

		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>0035956</u></p> <p>Facility Name: <u>Centralia Manor</u></p> <p>Address: <u>R.R. 1, Box 387 A</u> <u>Centralia</u> <u>62801</u> <small>Number City Zip Code</small></p> <p>County: <u>Marion</u></p> <p>Telephone Number: <u>(618) 533-1200</u> Fax # <u>(618) 533-1257</u></p> <p>IDPA ID Number: <u>36-3114893009</u></p> <p>Date of Initial License for Current Owners: <u>11/08/89</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 type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u></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 type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>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>1/1/01</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 rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date)</td> </tr> <tr> <td>(Type or Print Name) <u>Ron Wilson</u></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>See Independent Accountant's Report</u> (Date)</td> </tr> <tr> <td>(Print Name and Title) <u>McGladrey & Pullen, LLP</u></td> </tr> <tr> <td>(Firm Name & Address) <u>117 East Main, Suite 210, P.O. Box 1070 Galesburg, Illinois 61402</u></td> </tr> <tr> <td>(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u></td> </tr> </table> <p align="center">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) <u>Ron Wilson</u>		(Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) <u>See Independent Accountant's Report</u> (Date)	(Print Name and Title) <u>McGladrey & Pullen, LLP</u>	(Firm Name & Address) <u>117 East Main, Suite 210, P.O. Box 1070 Galesburg, Illinois 61402</u>	(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</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 Centralia Manor

0035956 Report Period Beginning: 1/1/01 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>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</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>120</u>	TOTALS	<u>120</u>	<u>43,800</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>5,302</u>	<u>5,315</u>	<u>4,915</u>	<u>15,532</u>	8
9	SNF/PED					9
10	ICF	<u>10,604</u>	<u>12,028</u>	<u>0</u>	<u>22,632</u>	10
11	ICF/DD					11
12	SC			<u>0</u>		12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,906</u>	<u>17,343</u>	<u>4,915</u>	<u>38,164</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.13%

D. How many bed-hold days during this year were paid by Public Aid? 75 (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

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 11/08/89

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/24/89 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 19 and days of care provided 4,915

Medicare Intermediary AdminaStar Federal Inc.

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.

Facility Name & ID Number

Centralia Manor

0035956

Report Period Beginning:

1/1/01

Ending:

12/31/01

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
	A. General Services										
1	Dietary	144,183	25,332	13,835	183,350		183,350		183,350		1
2	Food Purchase		232,610		232,610		232,610	(43,513)	189,097		2
3	Housekeeping	70,435	25,076	35	95,546		95,546		95,546		3
4	Laundry	54,328	19,949		74,277		74,277		74,277		4
5	Heat and Other Utilities			122,178	122,178		122,178	325	122,503		5
6	Maintenance	28,871	18,470	33,793	81,134		81,134	467	81,601		6
7	Other (specify):*										7
8	TOTAL General Services	297,817	321,437	169,841	789,095		789,095	(42,721)	746,374		8
	B. Health Care and Programs										
9	Medical Director			2,000	2,000		2,000		2,000		9
10	Nursing and Medical Records	1,124,307	155,337	1,520	1,281,164		1,281,164		1,281,164		10
10a	Therapy	182,610		16,723	199,333		199,333		199,333		10a
11	Activities	48,027	2,678	69	50,774		50,774		50,774		11
12	Social Services	37,958			37,958		37,958		37,958		12
13	Nurse Aide Training			245	245		245		245		13
14	Program Transportation			486	486	625	1,111		1,111		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,392,902	158,015	21,043	1,571,960	625	1,572,585		1,572,585		16
	C. General Administration										
17	Administrative	86,041			86,041		86,041	82,483	168,524		17
18	Directors Fees										18
19	Professional Services			171,029	171,029		171,029	(153,115)	17,914		19
20	Dues, Fees, Subscriptions & Promotions			23,735	23,735		23,735	(13,214)	10,521		20
21	Clerical & General Office Expenses	45,659	30,487	15,448	91,594		91,594	7,064	98,658		21
22	Employee Benefits & Payroll Taxes			290,960	290,960		290,960	13,135	304,095		22
23	Inservice Training & Education			1,381	1,381		1,381		1,381		23
24	Travel and Seminar			3,430	3,430		3,430	2,636	6,066		24
25	Other Admin. Staff Transportation			1,249	1,249	(625)	624	3,198	3,822		25
26	Insurance-Prop.Liab.Malpractice			58,063	58,063		58,063	235	58,298		26
27	Other (specify):* See Attached Sch VI			5,972	5,972		5,972	(5,972)			27
28	TOTAL General Administration	131,700	30,487	571,267	733,454	(625)	732,829	(63,550)	669,279		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,822,419	509,939	762,151	3,094,509		3,094,509	(106,271)	2,988,238		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

Centralia Manor

#0035956

Report Period Beginning:

1/1/01

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			31,593	31,593		31,593	124,240	155,833			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,331	1,331		1,331	54,827	56,158			32
33	Real Estate Taxes			124,205	124,205		124,205	287	124,492			33
34	Rent-Facility & Grounds			584,064	584,064		584,064	(580,155)	3,909			34
35	Rent-Equipment & Vehicles			528	528		528	656	1,184			35
36	Other (specify):* Amortization							2,264	2,264			36
37	TOTAL Ownership			741,721	741,721		741,721	(397,881)	343,840			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			6,971	6,971		6,971		6,971			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			72,671	72,671		72,671		72,671			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,822,419	509,939	1,576,543	3,908,901		3,908,901	(504,152)	3,404,749			45

*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

Facility Name & ID Number Centralia Manor

0035956

Report Period Beginning: 1/1/01

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	(41,870)	2		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	2,578	30		9
10	Interest and Other Investment Income	(41,742)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,643)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,532)	27		24
25	Fund Raising, Advertising and Promotional	(12,346)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(882)	20		28
29	Other-Attach Schedule See Attached Schedule VII	(1,716)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (103,153)		\$	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		31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(400,999)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (400,999)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (504,152)		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

Centralia Manor

ID# 0035956

Report Period Beginning: 1/1/01

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
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Centralia Manor

0035956 Report Period Beginning:

1/1/01

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	(43,513)	0	0	0	0	0	0	0	0	0	0	(43,513)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(43,513)	0	0	0	0	0	0	0	0	0	0	(43,513)	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	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(34,230)	0	0	0	0	0	0	0	0	0	(34,230)	19
20	Fees, Subscriptions & Promotions	(13,228)	0	0	0	0	0	0	0	0	0	0	(13,228)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(5,532)	0	0	0	0	0	0	0	0	0	0	(5,532)	27
28	TOTAL General Administration	(18,760)	(34,230)	0	(52,990)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(62,273)	(34,230)	0	(96,503)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Centralia Manor# 0035956 Report Period Beginning:

1/1/01 Ending:

12/31/01

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	2,578	0	0	0	0	0	0	0	0	0	0	2,578 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(41,742)	0	0	0	0	0	0	0	0	0	0	(41,742) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	(366,769)	0	0	0	0	0	0	0	0	0	(366,769) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(39,164)	(366,769)	0	(405,933) 37								
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(101,437)	(400,999)	0	(502,436) 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
<u>Illini Manors, Inc.</u> <u>(100% owned by Don Fike)</u>	<u>100%</u>	<u>See Attached Schedule I</u>		<u>RFMS, Inc.</u>	<u>Galesburg</u>	<u>Admin. Svcs.</u>
				<u>Centralia Retirement Partnership</u>	<u>Galesburg</u>	<u>Lessor</u>

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		
	V		\$			\$	\$	1
2	V	<u>34 Facility Rental</u>	<u>584,064</u>	<u>Centralia Retirement Partnership</u> <u>(100% owned by Don Fike)</u>	<u>None</u>	<u>217,295</u>	<u>(366,769)</u>	2
3	V							3
4	V							4
5	V	<u>19 Administrative Services</u>	<u>156,000</u>	<u>RFMS, Inc.</u> <u>(100% owned by Don Fike)</u>	<u>None</u>	<u>121,770</u>	<u>(34,230)</u>	5
6	V							6
7	V							7
8	V							8
9	V			<u>See Attached Schedules III and IV</u>				9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>740,064</u>			\$ <u>339,065</u>	\$ * <u>(400,999)</u>	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Centralia Manor # 0035956 Report Period Beginning: 1/1/01 Ending: 12/31/01

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	Don Fike	President	Management	100.00	See Attached Schedule III	>40	100.00	Salary	8,686	17-7	2
3								Benefits	585	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,271		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Centralia Manor # 0035956 Report Period Beginning: 1/1/01 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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$			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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Centralia Manor# 0035956

Report Period Beginning:

1/1/01

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		7	8	9	10
		Related**					Amount of Note					
Name of Lender		YES	NO	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
A. Directly Facility Related												
Long-Term												
1							\$	\$			\$	1
2	Bank One, Springfield		x	Refinanced building mortgage	Varies Pd	05/09/96	2,140,357	1,290,000	04/01/11	6.6600	96,418	2
3					Quarterly							3
4	Interest Income Adjustment			From page 5, line 10							(41,742)	4
5												5
Working Capital												
6												6
7	Miscellaneous Vendors		x	Miscellaneous operating							1,331	7
8	Home Office Allocation Adj.			See Attached Schedule III							151	8
9	TOTAL Facility Related						\$ 2,140,357	\$ 1,290,000			\$ 56,158	9
B. Non-Facility Related*												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 2,140,357	\$ 1,290,000			\$ 56,158	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

Facility Name & ID Number **Centralia Manor**# **0035956** Report Period Beginning: **1/1/01** Ending: **12/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2000 report.		\$	112,012	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.)		\$	116,017	2
3.	Under or (over) accrual (line 2 minus line 1).		\$	4,005	3
4.	Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	120,200	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	124,205	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1996	103,366	8	
		1997	110,489	9	
		1998	108,639	10	
		1999	112,013	11	
		2000	116,017	12	
Real estate tax accrual is based on estimated tax expense. The lessee, by terms of the lease agreement, is required to pay the applicable real estate taxes.					
				FOR OHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2000	\$	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.

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 Centralia Manor COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0035956

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

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>14-16-100-019</u>	<u>1st Galesburg Ntl Bk&Tr, Tr3725</u>	\$ <u>116,017.00</u>	\$ <u>116,017.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>116,017.00</u>	\$ <u>116,017.00</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 Centralia Manor# 0035956 Report Period Beginning:

1/1/01 Ending:

12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,758 B. General Construction Type: Exterior Brick Frame Wood 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).

Centralia Estates Retirement Apartments 39 units 30,367 square feetF. 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/ANature of Costs: N/A

(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>6.4 Acres</u>	<u>1988</u>	<u>\$ 87,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 87,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Centralia Manor

0035956

Report Period Beginning:

1/1/01

Ending:

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		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	110		1989	1989	\$ 2,723,233	\$ 90,774	30	\$ 90,774		\$ 1,127,110	4
5	10		1996	1996	547,731	21,909	25	21,909		122,325	5
6											6
7											7
8											8
	Improvement Type**										
9	Total improvements by year constructed:										
10	1989		1989		114,977	5,400	5-15	5,400		101,028	9
11	1990		1990								10
12	1991		1991								11
13	1992		1992								12
14	1993		1993		4,375		10	438	438	3,796	13
15	1994		1994		1,632	73	7	176	103	1,632	14
16	1995		1995		13,974	888	10-40	509	(379)	3,421	15
17	1996		1996		15,468	1,067	10-15	1,332	265	7,449	16
18	1997		1997		18,175	1,605	5-15	1,786	181	8,198	17
19	Detailed improvements from 1998 - 2001:										
20	Water Heater		1998		4,341	500	5	868	368	3,400	18
21	Water Heater		1998		5,551	640	5	1,110	470	4,070	19
22	Floor Tile		1998		5,124	640	7	732	92	2,501	20
23	Ceramic Tile Atrium		1998		8,600	1,075	7	1,229	154	3,892	21
24	Paving		2000		12,318	2,217	10	1,232	(985)	1,745	22
25	Remodeling		2000		4,080	734	10	408	(326)	544	23
26	Carpeting		2000		4,125	1,010	7	589	(421)	736	24
27	Painting		2000		1,680	538	5	336	(202)	420	25
28	Wallpaper		2001		5,030	1,006	5	419	(587)	419	26
29											27
30											28
31											29
32											30
33											31
34											32
35											33
36											34

*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

Facility Name & ID Number Centralia Manor

0035956

Report Period Beginning:

1/1/01

Ending:

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			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 3,490,414	\$ 130,076		\$ 129,247	\$ (829)	\$ 1,392,686		70

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	\$ 418,014	\$ 16,102	\$ 21,110	\$ 5,008	5-15 yrs	\$ 356,771	71
72	Current Year Purchases	22,921	4,028	2,427	(1,601)	5-15 yrs	2,427	72
73	Fully Depreciated Assets							73
74	Indirect Costs Allocated (See Attached Schedule III)		3,049	3,049				74
75	TOTALS	\$ 440,935	\$ 23,179	\$ 26,586	\$ 3,407		\$ 359,198	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	Bus	1993	\$ 38,250	\$	\$	\$	5 yrs	\$ 38,250	76
77	Patient Care	Van	1993	4,298				5 yrs	4,298	77
78										78
79										79
80	TOTALS			\$ 42,548	\$	\$	\$		\$ 42,548	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)	\$ 4,060,897	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 153,255	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 155,833	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,578	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,794,432	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: Centralia Retirement Partnership

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:				\$ <u>See Attached</u>			3
4	Additions				<u>Schedule IV -</u>			4
5					<u>Related Party</u>			5
6					<u>Lease</u>			6
7	TOTAL				\$ <u>***</u>			7

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. /2002 \$ _____
13. /2003 \$ _____
14. /2004 \$ _____

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: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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 checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 245	\$	\$ 245
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	\$	\$ 245	\$	\$ 245
10	SUM OF line 9, col. 1 and 2 (e)	\$	245		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ None

D. NUMBER OF AIDES TRAINED

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

- (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 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$		\$					\$	1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescrpts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$		\$		\$			\$		\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Centralia Manor

0035956

Report Period Beginning: 1/1/01

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	\$ 587,786	\$ 904,609	1
2 Cash-Patient Deposits	1,940	1,940	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	577,968	1,003,763	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance		27,491	6
7 Other Prepaid Expenses	1,723	1,723	7
8 Accounts Receivable (owners or related parties)		1,574,571	8
9 Other(specify): See Attached Schedule VIII	387,871	387,871	9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,557,288	\$ 3,901,968	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments	1,826,548	1,930,626	12
13 Land		87,000	13
14 Buildings, at Historical Cost		3,266,480	14
15 Leasehold Improvements, at Historical Cost	104,471	354,258	15
16 Equipment, at Historical Cost	249,211	1,105,778	16
17 Accumulated Depreciation (book methods)	(258,893)	(2,311,080)	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): Loan Financing Costs			23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,921,337	\$ 4,433,062	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,478,625	\$ 8,335,030	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 485,486	\$ 519,776	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	1,940	1,940	28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	160,645	286,597	30
31 Accrued Taxes Payable (excluding real estate taxes)	2,862	2,862	31
32 Accrued Real Estate Taxes(Sch.IX-B)	120,200	126,086	32
33 Accrued Interest Payable		6,120	33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 Interdivision Payable	497,305	497,305	36
37 Other Accrued Liabilities			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,268,438	\$ 1,440,686	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable		1,290,000	40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44 Resident Security Deposits	70,245	70,245	44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 70,245	\$ 1,360,245	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,338,683	\$ 2,800,931	46
47 TOTAL EQUITY(page 18, line 24)	\$ 2,139,942	\$ 5,534,099	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,478,625	\$ 8,335,030	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,999,084	1
2	Restatements (describe):		2
3	Year-end adjustments made subsequent to the filing of the		3
4	prior year's Medicaid cost report. (See Attached Schedule IX)	571,635	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,570,719	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,469,223	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	(1,900,000)	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)	\$ (430,777)	17
	B. Transfers (Itemize):		
18	Interdivision transfers		18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,139,942	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 4,825,424	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,825,424	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	55,905	6
7	Oxygen	5,680	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 61,585	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	346	12
13	Barber and Beauty Care	4,541	13
14	Non-Patient Meals	41,870	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 46,757	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	441,074	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 441,074	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	Durable Medical Equipment	3,284	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,284	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,378,124	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	789,095	31
32	Health Care	1,571,960	32
33	General Administration	733,454	33
B. Capital Expense			
34	Ownership	741,721	34
C. Ancillary Expense			
35	Special Cost Centers	6,971	35
36	Provider Participation Fee	65,700	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,908,901	40
41	Income before Income Taxes (line 30 minus line 40)**	1,469,223	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,469,223	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. See Attached Schedule V

*** 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 Centralia Manor

0035956

Report Period Beginning: 1/1/01

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	1,816	1,932	\$ 37,147	\$ 19.23	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	5,748	6,115	93,923	15.36	3
4	Licensed Practical Nurses	16,280	17,319	222,209	12.83	4
5	Nurse Aides & Orderlies	84,907	90,326	689,189	7.63	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,471	1,565	46,936	29.99	7
8	Rehab/Therapy Aides	6,912	7,354	135,674	18.45	8
9	Activity Director	1,843	1,960	20,583	10.50	9
10	Activity Assistants	3,608	3,838	27,444	7.15	10
11	Social Service Workers	3,568	3,796	37,958	10.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,381	21,682	144,183	6.65	15
16	Dishwashers					16
17	Maintenance Workers	2,632	2,800	28,871	10.31	17
18	Housekeepers	10,766	11,453	70,435	6.15	18
19	Laundry	8,358	8,892	54,328	6.11	19
20	Administrator	1,956	2,080	64,271	30.90	20
21	Assistant Administrator	1,934	2,058	21,770	10.58	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,706	5,006	45,659	9.12	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	1,887	2,007	19,470	9.70	31
32	Other Health C: Supervisors	6,297	6,699	62,369	9.31	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	185,070	196,882	\$ 1,822,419 *	\$ 9.26	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	***	\$ 13,835	1-3	35
36	Medical Director	***	2,000	9-3	36
37	Medical Records Consultant	***	695	10-3	37
38	Nurse Consultant	***		10-3	38
39	Pharmacist Consultant	***	825	10-3	39
40	Physical Therapy Consultant	***	16,723	10a-3	40
41	Occupational Therapy Consultant	***	0	10a-3	41
42	Respiratory Therapy Consultant	***		10a-3	42
43	Speech Therapy Consultant	***	0	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***	0	12-3	45
46	Other(specify) Dental Consultant	***	0	10-3	46
47	Psychological Consultant	***		10-3	47
48	***=Monthly Fee Arrangement				48
49	TOTAL (lines 35 - 48)		\$ 34,078		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			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

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	None		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
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. See page 21, Section F
- (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? 8 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,384 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 65,700
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? Yes Indicate the amount. \$ 41,870
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen, LLP 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 not yet 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

FACILITY NAME: Centralia Manor

YEAR ENDED: 12/31/01

COST REPORT GROUPINGS
DATA INPUT SHEET

Cost Center	Cost Type	Grouping Code	\$ Amount	Balance Sheet	Grouping Code	\$ Amount
Dietary	Labor	1-1	144,183	Cash	A1	587,786
Dietary	Supplies	1-2	25,332	Patient Deposits	A2	1,940
Dietary	Other	1-3	13,835	Accounts Receivable	A3	577,968
Nursing	Labor	10-1	1,124,307	Prepaid Insurance	A6	0
Nursing	Supplies	10-2	155,337	Other Prepaid Exp	A7	1,723
Nursing	Other	10-3	1,520	Related Party Rec'ble	A8	0
Therapy	Labor	10A-1	182,610	Interdivision Receivable	A9	0
Therapy	Other	10A-3	16,723	Interest Receivable	A9a	387,871
Activities	Labor	11-1	48,027	Long-Term Investments	B12	1,826,548
Activities	Supplies	11-2	2,678	Land	B13	0
Activities	Other	11-3	69	Buildings	B14	0
SocSerDir	Labor	12-1	37,958	Leasehold Improve	B15	104,471
SocSerDir	Other	12-3	0	Equipment	B16	249,211
NurseAideTrng	Labor	13-1	0	Accum Depreciation	B17	(258,893)
NurseAideTrng	Supplies	13-2	0	Deferred Maintenance	B18	0
NurseAideTrng	Other	13-3	245	Org & Pre-Op Costs	B19	0
ProgramTransp	Other	14-3	486	Accum Amortization	B20	0
Administrative	Labor	17-1	86,041	Loan Financing Costs	B23a	0
Prof. Services	Other	19-3	171,029	Leasehold Deposit	B23b	0
FoodPurchase	Supplies	2-2	232,610			
Fees,Subs&Promo	Other	20-3	23,735	Total Assets		<u>3,478,625</u>
Clerical&GO	Labor	21-1	45,659			
Clerical&GO	Supplies	21-2	30,487	Accounts Payable	C26	485,486
Clerical&GO	Other	21-3	15,448	A/P-Patient Deposits	C28	1,940
EmployeeBen	Other	22-3	290,960	Accrued Salaries	C30	160,645
Inservice Training	Other	23-3	1,381	Accrued Taxes	C31	2,862
Travel	Other	24-3	562	AccrRealEstateTax	C32	120,200
Seminar	Other	24-3a	2,868	Accrued Interest	C33	0
Admin Staff Transp	Other	25-3	1,249	Interdivision Payable	C36	497,305
Insurance	Other	26-3	58,063	Other Current Liab	C37	0
Bad Debts	Other	27-3	5,532	Mortgage Payable	D40	0
Lobbying	Other	27-3a	440	Security Deposits	D44	70,245
Housekeeping	Labor	3-1	70,435	Retained Earnings	E1	2,570,719
Housekeeping	Supplies	3-2	25,076	Distributions	E13	(1,900,000)
Housekeeping	Other	3-3	35	Transfers	E18	0
Depreciation	Other	30-3	31,593	Total Liab & Equity		<u>2,009,402</u>
Amort of Pre-Op	Other	31-3	0			
Interest	Other	32-3	1,331	Net Income(Loss)		1,469,223
RealEstateTax	Other	33-3	124,205	Ending RE		<u>2,139,942</u>
Rent-Facility	Other	34-3	584,064			
Rent-Equip&Vehicl	Other	35-3	528	Gross Revenue	R1	4,825,424
Amortization	Other	36-3	0	NurseAideTrngReimb	R11	0
Ancillary	Labor	39-1	0	Vending	R12	346
Ancillary	Other	39-3	6,971	Barber & Beauty	R13	4,541
Laundry	Labor	4-1	54,328	Non-Patient Meals	R14	41,870
Laundry	Supplies	4-2	19,949	Telephone & TV	R15	0
Vending	Other	41-3	0	Non-Patient Supplies	R18	0
ProvParticFee	Other	42-3	65,700	Contributions	R24	0
Utilities	Other	5-3	122,178	Interest	R25	441,074
Maintenance	Labor	6-1	28,871	Recoveries	R28	0
Maintenance	Supplies	6-2	18,470	Durable Med Equip	R28a	3,284
Maintenance	Other	6-3	33,793	Gain(loss)-equipment	R28b	0
MedicalDirector	Other	9-3	2,000	Outpatient Services	R5	0
				Therapy	R6	55,905
				Oxygen	R7	5,680
				Income Tax (expense)	R42	0
				Total Revenue		<u>5,378,124</u>
				Total Costs		<u>3,908,901</u>
				Net Income(Loss)		<u>1,469,223</u>
				Input Error (s/b -0-)		<u>0</u>

FACILITY NAME: Centralia Manor YEAR ENDED: 12/31/01

**OTHER INFORMATION
DATA INPUT SHEET**

Sales Tax	<u>1,643</u>	Beginning Equity Adjustments	
(Grouping Code 2-2 a/c # 9850 - Sales Tax)		Uncollectible patient accounts	0
Diaper Expense	<u>9,384</u>	Medicare cost report settlements	2,115
(Grouping Code 10-2 a/c # 4115 - Incontinence)		Related party accrued interest income	636,520
Prior Year Ending Equity	<u>0</u>	Workers' comp insurance	0
(page 17, line 47)	var	Miscellaneous	0
Prior Year Accrued Real Estate Tax	<u>112,012</u>	Illinois replacement tax	(67,000)
(page 17, line 32)			
Amount of Note - Original	<u>2,140,357</u>	Net Prior Period Adjustments	<u>571,635</u>
(prior year page 9, column 6)			
Accrued Employee Time	<u>Ending 66,729</u>	Tax Return Info	
(Grouping Code C30, a/c # 1715)	<u>Beginning 70,930</u>	Meals expenses:	14-3 45
		(by grouping code)	24-3 28
			23-3 65
Vehicle Expense	<u>921</u>		24-3a 31
(Grouping Code 25-3 a/c # 9305)		50% tax limitation =	85 169
Interdivision Transfers	<u>0</u>	Tax depreciation expense	<u>33,767</u>
var	0		
Shareholder Distributions	<u>0</u>	Capital Lease Depreciation	<u>118,613</u>
var	(1,900,000)		
		Fines and Penalties	<u>0</u>
MEDICARE BEDS	<u>Ending 19</u>		
		Out-of-State Training	<u>1,276</u>
CENSUS INFORMATION (beds)	<u>Beginning 120</u>		
	<u>Ending 120</u>		

SALARY COSTS				Page 20	Line/Amt
1,124,307	10-1	4000	37,147	1	37,147
0		4005	0	2	0
var		4006	11,014	32	62,369
		4007	9,620	32	
		4008	19,470	31	19,470
		4010	61,204	3	93,923
		4011	32,719	3	
		4015	177,436	4	222,209
		4016	44,773	4	
		4018	23,736	32	
		4020	306,931	5	689,189
		4021	17,999	32	
		4022	178,330	5	
		4023	86,369	5	
		4024	100,454	5	
		4025	16,386	5	
		4026	719	5	
182,610	10A-1	4050	15,624	7	46,936
0		4051	76,257	8	135,674
		4052	0	8	
		4055	10,719	7	
		4056	59,417	8	
48,027	11-1	2000	20,583	9	20,583
0		2005	27,444	10	27,444
86,041	17-1	8000	64,271	20	64,271
0		8005	21,770	21	21,770
		Total	1,440,985		1,440,985

Real Estate Tax History	1996	103,366
(prior year page 10)	1997	110,489
	1998	108,639
2000 tax payments	1999	112,013
(per tax bill)	var	0

CENSUS INFORMATION (days)		CENSUS SUMMARY	
Private Skilled	1,960	Private Skilled	5,315
Paid Bedhold	91	Private Intermediate	12,028
Non-paid Bedhold	0	Sheltered Care	0
Paid Discharge	0	Medicare	4,915
Private Intermediate	12,028	Medicaid	15,906
Paid Bedhold	586	V.A.	0
Non-paid Bedhold	0	Total Patient Day:	38,164
Paid Discharge	0	Bed hold Days	920
Private Other	3,355	Total Days	39,084
Paid Bedhold	168		
Paid Discharge	0		
Sheltered Care	0		
Paid Bedhold	0		
Paid Discharge	0		
Medicare	4,915		
Paid Bedhold	0	Medicaid Allocation:	
Non-paid Bedhold	0	Skilled (1/3)	5,302
Paid Discharge	0	Intermediate (2/3)	10,604
Medicaid	15,906	Medicaid Paid Bedhold	75
Paid Bedhold	75		
Non-paid Bedhold	0		
Paid Discharge	0		
V.A. days	0		
Total Days	39,084		

CONSULTANT SERVICES				Pg 20	Ln/Amt
1,520	10-3	4400	825	39	825
0		4425	0	46	0
		4455	695	37	695
16,723	10A-3	4550	0	40	16,723
0		4551	0	40	
		4552	0	40	
		4575	0	41	0
		4576	0	41	
		4577	0	41	
		4600	0	43	0
		4601	0	43	
		4602	0	43	
		4650	16,723	40	
		Total	18,243		18,243

FACILITY NAME: Centralia Manor BEGINNING: 1/1/01
 ID#: 0035956 ENDING: 12/31/01

RELATED PARTIES
DATA INPUT SHEET

1	<u>Balance Sheet</u>	<u>Grouping Code</u>	<u>Facility \$ Amount</u>	<u>RFMS Mngmnt Amount</u>	<u>Lessor Amount</u>	<u>Consolidated Total</u>
	Cash	A1	587,786	81,255	235,568	904,609
	Patient Deposits	A2	1,940	0	0	1,940
	Accounts Receivable	A3	577,968	425,795	0	1,003,763
	Prepaid Insurance	A6	0	27,491	0	27,491
	Other Prepaid Exp	A7	1,723	0	0	1,723
	Related Party Rec'ble	A8	0	1,574,571	0	1,574,571
	Interdivision Receivable	A9	0	0	0	0
	Interest Receivable	A9a	387,871	0	0	387,871
	Long-term Investments	B12	1,826,548	104,078	0	1,930,626
	Land	B13	0	0	87,000	87,000
	Buildings	B14	0	0	3,266,480	3,266,480
	Leasehold Improve	B15	104,471	134,810	114,977	354,258
	Equipment	B16	249,211	622,295	234,272	1,105,778
	Accum Depreciation	B17	(258,893)	(601,776)	(1,450,411)	(2,311,080)
	Deferred Maintenance	B18	0	0	0	0
	Org & Pre-Op Costs	B19	0	0	0	0
	Accum Amortization	B20	0	0	0	0
	Loan Financing Costs	B23a	0	0	0	0
	Leasehold Deposit	B23b	0	0	0	0
	Total Assets		3,478,625	2,368,519	2,487,886	8,335,030
	Accounts Payable	C26	485,486	34,290	0	519,776
	A/P-Patient Deposits	C28	1,940	0	0	1,940
	Short-Term Notes Pay	C29	0	0	0	0
	Accrued Salaries	C30	160,645	125,952	0	286,597
	Accrued Taxes	C31	2,862	0	0	2,862
	AccrRealEstateTax	C32	120,200	5,886	0	126,086
	Accrued Interest	C33	0	0	6,120	6,120
	Interdivision Payable	C36	497,305	0	0	497,305
	Other Current Liab	C37	0	0	0	0
	Mortgage Payable	D40	0	0	1,290,000	1,290,000
	Patient Deposits	D44	70,245	0	0	70,245
	Retained Earnings	E1	2,570,719	2,202,391	1,191,766	5,964,876
	Distributions	E13	(1,900,000)	0	0	(1,900,000)
	Transfers	E18	0	0	0	0
	Total Liab & Equity		2,009,402	2,368,519	2,487,886	6,865,807
	Net Income(Loss)		1,469,223	0	0	1,469,223
2	Lessor - Interest Expense				<u>96,418</u>	
	Lessor - Loan Fee Amortization				<u>2,264</u>	

FACILITY NAME: Centralia Manor
 ID #: 0035956

BEGINNING: 1/1/01
 ENDING: 12/31/01

ATTACHED SCHEDULE I

VII. RELATED NURSING HOMES

<u>FACILITY NAME</u>	<u>CITY</u>
Care Center of Abingdon	Abingdon
Centralia Manor	Centralia
Jerseyville Manor	Jerseyville
Lawrenceville Manor	Lawrenceville
Leroy Manor	Leroy
Maryville Manor	Maryville
Parkway Manor	Marion
Pekin Manor	Pekin
Pittsfield Manor	Pittsfield
Seminary Manor	Galesburg
Shelbyville Manor	Shelbyville

<u>RECLASSIFICATION ENTRY</u>	Schedule and Ledger Line #	Total Per General Ledger (Column 4)	Reclass Increase or (Decrease) (Column 5)	Reclassified Total (Column 6)
(1) To Allocate a % of Vehicle Expenses To Program				
Program Transportation	V-14	486	625	1,111
Other Admin. Staff Transportation	V-25	1,249	(625)	624

SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:	
Fuel and miscellaneous supplies	921
Repairs and maintenance	328
Total vehicle expenses	<u>1,249</u>

FACILITY NAME: Centralia Manor
ID #: 0035956

BEGINNING: 1/1/01
ENDING: 12/31/01

ATTACHED SCHEDULE II **Bed Allocation**

FACILITY NAME: Centralia Manor
 ID#: 0035956

BEGINNING: 1/1/01
 ENDING: 12/31/01

ATTACHED SCHEDULE III Allocation of Related Party Administrative Service Costs

SUMMARY SCHEDULE

Sch. V (See attached detail schedule)
Line # Salaries Other Total

Line #		Salaries	Other	Total
1	Dietary			0
2	Food Purchase			0
3	Housekeeping			0
4	Laundry			0
5	Heat & Other Utilities		325	325
6	Maintenance		467	467
7	Other			0
9	Medical Director			0
10	Nursing & Med Records			0
10A	Therapy			0
11	Activities			0
12	Social Services			0
13	Nurse Aide Training			0
14	Program Transportation			0
15	Other			0
17	Administrative	82,483		82,483
18	Directors Fees			0
19	Professional Services		2,885	2,885
20	Fees, Subs. & Pro.		14	14
21	Clerical & General		7,064	7,064
22	Employee Ben. & P/R		13,135	13,135
23	Inservice Training & Ed.			0
24	Travel & Seminar		3,912	3,912
25	Admin. Staff Transp.		3,198	3,198
26	Insurance		235	235
27	Other			0
30	Depreciation		3,049	3,049
31	Amortization of Pre-Op.			0
32	Interest		151	151
33	Real Estate Taxes		287	287
34	Rent-Facility & Grounds		3,909	3,909
35	Rent-Equip. & Vehicles		656	656
36	Other - Amortization			0

TOTALS 82,483 39,287 121,770

19 Amount per G/L - administrative services recorded as professional fees (156,000)
 Net adjustment required (34,230)

FACILITY NAME: Centralia Manor BEGINNING: 1/1/01
 ID#: 0035956 ENDING: 12/31/01

ATTACHED SCHEDULE III Allocation of Related Party Administrative Service Costs
DETAIL SCHEDULE

ALLOCATION FACTORS	Total	Facility	Allocation		
	Y-T-D Beds	Y-T-D Beds	Percentage		
ALL FACILITIES	33,156	1,440	4.3431%		
NURSING HOME FACILITIES	16,128	1,440	8.9286%		

ALL FACILITIES:	Total	Non-	Adjusted	Allocated	Schedule
	Costs	Allowable	Costs	Costs	& Line
	Incurred	Costs			Reference
Salaries - Owner	200,000		200,000	8,686	V-17
Salaries and wages	816,159	49,212	766,947	33,309	V-17
Advertising	317		317	14	V-20
Insurance	5,401		5,401	235	V-26
Payroll taxes & other benefits - Owner	37,441	23,970	13,471	585	V-22
Payroll taxes & other benefits	156,214	10,580	145,634	6,325	V-22
Utilities	8,579	1,089	7,490	325	V-5
Telephone	35,472		35,472	1,541	V-21
Building rental	90,000		90,000	3,909	V-34
Depreciation	70,200		70,200	3,049	V-30
Interest	3,481		3,481	151	V-32
Legal fees	13,898	6,364	7,534	327	V-19
Accounting fees	92,167	50,765	41,402	1,798	V-19
Outside management consultants	17,500		17,500	760	V-19
Supplies	100,911		100,911	4,383	V-21
Airplane & vehicle rental	15,098		15,098	656	V-35
Vehicle expense	15,156		15,156	658	V-25
Travel reimbursements	38,443	34,103	4,340	188	V-24
Meal expense	15,657	8,137	7,520	327	V-24
Training	4,985	2,350	2,635	114	V-24
Real estate taxes	6,612		6,612	287	V-33
Building & equipment maintenance	10,752		10,752	467	V-6
Other	28,403	28,403	0	0	V-21
Printing	4,030	48	3,982	173	V-21
SUBTOTALS	1,786,876	215,021	1,571,855	68,267	

NURSING HOME FACILITIES:	Total	Non-	Adjusted	Allocated	Schedule
	Costs	Allowable	Costs	Costs	& Line
	Incurred	Costs			Reference
Salaries and wages	453,471		453,471	40,488	V-17
Insurance	0		0	0	V-26
Payroll taxes & other benefits	69,718		69,718	6,225	V-22
Telephone	10,835		10,835	967	V-21
Vehicle expense	28,445		28,445	2,540	V-25
Vehicle lease	0		0	0	V-35
Travel reimbursements	21,672		21,672	1,935	V-24
Meal expense	2,792		2,792	249	V-24
Training	12,306		12,306	1,099	V-24
SUBTOTALS	599,239	0	599,239	53,503	

TOTALS	Total	Non-	Adjusted	Allocated	Schedule
	Costs	Allowable	Costs	Costs	& Line
	Incurred	Costs			Reference
TOTALS	2,386,115	215,021	2,171,094	121,770	

SUMMARY SCHEDULE

Salaries - Administrative	82,483	V-17
Heat & Other Utilities	325	V-5
Maintenance	467	V-6
Professional Services	2,885	V-19
Fees, Subscriptions & Promotion	14	V-20
Clerical & General Office Exp.	7,064	V-21
Employee Benefits & P/R Taxes	13,135	V-22
Travel & Seminar	3,912	V-24
Other Admin. Staff Transp.	3,198	V-25
Insurance	235	V-26
Depreciation	3,049	V-30
Interest	151	V-32
Real Estate Taxes	287	V-33
Rent - Facility	3,909	V-34
Rent - Equipment & Vehicles	656	V-35
	39,287	
	121,770	

FACILITY NAME: Centralia Manor
 ID#: 0035956

BEGINNING: 1/1/01
 ENDING: 12/31/01

ATTACHED SCHEDULE IV **Related Party Cost Adjustment
 Facility Rent**

Cost to Related Party Lessor:		
Depreciation (Reported on Sch. XI)	118,613	V-30
Interest	96,418	V-32
Loan Fee Amortization	<u>2,264</u>	V-36
Total lessor cost	217,295	
Cost Per General Ledger - Facility Rent	584,064	V-34
Cost Adjustment Required	<u><u>(366,769)</u></u>	

Page 5, Line 10, Interest and Other Investment Income Adjustment

Allocation of Investment Income
 (Centralia Manor a/c #1929 & 1930)

Facility	Beds/Units	%	Allocated	Adjust
Centralia Manor	120	9.4637%	41,742	41,742
Jerseyville Manor	84	6.6246%	29,219	
Lawrenceville Manor	123	9.7003%	42,786	
Leroy Manor	96	7.5710%	33,394	
Maryville Manor	120	9.4637%	41,742	
Parkway Manor	119	9.3849%	41,394	
Pekin Manor	151	11.9085%	52,525	
Pittsfield Manor	105	8.2808%	36,524	
Shelbyville Manor	131	10.3312%	45,568	
Centralia Estates	39	3.0757%	13,566	
Liberty Estates	59	4.6530%	20,523	
Parkway Estates	42	3.3123%	14,610	
Pekin Estates	79	6.2303%	27,480	
Totals	<u>1,268</u>	<u>100%</u>	<u>441,074</u>	(441,074)

Interest and Other Investment Income (Page 19, Line 25)	441,074
Required Adjustment (Page 5, Line 10)	<u><u>41,742</u></u>

FACILITY NAME: Centralia Manor
ID #: 0035956

BEGINNING: 1/1/01
ENDING: 12/31/01

ATTACHED SCHEDULE V

PAGE 19, XVII. INCOME STATEMENT

Federal Income Tax Return Reconciliation:

Income (loss) before income taxes (Line 41)		1,469,223
Nondeductible expenses:		
50% meal exclusion	85	
Fines and penalties	0	
Lobbying expenses	440	
	<hr/>	525
Timing differences:		
Depreciation expense - tax basis	(33,767)	
Depreciation expense - book basis	31,593	
Accrued vacation exp. - prior year	(70,930)	
Accrued vacation exp. - current year	66,728	
	<hr/>	(6,376)
Taxable income (loss)		<u>1,463,372</u>

FACILITY NAME: Centralia Manor
 ID#: 0035956

BEGINNING: 1/1/01
 ENDING: 12/31/01

ATTACHED SCHEDULE VI

SCHEDULE V - COST CENTER EXPENSES

LINE 27 - OTHER:

Bad Debts	5,532
Lobbying	440
Total	<u>5,972</u>

ATTACHED SCHEDULE VII

SCHEDULE VI - ADJUSTMENT DETAIL

LINE 29 - OTHER:

Out-of-state Training	V-24	1,276
Lobbying	V-27	440
Activity fund income	V-11	0
Total		<u>1,716</u>

ATTACHED SCHEDULE VIII

Page 17, XV. BALANCE SHEET

	Operating	After Consolidated
Line 9, Other Current Assets:		
Interdivision Receivable	0	0
Interest Receivable	387,871	387,871
Total	<u>387,871</u>	<u>387,871</u>

ATTACHED SCHEDULE IX

Page 18, XVI. STATEMENT OF CHANGES IN EQUITY

Line 4, Restatements:	
Uncollectible patient accounts	0
Medicare cost report settlements	2,115
Related party accrued interest income	636,520
Workers' comp insurance	0
Miscellaneous	0
Illinois replacement tax	<u>(67,000)</u>
Total	<u>571,635</u>

Restatements are year end adjustments which were made subsequent to the preparation of the Medicaid cost report for the prior year. The equity balance at the beginning of the year, restated by the above adjustments, agrees with the financial statements.

FACILITY NAME: Centralia Manor
ID#: 0035956

BEGINNING: 1/1/01
ENDING: 12/31/01