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 82,768
- (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? 100%ln14  
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? \_\_\_\_\_  
**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? Yes  
Firm Name: Frost, Ruttenberg & Rothblatt The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not Completed
- (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 \$2500, 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.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette  
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 1, do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

**WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.**

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 1/2 by 14 size white paper with an 8 1/2 by 14 image on the paper. To ensure an 8 1/2 by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 1/2 by 11. We cannot accept a report with an 8 1/2 by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

**Notes Applicable only to Lotus users**

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

**Notes Applicable only to Excel users**

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/ov