

		FOR OHF USE				

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**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0044743</u></p> <p>Facility Name: <u>CLC Sumner</u></p> <p>Address: <u>1 Poplar Drive</u> <u>Sumner</u> <u>62466</u> Number City Zip Code</p> <p>County: <u>Lawrence</u></p> <p>Telephone Number: <u>(618) 936-2311</u> Fax # <u>(618) 936-9000</u></p> <p>IDPA ID Number: <u>770535048003</u></p> <p>Date of Initial License for Current Owners: <u>4/01/00</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael G. Kaplan</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/1/01</u> to <u>12/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1144 678 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 678 1921 722">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1144 722 1281 828"></td> <td data-bbox="1281 722 1921 771">(Type or Print Name) _____</td> </tr> <tr> <td data-bbox="1144 771 1281 828"></td> <td data-bbox="1281 771 1921 828">(Title) _____</td> </tr> <tr> <td data-bbox="1144 828 1281 1039">Paid Preparer</td> <td data-bbox="1281 828 1921 885">(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____</td> </tr> <tr> <td data-bbox="1144 885 1281 1039"></td> <td data-bbox="1281 885 1921 933">(Print Name and Title) _____</td> </tr> <tr> <td data-bbox="1144 933 1281 1039"></td> <td data-bbox="1281 933 1921 982">(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td data-bbox="1144 982 1281 1039"></td> <td data-bbox="1281 982 1921 1039">(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLC Sumner

0044743 Report Period Beginning: 01/1/01 Ending: 12/31/01

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 N/A

	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	<u>82</u>	Skilled (SNF)	<u>82</u>	<u>29,930</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>82</u>	TOTALS	<u>82</u>	<u>29,930</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	4 Other		
8	SNF	<u>14,762</u>	<u>3,600</u>	<u>992</u>	<u>19,354</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,762</u>	<u>3,600</u>	<u>992</u>	<u>19,354</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.66%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 04/01/00

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/00 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 15 and days of care provided 931

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/01 Fiscal Year: 12/31/01

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

STATE OF ILLINOIS

Facility Name & ID Number CLC Sumner # 0044743 Report Period Beginning: 01/01 Ending: 12/31/01

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjustments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	80,541	5,736	3,881	90,158		90,158	(597)	89,561		1
2	Food Purchase		74,770		74,770		74,770		74,770		2
3	Housekeeping	62,730	11,260	340	74,330		74,330		74,330		3
4	Laundry	33,250	7,329		40,579		40,579		40,579		4
5	Heat and Other Utilities			65,354	65,354		65,354	5	65,359		5
6	Maintenance	35,045	2,481	38,312	75,838		75,838	(1,109)	74,729		6
7	Other (specify):*										7
8	TOTAL General Services	211,566	101,576	107,887	421,029		421,029	(1,701)	419,328		8
	B. Health Care and Programs										
9	Medical Director			3,300	3,300		3,300		3,300		9
10	Nursing and Medical Records	722,768	44,029	7,389	774,186		774,186		774,186		10
10a	Therapy		1,959	105,179	107,138		107,138		107,138		10a
11	Activities	38,386	5,599	2,103	46,088		46,088		46,088		11
12	Social Services	22,916	134	8,273	31,323		31,323		31,323		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	784,070	51,721	126,244	962,035		962,035		962,035		16
	C. General Administration										
17	Administrative	52,645		211,611	264,256		264,256	(211,611)	52,645		17
18	Directors Fees										18
19	Professional Services			7,680	7,680		7,680	9,143	16,823		19
20	Dues, Fees, Subscriptions & Promotions			15,905	15,905		15,905	(1,117)	14,788		20
21	Clerical & General Office Expenses	32,683	6,428	39,164	78,275		78,275	128,945	207,220		21
22	Employee Benefits & Payroll Taxes			199,087	199,087		199,087	12,903	211,990		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,190	12,190		12,190	17,842	30,032		24
25	Other Admin. Staff Transportation			786	786		786		786		25
26	Insurance-Prop.Liab.Malpractice			120,752	120,752		120,752	4,289	125,041		26
27	Other (specify):*										27
28	TOTAL General Administration	85,328	6,428	607,175	698,931		698,931	(39,606)	659,325		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,080,964	159,725	841,306	2,081,995		2,081,995	(41,307)	2,040,688		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

CLC Sumner

#0044743

Report Period Beginning:

01/1/01

Ending:

12/31/01

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	
	D. Ownership											
30	Depreciation			2,446	2,446		2,446	69,747	72,193			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			41,715	41,715		41,715	183,076	224,791			32
33	Real Estate Taxes			29,552	29,552		29,552		29,552			33
34	Rent-Facility & Grounds			65,004	65,004		65,004	(60,303)	4,701			34
35	Rent-Equipment & Vehicles			5,427	5,427		5,427	2,808	8,235			35
36	Other (specify):*											36
37	TOTAL Ownership			144,144	144,144		144,144	195,328	339,472			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,075	1,075		1,075		1,075			38
39	Ancillary Service Centers		56,588		56,588		56,588		56,588			39
40	Barber and Beauty Shops			100	100		100		100			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,461	45,461		45,461		45,461			42
43	Other (specify):* Nonallowable costs			44,857	44,857		44,857	(44,857)				43
44	TOTAL Special Cost Centers		56,588	91,493	148,081		148,081	(44,857)	103,224			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,080,964	216,313	1,076,943	2,374,220		2,374,220	109,164	2,483,384			45

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

**See schedule of adjustments attached at end of cost report

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLC Sumner

0044743

Report Period Beginning: 01/1/01

Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,671)	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	(661)	20		17
18	Fines and Penalties	(5,886)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(26,260)	43		24
25	Fund Raising, Advertising and Promotional	(2,133)	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 See Sch 5A	(14,599)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (57,210)		\$	30

OHF USE ONLY					
48		49	50	51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	166,374		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 166,374		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 109,164		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name CLC Sumner
PROVIDER # 0044743
Period Ending 12/31/01

Schedule 5A

VI. ADJUSTMENT DETAIL

LINE 29 - Other

Description	Amount	Schedule V Reference
Vending Income Offset	(597)	1
Personal Need Income	(2)	21
Laboratory Expense	(1,728)	43
X-Ray Expense	(86)	43
Marketing & Public Relations	(8,031)	43
Client Relations	(1,879)	43
Cable Expense	(987)	43
To capitalize overbed lights	(1,289)	6
Total	(14,599)	

See Accountants' Compilation Report

CLC Summer

ID# 0044743

Report Period Beginning: 01/1/01

Ending: 12/31/01

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CLC Summer

0044743

Report Period Beginning:

01/1/01

Ending:

12/31/01

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	5	0	0	0	0	0	0	0	0	0	5	5
6	Maintenance	0	180	0	0	0	0	0	0	0	0	0	180	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	185	0	0	0	0	0	0	0	0	0	185	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(211,611)	0	0	0	0	0	0	0	0	0	(211,611)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,143	0	0	0	0	0	0	0	0	0	9,143	19
20	Fees, Subscriptions & Promotions	(2,794)	1,677	0	0	0	0	0	0	0	0	0	(1,117)	20
21	Clerical & General Office Expenses	0	128,947	0	0	0	0	0	0	0	0	0	128,947	21
22	Employee Benefits & Payroll Taxes	0	12,903	0	0	0	0	0	0	0	0	0	12,903	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	17,842	0	0	0	0	0	0	0	0	0	17,842	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	4,289	0	0	0	0	0	0	0	0	0	4,289	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(2,794)	(36,810)	0	0	0	0	0	0	0	0	0	(39,604)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,794)	(36,625)	0	0	0	0	0	0	0	0	0	(39,419)	29

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
Centers For Long Term Care of Illinois, Inc	100%	See Attached Schedules		Centers for Long Term Care, Inc.	Irving, Texas	Healthcare Co.
				LTC Healthcare of	Oxnard, CA.	Lessor
				Red Hills, Inc.		
				BMW Healthcare, Inc	Irving, Texas	Healthcare Co.

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
1	V	5 Utilities	\$	Centers For Long Term Care, Inc.	100.00%	\$	\$
2	V	6 Maintenance		Centers For Long Term Care, Inc.	100.00%	180	180
3	V	17 Administrative	211,611	Centers For Long Term Care, Inc.	100.00%		(211,611)
4	V	19 Professional Services		Centers For Long Term Care, Inc.	100.00%	9,143	9,143
5	V	20 Fees, Subscriptions		Centers For Long Term Care, Inc.	100.00%	1,677	1,677
6	V	21 Clerical & General		Centers For Long Term Care, Inc.	100.00%	128,947	128,947
7	V	22 Employee Benefits		Centers For Long Term Care, Inc.	100.00%	12,903	12,903
8	V	24 Travel & Seminar		Centers For Long Term Care, Inc.	100.00%	17,842	17,842
9	V	26 Insurance		Centers For Long Term Care, Inc.	100.00%	4,289	4,289
10	V	30 Depreciation		Centers For Long Term Care, Inc.	100.00%	8,351	8,351
11	V	34 Rent - Facility & Grounds		Centers For Long Term Care, Inc.	100.00%	3,501	3,501
12	V	35 Rent - Equipment		Centers For Long Term Care, Inc.	100.00%	776	776
13	V	35 Rent - Vehicles		Centers For Long Term Care, Inc.	100.00%	2,032	2,032
14	Total		\$ 211,611			\$ 189,646	\$ * (21,965)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	30 Depreciation	\$	LTC Healthcare of Red Hills, Inc.	0.00%	\$ 69,067	\$ 69,067
16	V	32 Interest Expense		LTC Healthcare of Red Hills, Inc.	0.00%	183,076	183,076
17	V	34 Rent - Facility & Grounds	63,804	LTC Healthcare of Red Hills, Inc.	0.00%		(63,804)
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 63,804			\$ 252,143	\$ * 188,339

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1									\$		1	
2	N/A											2
3	This is a publicly traded company.										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 CLC Sumner # 0044743 Report Period Beginning: 01/1/01 Ending: 12/31/01

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

Name of Related Organization Centers for Long Term Care, Inc.
 Street Address 2621 W. Airport Freeway, Suite 220
 City / State / Zip Code Irving, Texas 75062
 Phone Number (214) 441-9600
 Fax Number (214) 441-9681

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/(col.4)x col.6)	
1	5	Utilities	Accum. Cost	98,096,963	33	\$ 225	\$ 2,342,548	\$ 5	1
2	6	Maintenance	Accum. Cost	98,096,963	33	7,535	2,342,548	180	2
3	19	Professional Services	Accum. Cost	98,096,963	33	382,868	2,342,548	9,143	3
4	20	Fees, Subscriptions	Accum. Cost	98,096,963	33	70,247	2,342,548	1,677	4
5	21	Clerical & General	Accum. Cost	98,096,963	33	5,399,805	4,387,052	128,947	5
6	22	Employee Benefits	Accum. Cost	98,096,963	33	540,338	2,342,548	12,903	6
7	24	Travel & Seminar	Accum. Cost	98,096,963	33	747,136	2,342,548	17,842	7
8	26	Insurance	Accum. Cost	98,096,963	33	179,588	2,342,548	4,289	8
9	30	Depreciation - Building	Accum. Cost	98,096,963	33	1,400	2,342,548	33	9
10	30	Depreciation - Equipment	Accum. Cost	98,096,963	33	348,334	2,342,548	8,318	10
11	34	Rent - Facility & Grounds	Accum. Cost	98,096,963	33	146,598	2,342,548	3,501	11
12	35	Rent - Equipment	Accum. Cost	98,096,963	33	32,506	2,342,548	776	12
13	35	Rent - Vehicles	Accum. Cost	98,096,963	33	85,078	2,342,548	2,032	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					\$ 7,941,658	\$ 4,387,052	\$ 189,646	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLC Sumner# 0044743

Report Period Beginning:

01/1/01

Ending:

12/31/01

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
	A. Directly Facility Related																		
	Long-Term																		
1	LTC Healthcare of	x		Purchase of Facility	\$15,951.00	10/20/94	\$ 1,600,000	\$ 1,547,523	9/20/04	0.1100	\$ 183,076	1							
2	Red Hills, Inc.											2							
3												3							
4												4							
5												5							
	Working Capital																		
6	Intercompany Interest										41,715	6							
7												7							
8												8							
9	TOTAL Facility Related				\$15,951.00		\$ 1,600,000	\$ 1,547,523			\$ 224,791	9							
	B. Non-Facility Related*																		
10	Allocated from Home Office											10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 1,600,000	\$ 1,547,523			\$ 224,791	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CLC Sumner COUNTY Lawrence

FACILITY IDPH LICENSE NUMBER 0044743

CONTACT PERSON REGARDING THIS REPORT Del Smith

TELEPHONE (214) 441-9600 FAX #: (214) 441-9681

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-001-585-00</u>	<u>Facility Lot</u>	\$ <u>17,136.70</u>	\$ <u>17,136.70</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>17,136.70</u>	\$ <u>17,136.70</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number CLC Sumner# 0044743 Report Period Beginning:01/1/01 Ending:12/31/01**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame Block\Steel Studs Number of Stories 1C. 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).

NoneF. 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2000</u>	<u>\$ 24,801</u>	1
2					2
3	TOTALS			\$ 24,801	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLC Sumner

0044743

Report Period Beginning:

01/1/01

Ending:

12/31/01

XL 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	82	2000	1976	\$ 978,000	\$	35	\$ 27,943	\$ 27,943	\$ 41,915	4
5		2000	1976	4,330		35	124	124	185	5
6										6
7										7
8										8
Improvement Type**										
9	Original Building Improvements 84		1984	1,000		35	29	29	43	9
10	Original Building Improvements 85		1985	6,834		35	195	195	293	10
11	Original Building Improvements 86		1986	2,373		35	68	68	102	11
12	Original Building Improvements 88		1988	5,117		35	146	146	219	12
13	Original Building Improvements 89		1989	6,458		35	185	185	277	13
14	Original Building Improvements 90		1990	19,521		35	558	558	837	14
15	Original Building Improvements 91		1991	10,899		35	311	311	467	15
16	Original Building Improvements 92		1992	20,008		35	572	572	858	16
17	Original Building Improvements 93		1993	47,458		35	1,356	1,356	2,034	17
18	Cubicle Curtains 95		1992	6,939		35	198	198	297	18
19	HW Heater System 95		1995	9,162		35	262	262	393	19
20	AC-Whirlpool 25000 BTUS		1995	1,003		35	29	29	43	20
21	Interior Design 96		1996	661		35	19	19	28	21
22	Exterior Sign 96		1996	5,018		35	143	143	215	22
23	Boiler/Homes Plumb		1997	5,645		35	161	161	242	23
24	Cubicle Curtains 97		1997	2,312		35	66	66	99	24
25	Air Condition System 97		1997	1,914		35	55	55	82	25
26	RPL Vinyl Flooring 97		1997	1,300		35	37	37	56	26
27	Air Curtain 98		1998	1,138		35	33	33	49	27
28	Refurb/Wall Covering 98		1998	15,294		35	437	437	655	28
29	Refurb/ Draperies 98		1998	4,038		35	115	115	173	29
30	Refurb/ Carpeting 98		1998	2,151		35	61	61	92	30
31	Refurb/ Vinyl Flooring 98		1998	8,500		35	243	243	364	31
32	Refurb/Nurse Call System 98		1998	4,898		35	140	140	210	32
33	Refurb/ Kick Plates 98		1998	3,452		35	99	99	148	33
34	Refurb/ Wood Counter		1998	1,620		35	46	46	69	34
35	Refurb/Signage 98		1998	6,219		35	178	178	267	35
36	Refurb/Lighting 98		1998	7,133		35	204	204	306	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number CLC Sumner

0044743

Report Period Beginning:

01/1/01

Ending:

Page 12A

12/31/01

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Refurb/Mirrors 98	1998	\$ 820	\$	35	\$ 23	\$ 23	\$ 35	37
38	Refurb/Handrails 98	1998	8,148		35	233	233	349	38
39	Refurb/Contractors Fee 98	1998	69,530		35	1,987	1,987	2,980	39
40	Electric Repair 98	1998	1,769		35	51	51	76	40
41	Sign - Exterior Logo 98	1998	5,410		35	155	155	232	41
42	Air Condition Pameco 98	1998	746		35	21	21	32	42
43	Tank - 300 Gallon/WW Barnhart 98	1998	1,084		35	31	31	46	43
44	Contract Fees 99	1999	5,934		35	170	170	255	44
45	Water Heater	1999	2,774		35	79	79	119	45
46	CK60 Condensing Units 99	1999	2,841		35	81	81	122	46
47	Automatic Transfer Switch 99	1999	16,974		35	485	485	727	47
48	A/C unit	2000	2,085	417	5	417		626	48
49									49
50	Allocated from Home Office					33	33		50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,308,510	\$ 417		\$ 37,779	\$ 37,362	\$ 56,617	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 1,308,510	\$ 417		\$ 37,779	\$ 37,362	\$ 56,617		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,308,510	\$ 417		\$ 37,779	\$ 37,362	\$ 56,617		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 1,308,510	\$ 417		\$ 37,779	\$ 37,362	\$ 56,617		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,308,510	\$ 417		\$ 37,779	\$ 37,362	\$ 56,617		34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 1,308,510	\$ 417		\$ 37,779	\$ 37,362	\$ 56,617		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,308,510	\$ 417		\$ 37,779	\$ 37,362	\$ 56,617		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 246,470	\$ 1,116	\$ 25,119	\$ 24,003	10 yrs	\$ 37,309	71
72	Current Year Purchases	3,846	613	677	64	5-10 yrs	677	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office			8,318	8,318			74
75	TOTALS	\$ 250,316	\$ 1,729	\$ 34,114	\$ 32,385		\$ 37,986	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Van	Used	2000	\$ 3,000	\$ 300	\$ 300		10	\$ 450	76
77										77
78										78
79										79
80	TOTALS			\$ 3,000	\$ 300	\$ 300			\$ 450	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,586,627	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 2,446	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 72,193	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 69,747	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 95,053	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		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	<u>Storage Building</u>			<u>1,200</u>			4
5		<u>Allocated from Home Office</u>			<u>3,501</u>			5
6								6
7	TOTAL				\$ 4,701			7

10. Effective dates of current rental agreement:
 Beginning N/A
 Ending N/A

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2002</u>	\$ <u>N/A</u>
13.	<u>/2003</u>	\$ <u>N/A</u>
14.	<u>/2004</u>	\$ <u>N/A</u>

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

9. Option to Buy: YES NO Terms: N/A *

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: \$ 6,203 Description: Dishwasher \$ 660, Copier \$3,500, Postage Meter \$ 577, and \$690 Time Clock Software Home Office \$ 776
 (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	<u>Allocated from Home Office</u>			<u>2,032</u>	19
20					20
21	TOTAL		\$	\$ 2,032	21

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

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

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

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>It is the policy of this facility to only hire certified nurses aides. 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)	
TOTAL TRAINED	

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost												
1	Licensed Occupational Therapist	L. 10a C 2,3	hrs	\$	1,995	\$ 34,386	\$ 90	1,995	\$ 34,476	1						
2	Licensed Speech and Language Development Therapist	L. 10a C 3	hrs		85	5,047	0	85	5,047	2						
3	Licensed Recreational Therapist		hrs							3						
4	Licensed Physical Therapist	L. 10a C 2,3	hrs		3,399	61,252	1,584	3,399	62,836	4						
5	Physician Care		visits							5						
6	Dental Care		visits							6						
7	Work Related Program		hrs							7						
8	Habilitation		hrs							8						
9	Pharmacy	L. 39 C 2	# of prescripts				56,588		56,588	9						
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10						
11	Academic Education		hrs							11						
12	Exceptional Care Program									12						
13	Other (specify): See Sch 16A					4,494	285		4,779	13						
14	TOTAL			\$	5,479	\$ 105,179	\$ 58,547	5,479	\$ 163,726	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.

SEE ACCOUNTANTS' COMPILATION REPORT

PROVIDER NAME CLC Sumner
 PROVIDER # 0044743
 REPORT PERIOD 12/31/01

SCHEDULE 16A

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

	Service	Schedule V Line & Column Reference	2		4		5	6	7	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
					Units	Cost					
13a	OTHER:		hrs	\$		\$	\$	0	\$		1
13b	IV Therapy	L. 10a, C3				4,066		0		4,066	2
13c	Respiratory Therapy	L. 10a, C2	hrs				285	0		285	3
13d	Physical Therapy Equipment	L. 10a C3	hrs			342		0		342	4
13e	Occupational Therapy Equipment	L. 10a C3	hrs			86		0		86	5
			hrs					0			6
			hrs					0			7
			hrs					0			8
	TOTAL							0			9
			hrs					0			11
								0			12
								0			13
	TOTAL			\$		4,494	285	\$	4,779		14

See Accountants' Compilation Report

Facility Name & ID Number CLC Sumner

0044743

Report Period Beginning: 01/1/01

Ending:

12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 28,364	\$ 28,364	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 160,343)	216,468	216,468	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,602	18,602	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 263,434	\$ 263,434	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		24,801	13
14	Buildings, at Historical Cost		1,306,425	14
15	Leasehold Improvements, at Historical Cost	2,085	2,085	15
16	Equipment, at Historical Cost	11,891	253,316	16
17	Accumulated Depreciation (book methods)	(2,977)	(95,053)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,999	\$ 1,491,574	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 274,433	\$ 1,755,008	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 66,072	\$ 66,072	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	75,263	75,263	30
31	Accrued Taxes Payable (excluding real estate taxes)	37,745	37,745	31
32	Accrued Real Estate Taxes(Sch.IX-B)	18,341	18,341	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Accrued Expense	32,339	32,339	36
37	Intercompany Payable	782,810	782,810	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,012,570	\$ 1,012,570	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,547,523	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,547,523	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,012,570	\$ 2,560,093	46
47	TOTAL EQUITY(page 18, line 24)	\$ (738,137)	\$ (805,085)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 274,433	\$ 1,755,008	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (207,007)	1
2	Restatements (describe):		2
3	Adjust Accrued Vacation	7,673	3
4	Adjusted Bad Debt Allowance	(117,499)	4
5	Clear Intercompany	189,837	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (126,996)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(611,141)	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)	\$ (611,141)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (738,137)	24 *

Operating entity only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLC Sumner

0044743

Report Period Beginning: 01/1/01

Ending: 12/31/01

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,704,812	1
2	Discounts and Allowances for all Levels	(222,861)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,481,951	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	237,775	6
7	Oxygen	1,773	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 239,548	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	33,699	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,916	19
20	Radiology and X-Ray	546	20
21	Other Medical Services	2,820	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 40,981	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Personal Needs	2	28
28a	Vending Income	597	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 599	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,763,079	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	421,029	31
32	Health Care	962,035	32
33	General Administration	698,931	33
B. Capital Expense			
34	Ownership	144,144	34
C. Ancillary Expense			
35	Special Cost Centers	102,620	35
36	Provider Participation Fee	45,461	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,374,220	40
41	Income before Income Taxes (line 30 minus line 40)**	(611,141)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (611,141)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. This Entity files as part of a consolidated tax return

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number CLC Sumner

0044743

Report Period Beginning: 01/1/01

Ending: 12/31/01

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,068	2,117	\$ 44,759	\$ 21.14	1
2	Assistant Director of Nursing	4,231	4,529	75,681	16.71	2
3	Registered Nurses	6,473	6,824	109,570	16.06	3
4	Licensed Practical Nurses	9,646	10,110	135,833	13.44	4
5	Nurse Aides & Orderlies	39,358	41,453	339,277	8.18	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,066	2,165	23,970	11.07	9
10	Activity Assistants	1,889	2,058	14,416	7.00	10
11	Social Service Workers	1,964	2,067	22,916	11.09	11
12	Dietician					12
13	Food Service Supervisor	2,049	2,286	32,163	14.07	13
14	Head Cook	2,031	2,100	16,556	7.88	14
15	Cook Helpers/Assistants	4,571	4,912	31,822	6.48	15
16	Dishwashers					16
17	Maintenance Workers	2,045	2,240	35,045	15.65	17
18	Housekeepers	9,336	9,741	62,730	6.44	18
19	Laundry	4,575	4,758	33,250	6.99	19
20	Administrator	1,939	2,117	51,899	24.52	20
21	Assistant Administrator	75	83	746	8.99	21
22	Other Administrative					22
23	Office Manager	1,861	2,037	20,040	9.84	23
24	Clerical	1,473	1,546	12,643	8.18	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	1,224	1,286	11,492	8.94	31
32	Other Health C: Supply Clerk	655	689	6,156	8.93	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	99,529	105,118	\$ 1,080,964 *	\$ 10.28	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	99	\$ 3,827	L. 1 C.3	35
36	Medical Director	66	3,300	L. 9 C.3	36
37	Medical Records Consultant	46	2,582	L. 10 C.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	8	400	L. 10 C.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	41	2,103	L. 11 C.3	44
45	Social Service Consultant	105	8,273	L. 12 C.3	45
46	Other(specify)				46
47	Physician Consultant	1	135	L. 10 C.3	47
48					48
49	TOTAL (lines 35 - 48)	366	\$ 20,620		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Sharon Mathis	Administrator	0%	\$ 51,899	Workers' Compensation Insurance	\$ 28,826	IDPH License Fee	\$ 6,895	
Julie Fiscus	Asst Admin	0%	746	Unemployment Compensation Insurance	23,615	Advertising: Employee Recruitment		
				FICA Taxes	78,602	Health Care Worker Background Check		
				Employee Health Insurance	62,970	(Indicate # of checks performed <u>36</u>)	432	
				Employee Meals		Illinois Health Care Association	4,439	
				Illinois Municipal Retirement Fund (IMRF)*		Various Dues & Subscriptions	286	
				Uniform	172	Various Licenses	1,059	
				Employee Relations	4,169	Allocated from Home Office	1,677	
				Employee Physical	140			
				Other Employee Benefits	593	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 52,645	Allocated from Home Office	12,903	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,788	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees (Eliminated in Column 7)			\$ 211,611	N/A			Out-of-State Travel	\$
							In-State Travel	10,004
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 211,611				Seminar Expense	2,186
(Attach a copy of any management service agreement)							Allocated from Home Office	17,842
C. Professional Services				TOTAL			Entertainment Expense ()	
Vendor/Payee	Type		Amount	\$			(agree to Sch. V, line 24, col. 8)	
Duane, Morris & Heckscher LLP	Legal		\$ 4,367				\$ 30,032	
Altschuler, Melvoin and								
Glasser LLP	Accounting		3,183					
National Corporate Research	Administrative Consulting		130					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 7,680					
(If total legal fees exceed \$2500 attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name	CLC Sumner
PROVIDER #	0044743
Period Ending	12/31/01

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	7,680
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Allocated from Home Office	9,143
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Total (agree to Schedule V, line 19, column 8)	<u>16,823</u>
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See Accountants' Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	
2	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

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. Illinois Health Care Association \$ 4,439
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7.5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,339 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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 45,461
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? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation. Air Fare to Home Office
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Adequate records are maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ernst & Young 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. Audit has not been 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.

SEE ACCOUNTANTS' COMPILATION REPORT

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	80,541	5,736	3,881	90,158	0	90,158	-597	89,561
2. Food Purchase	0	74,770	0	74,770	0	74,770	0	74,770
3. Housekeeping	62,730	11,260	340	74,330	0	74,330	0	74,330
4. Laundry	33,250	7,329	0	40,579	0	40,579	0	40,579
5. Heat and Other Utilities	0	0	65,354	65,354	0	65,354	5	65,359
6. Maintenance	35,045	2,481	38,312	75,838	0	75,838	-1,109	74,729
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	211,566	101,576	107,887	421,029	0	421,029	-1,701	419,328
9. Medical Director	0	0	3,300	3,300	0	3,300	0	3,300
10. Nursing & Medical Records	722,768	44,029	7,389	774,186	0	774,186	0	774,186
10a. Therapy	0	1,959	105,179	107,138	0	107,138	0	107,138
11. Activities	38,386	5,599	2,103	46,088	0	46,088	0	46,088
12. Social Services	22,916	134	8,273	31,323	0	31,323	0	31,323
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	784,070	51,721	126,244	962,035	0	962,035	0	962,035
17. Administrative	52,645	0	211,611	264,256	0	264,256	-211,611	52,645
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	7,680	7,680	0	7,680	9,143	16,823
20. Fees, Subscriptions & Promotion	0	0	15,905	15,905	0	15,905	-1,117	14,788
21. Clerical & General Office	32,683	6,428	39,164	78,275	0	78,275	128,945	207,220
22. Employee Benefits & Payroll	0	0	199,087	199,087	0	199,087	12,903	211,990
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	12,190	12,190	0	12,190	17,842	30,032
25. Other Admin. Staff Trans	0	0	786	786	0	786	0	786
26. Insurance-Prop.Liab.Malpractice	0	0	120,752	120,752	0	120,752	4,289	125,041
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	85,328	6,428	607,175	698,931	0	698,931	-39,606	659,325
29. Total General Administrative	1,080,964	159,725	841,306	2,081,995	0	2,081,995	-41,307	2,040,688
30. Depreciation	0	0	2,446	2,446	0	2,446	69,747	72,193
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	41,715	41,715	0	41,715	183,076	224,791
33. Real Estate	0	0	29,552	29,552	0	29,552	0	29,552
34. Rent - Facility & Grounds	0	0	65,004	65,004	0	65,004	-60,303	4,701
35. Rent - Equipment & Vehicles	0	0	5,427	5,427	0	5,427	2,808	8,235
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	144,144	144,144	0	144,144	195,328	339,472
38. Medically Necessary T	0	0	1,075	1,075	0	1,075	0	1,075
39. Ancillary Service Cent	0	56,588	0	56,588	0	56,588	0	56,588
40. Barber and Beauty Shop	0	0	100	100	0	100	0	100
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	45,461	45,461	0	45,461	0	45,461
43. Other (specify):*	0	0	44,857	44,857	0	44,857	-44,857	0
44. Total Special Cost Ce	0	56,588	91,493	148,081	0	148,081	-44,857	103,224
45. Grand Total	1,080,964	216,313	1,076,943	2,374,220	0	2,374,220	109,164	2,483,384

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	28,364	28,364
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	216,468	216,468
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	18,602	18,602
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	263,434	263,434
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	24,801
14. Buildings, at Historical Cost	0	1,306,425
15. Leasehold Improvements, Historical Cost	2,085	2,085
16. Equipment, at Historical Cost	11,891	253,316
17. Accumulated Depreciation (book methods)	-2,977	-95,053
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	10,999	1,491,574
25. Total Assets	274,433	1,755,008
CURRENT LIABILITIES		
26. Accounts Payable	66,072	66,072
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	75,263	75,263
31. Accrued Taxes Payable	37,745	37,745
32. Accrued Real Estate Taxes	18,341	18,341
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	32,339	32,339
37. Other Current Liabilities (specify):	782,810	782,810
38. Total Current Liabilities	1,012,570	1,012,570
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	1,547,523
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	0	1,547,523
46. Total Liabilities	1,012,570	2,560,093
47. Total Equity	-738,137	-805,085
48. Total Liabilities and Equity	274,433	1,755,008

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,704,812
2. Discounts and Allowances for all Levels	-222,861
Subtotal - Inpatient Care	1,481,951
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	237,775
7. Oxygen	1,773
Subtotal - Ancillary Revenue	239,548
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	33,699
18. Sale of Supplies to Non-Patients	0
19. Laboratory	3,916
20. Radiology and X-Ray	546
21. Other Medical Services	2,820
22. Laundry	0
Subtotal - Other Operating Revenue	40,981
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	2
28. Other Revenue (specify):	597
Subtotal - Other Revenue	599
30. Total Revenue	1,763,079
31. General Services	295,113
32. Health Care	590,962
33. General Administration	374,678
34. Ownership	176,199
35. Special Cost Centers	56,647
35. Provider Participation Fee	50,060
37. Other	0
40. Total Expenses	1,543,659
41. Income Before Income Taxes	219,420
42. Income Taxes	0
43. Net Income or Loss for the Year	219,420

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached

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19 The bottom right side of page under **, you must write in any comments

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RECONCILIATION REPORT

CLC Sumner

02:22 PM 11/07/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	109,164	equal to	109,164	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	224,791	equal to	224,791	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	29,552	equal to	29,552	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	72,193	equal to	72,193	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	4,701	equal to	4,701	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	8,235	equal to	8,235	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	102,359	equal to	107,138	-4,779	FAILED	Pg16 Z12+Z14...	N/A,B	1-4-40-43	8:2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	58,547	equal to	58,547	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	421,029	equal to	421,029	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	962,035	equal to	962,035	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administration	698,931	equal to	698,931	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	144,144	equal to	144,144	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	102,620	equal to	102,620	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+	N/A	38to41+43	4
Income Stat. Prov. Partic.	45,461	equal to	45,461	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	716,612	equal to	722,768	-6,156	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	38,386	equal to	38,386	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	22,916	equal to	22,916	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	80,541	equal to	80,541	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	35,045	equal to	35,045	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	62,730	equal to	62,730	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	33,250	equal to	33,250	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	52,645	equal to	52,645	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	32,683	equal to	32,683	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,080,964	equal to	1,080,964	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	3,827	< or = to	3,881	-54	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	3,300	< or = to	3,300	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	2,982	< or = to	7,389	-4,407	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	2,103	< or = to	2,103	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	8,273	< or = to	8,273	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	52,645	equal to	52,645	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	211,611	equal to	211,611	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	7,680	equal to	7,680	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	211,990	equal to	211,990	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues...	14,788	equal to	14,788	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	30,032	equal to	30,032	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	45,461	equal to	45,461	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	12,903	-12,903	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	931	equal to	992	-61	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	166,374	equal to	166,374	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4l	B.	14	8
Total loan balance	1,547,523	equal to	1,547,523	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	18,341	equal to	18,341	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	24,801	equal to	24,801	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,308,510	equal to	1,308,510	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	253,316	equal to	253,316	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	95,053	equal to	95,053	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-738,137	equal to	-738,137	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-611,141	equal to	-611,141	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	274,433	equal to	274,433	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1