

		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>0043513</u></p> <p>Facility Name: <u>COTTONWOOD HEALTH CARE CENTER</u></p> <p>Address: <u>820 EAST 5TH ST, P.O. BOX 950</u> <u>GALESBURG</u> <u>61402</u> <small>Number City Zip Code</small></p> <p>County: <u>KNOX</u></p> <p>Telephone Number: <u>(309) 342-5135</u> Fax # <u>(309) 342-9974</u></p> <p>IDPA ID Number: <u>830320180011</u></p> <p>Date of Initial License for Current Owners: <u>02/07/98</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 type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" 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>William H. Keys</u> Telephone Number: <u>(317) 208-2740</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 type="checkbox"/> "Sub-S" Corp.			<input checked="" 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>1/1/2001</u> to <u>12/31/2001</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="1155 673 1291 820">Officer or Administrator of Provider</td> <td data-bbox="1291 673 1950 738">(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td data-bbox="1291 738 1950 803">(Type or Print Name) <u>Larry Bonds</u></td> </tr> <tr> <td></td> <td data-bbox="1291 803 1950 868">(Title) <u>President</u></td> </tr> <tr> <td data-bbox="1155 868 1291 1031">Paid Preparer</td> <td data-bbox="1291 868 1950 933">(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td data-bbox="1291 933 1950 998">(Print Name and Title) _____</td> </tr> <tr> <td></td> <td data-bbox="1291 998 1950 1063">(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td data-bbox="1291 1063 1950 1123">(Telephone) _____ Fax # () _____</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) <u>Larry Bonds</u>		(Title) <u>President</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) _____ Fax # () _____
<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																																					
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Paid Preparer	(Signed) _____ (Date) _____																																						
	(Print Name and Title) _____																																						
	(Firm Name & Address) _____																																						
	(Telephone) _____ Fax # () _____																																						

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER

0043513 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	0	Skilled (SNF)	0	0	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	97	Intermediate (ICF)	97	35,405	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	97	TOTALS	97	35,405	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5	
		Public Aid Recipient	Private Pay	Other		Total
		8	SNF	0		0
9	SNF/PED	0	0	0	9	
10	ICF	31,049	890	0	31,939	10
11	ICF/DD	0	0	0	11	
12	SC	0	0	0	12	
13	DD 16 OR LESS	0	0	0	13	
14	TOTALS	31,049	890		31,939	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.21%

D. How many bed-hold days during this year were paid by Public Aid? 215 (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)

N/A - 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 02/07/98

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/07/98 NO

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

Medicare Intermediary _____

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 COTTONWOOD HEALTH CARE CENTE # 0043513 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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	152,046	9,277	7,966	169,289		169,289		169,289		1
2	Food Purchase		117,517		117,517		117,517		117,517		2
3	Housekeeping	123,634	10,443	287	134,364		134,364		134,364		3
4	Laundry	48,056	3,240		51,296		51,296		51,296		4
5	Heat and Other Utilities			56,487	56,487		56,487	78	56,565		5
6	Maintenance	34,035	9,170	18,158	61,363		61,363	210	61,573		6
7	Other (specify):* Waste Removal			4,834	4,834		4,834		4,834		7
8	TOTAL General Services	357,771	149,647	87,732	595,150		595,150	288	595,438		8
B. Health Care and Programs											
9	Medical Director	10,067		1,300	11,367		11,367		11,367		9
10	Nursing and Medical Records	1,003,580	25,031	8,287	1,036,898		1,036,898		1,036,898		10
10a	Therapy		2,830	574	3,404		3,404	9	3,413		10a
11	Activities	77,205	1,666	3,452	82,323		82,323		82,323		11
12	Social Services	88,312		3,452	91,764		91,764		91,764		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,179,164	29,527	17,065	1,225,756		1,225,756	9	1,225,765		16
C. General Administration											
17	Administrative	60,657			60,657		60,657		60,657		17
18	Directors Fees										18
19	Professional Services			83,034	83,034		83,034	157,729	240,763		19
20	Dues, Fees, Subscriptions & Promotions			1,286	1,286		1,286	582	1,868		20
21	Clerical & General Office Expenses	73,755	49,827	161,448	285,030		285,030	54,769	339,799		21
22	Employee Benefits & Payroll Taxes			316,435	316,435		316,435	10	316,445		22
23	Inservice Training & Education										23
24	Travel and Seminar			23,211	23,211		23,211	6,343	29,554		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			107,824	107,824		107,824	66,176	174,000		26
27	Other (specify):*										27
28	TOTAL General Administration	134,412	49,827	693,238	877,477		877,477	285,609	1,163,086		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,671,347	229,001	798,035	2,698,383		2,698,383	285,906	2,984,289		29

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

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

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			51,388	51,388		51,388		51,388			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			394,452	394,452		394,452	2,813	397,265			32
33	Real Estate Taxes			24,326	24,326		24,326	98	24,424			33
34	Rent-Facility & Grounds							3,217	3,217			34
35	Rent-Equipment & Vehicles			2,523	2,523		2,523	612	3,135			35
36	Other (specify):* See Attached			2,304,439	2,304,439		2,304,439	(2,265,635)	38,804			36
37	TOTAL Ownership			2,777,128	2,777,128		2,777,128	(2,258,895)	518,233			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,184	1,184		1,184		1,184			38
39	Ancillary Service Centers		244		244		244		244			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,654	63,654		63,654		63,654			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		244	64,838	65,082		65,082		65,082			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,671,347	229,245	3,640,001	5,540,593		5,540,593	(1,972,989)	3,567,604			45

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

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	\$ #VALUE!	#####	\$	1
2 Other Care for Outpatients	#VALUE!	#####		2
3 Governmental Sponsored Special Programs	#VALUE!	#####		3
4 Non-Patient Meals	#VALUE!	#####		4
5 Telephone, TV & Radio in Resident Rooms	#VALUE!	#####		5
6 Rented Facility Space	#VALUE!	#####		6
7 Sale of Supplies to Non-Patients	#VALUE!	#####		7
8 Laundry for Non-Patients	#VALUE!	#####		8
9 Non-Straightline Depreciation	#VALUE!	#####		9
10 Interest and Other Investment Income	#VALUE!	#####		10
11 Discounts, Allowances, Rebates & Refunds	#VALUE!	#####		11
12 Non-Working Officer's or Owner's Salary	#VALUE!	#####		12
13 Sales Tax	#VALUE!	#####		13
14 Non-Care Related Interest	#VALUE!	#####		14
15 Non-Care Related Owner's Transactions	#VALUE!	#####		15
16 Personal Expenses (Including Transportation)	#VALUE!	#####		16
17 Non-Care Related Fees	#VALUE!	#####		17
18 Fines and Penalties	#VALUE!	#####		18
19 Entertainment	#VALUE!	#####		19
20 Contributions	#VALUE!	#####		20
21 Owner or Key-Man Insurance	#VALUE!	#####		21
22 Special Legal Fees & Legal Retainers	#VALUE!	#####		22
23 Malpractice Insurance for Individuals	#VALUE!	#####		23
24 Bad Debt	#VALUE!	#####		24
25 Fund Raising, Advertising and Promotional	#VALUE!	#####		25
26 Income Taxes and Illinois Personal Property Replacement Tax	#VALUE!	#####		26
27 Nurse Aide Training for Non-Employees	#VALUE!	#####		27
28 Yellow Page Advertising	#VALUE!	#####		28
29 Other-Attach Schedule (See page 5a)	#VALUE!	#####		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ #VALUE!		\$	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*	\$ #VALUE!	#####	31
32 Donated Goods-Attach Schedule*	#VALUE!	#####	32
33 Amortization of Organization & Pre-Operating Expense	#VALUE!	#####	33
34 Adjustments for Related Organization Costs (Schedule VII)	#VALUE!	#####	34
35 Other- Attach Schedule	#VALUE!	#####	35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ #VALUE!		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ #VALUE!		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		X			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

STATE OF ILLINOIS
 COTTONWOOD HEALTH CARE CENTER

ID# 0043513

Report Period Beginning: 1/1/2001

Ending: 12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	#VALUE!	\$ #VALUE!	#VALUE!	1
2	#VALUE!	#VALUE!	#VALUE!	2
3	#VALUE!	#VALUE!	#VALUE!	3
4	#VALUE!	#VALUE!	#VALUE!	4
5	#VALUE!	#VALUE!	#VALUE!	5
6	#VALUE!	#VALUE!	#VALUE!	6
7	#VALUE!	#VALUE!	#VALUE!	7
8	#VALUE!	#VALUE!	#VALUE!	8
9	#VALUE!	#VALUE!	#VALUE!	9
10	#VALUE!	#VALUE!	#VALUE!	10
11	#VALUE!	#VALUE!	#VALUE!	11
12	#VALUE!	#VALUE!	#VALUE!	12
13	#VALUE!	#VALUE!	#VALUE!	13
14	#VALUE!	#VALUE!	#VALUE!	14
15	#VALUE!	#VALUE!	#VALUE!	15
16	#VALUE!	#VALUE!	#VALUE!	16
17	#VALUE!	#VALUE!	#VALUE!	17
18	#VALUE!	#VALUE!	#VALUE!	18
19	#VALUE!	#VALUE!	#VALUE!	19
20	#VALUE!	#VALUE!	#VALUE!	20
21	#VALUE!	#VALUE!	#VALUE!	21
22	#VALUE!	#VALUE!	#VALUE!	22
23	#VALUE!	#VALUE!	#VALUE!	23
24	#VALUE!	#VALUE!	#VALUE!	24
25	#VALUE!	#VALUE!	#VALUE!	25
26				26
27	#VALUE!	#VALUE!	#VALUE!	27
28	#VALUE!	#VALUE!	#VALUE!	28
29	#VALUE!	#VALUE!	#VALUE!	29
30	Other - Goodwill	(2,304,439)	36	30
31				31
32	Vending revenue	(557)	21	32
33				33
34				34
35				35
36				36
37				37
38				38
39	Subtotal Line 29	(2,304,996)	#VALUE!	39
40			#VALUE!	40
41	#VALUE!	#VALUE!	#VALUE!	41
42	#VALUE!	#VALUE!	#VALUE!	42
43				43
44	#VALUE!	#VALUE!	#VALUE!	44
45				45
46	#VALUE!	#VALUE!	#VALUE!	46
47	#VALUE!	#VALUE!	#VALUE!	47
48				48
49	Total	#VALUE!		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER

0043513

Report Period Beginning:

1/1/2001

Ending:

12/31/2001

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	78	0	0	0	0	0	0	0	0	0	78	5
6	Maintenance	0	210	0	0	0	0	0	0	0	0	0	210	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	288	0	0	0	0	0	0	0	0	0	288	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	9	0	0	0	0	0	0	0	0	0	9	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	9	0	0	0	0	0	0	0	0	0	9	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	157,729	0	0	0	0	0	0	0	0	0	157,729	19
20	Fees, Subscriptions & Promotions	0	582	0	0	0	0	0	0	0	0	0	582	20
21	Clerical & General Office Expenses	(557)	55,326	0	0	0	0	0	0	0	0	0	54,769	21
22	Employee Benefits & Payroll Taxes	0	10	0	0	0	0	0	0	0	0	0	10	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,343	0	0	0	0	0	0	0	0	0	6,343	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	66,176	0	0	0	0	0	0	0	0	0	66,176	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(557)	286,166	0	0	0	0	0	0	0	0	0	285,609	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(557)	286,463	0	0	0	0	0	0	0	0	0	285,906	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER# 0043513

Report Period Beginning:

1/1/2001

Ending:

12/31/2001

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	2,813	0	0	0	0	0	0	0	0	0	2,813 32
33	Real Estate Taxes	0	0	98	0	0	0	0	0	0	0	0	98 33
34	Rent-Facility & Grounds	0	0	3,217	0	0	0	0	0	0	0	0	3,217 34
35	Rent-Equipment & Vehicles	0	0	612	0	0	0	0	0	0	0	0	612 35
36	Other (specify):*	(2,304,439)	0	38,804	0	0	0	0	0	0	0	0	(2,265,635) 36
37	TOTAL Ownership	(2,304,439)	2,813	42,731	0	(2,258,895) 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)	(2,304,996)	289,276	42,731	0	(1,972,989) 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
See attached Organizational Structure Description						

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)		
1	V	2 Food Purchase	\$	Senior Living Properties, LLC	100.00%	\$ 0	\$	1	
2	V	5 Heat and Other Utilities		Senior Living Properties, LLC	100.00%	78	78	2	
3	V	6 Maintenance		Senior Living Properties, LLC	100.00%	210	210	3	
4	V	7 Waste Removal		Senior Living Properties, LLC	100.00%	0		4	
5	V	10 Nursing & Medical Records		Senior Living Properties, LLC	100.00%	0		5	
6	V	10a Therapy		Senior Living Properties, LLC	100.00%	9	9	6	
7	V	19 Professional Services		Senior Living Properties, LLC	100.00%	157,729	157,729	7	
8	V	20 Dues, Fees, Subscriptions & Promotions		Senior Living Properties, LLC	100.00%	582	582	8	
9	V	21 Clerical & General Office Expenses		Senior Living Properties, LLC	100.00%	55,326	55,326	9	
10	V	22 Employee Benefits & Payroll Taxes		Senior Living Properties, LLC	100.00%	10	10	10	
11	V	24 Travel and Seminar		Senior Living Properties, LLC	100.00%	6,343	6,343	11	
12	V	26 Insurance - Prop Liab Malpractice		Senior Living Properties, LLC	100.00%	66,176	66,176	12	
13	V	32 Interest		Senior Living Properties, LLC	100.00%	2,813	2,813	13	
14	Total		\$			\$ 289,276	\$ *	289,276	14

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

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER # 0043513 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization		8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization						
15	V	33	Real Estate Taxes	\$	Senior Living Properties, LLC	100.00%	\$ 98	\$ 98		15	
16	V	34	Rent-Facility & Grounds		Senior Living Properties, LLC	100.00%	3,217		3,217	16	
17	V	35	Rent-Equipment & Vehicles		Senior Living Properties, LLC	100.00%	612		612	17	
18	V	36	Loss, Goodwill, & Depreciation		Senior Living Properties, LLC	100.00%	38,804		38,804	18	
19	V									19	
20	V									20	
21	V									21	
22	V									22	
23	V									23	
24	V									24	
25	V									25	
26	V									26	
27	V									27	
28	V									28	
29	V									29	
30	V									30	
31	V									31	
32	V									32	
33	V									33	
34	V									34	
35	V									35	
36	V									36	
37	V									37	
38	V									38	
39	Total			\$			\$ 42,731	\$ *	42,731	39	

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

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTE # 0043513 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER # 0043513 Report Period Beginning: 1/1/2001 Ending: 2/31/2001

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 Senior Living Properties, LLC
 Street Address 12400 N. Meridian Street, Suite 180
 City / State / Zip Code Carmel, Indiana 46032
 Phone Number (317) 208-2740
 Fax Number (317) 575-2562

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	2	Food Purchase	See attachment	See attachment	\$ 0	\$	See attachment	\$ 0	1
2	5	Heat and Other Utilities	See attachment	See attachment	2,029		See attachment	78	2
3	6	Maintenance	See attachment	See attachment	10,713		See attachment	210	3
4	7	Waste Removal	See attachment	See attachment	6		See attachment	0	4
5	10	Nursing & Medical Records	See attachment	See attachment	0		See attachment	0	5
6	10a	Therapy	See attachment	See attachment	452		See attachment	9	6
7	19	Professional Services	See attachment	See attachment	7,709,475		See attachment	157,729	7
8	20	Dues, Fees, Subscriptions & Prom	See attachment	See attachment	17,834		See attachment	582	8
9	21	Clerical & General Office Expens	See attachment	See attachment	2,749,973		See attachment	55,326	9
10	22	Employee Benefits & Payroll Tax	See attachment	See attachment	508		See attachment	10	10
11	24	Travel and Seminar	See attachment	See attachment	837,931		See attachment	6,343	11
12	26	Insurance - Prop Liab Malpractic	See attachment	See attachment	1,271,868		See attachment	66,176	12
13	32	Interest	See attachment	See attachment	53,649		See attachment	2,813	13
14	33	Real Estate Taxes	See attachment	See attachment	4,962		See attachment	98	14
15	34	Rent-Facility & Grounds	See attachment	See attachment	162,698		See attachment	3,217	15
16	35	Rent-Equipment & Vehicles	See attachment	See attachment	31,048		See attachment	612	16
17	36	Loss, Goodwill, & Depreciation	See attachment	See attachment	1,962,703		See attachment	38,804	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 14,815,849	\$		\$ 332,007	25

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER # 0043513 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

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	
						Original	Balance					
	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									
	A. Directly Facility Related											
	Long-Term											
1	GMAC Comm Mort Corp		X	Acquisition	\$25,006.00	02/06/98	\$ 3,566,506	\$ 3,556,316	02/01/08	0.0681	\$ 258,815	1
2	Complete Care Services		X	Acquisition	\$921.00	02/06/98	157,810	166,685	02/06/08	N/A - None	N/A - None	2
3	Manager Note		X	Acquisition	\$921.00	02/06/98	157,810	166,685	02/06/08	N/A - None	N/A - None	3
4												4
5												5
	Working Capital											
6	Line of Credit		X	Working Capital	None	02/06/98	Various	955,948	Demand	Prime + 2%	93,019	6
7	Other Interest										45,431	7
8												8
9	TOTAL Facility Related				\$26,848.00		\$ 3,882,126	\$ 4,845,634			\$ 397,265	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 3,882,126	\$ 4,845,634			\$ 397,265	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.)

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,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COTTONWOOD HEALTH CARE CENTER COUNTY KNOX

FACILITY IDPH LICENSE NUMBER 0043513

CONTACT PERSON REGARDING THIS REPORT William H. Keys

TELEPHONE (317) 208-2740 FAX #: (317)581-9513

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l 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>See Attached</u>	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct 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 hom (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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,321 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 1

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (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)

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	165,092	1998	\$ 32,300	1
2					2
3	TOTALS	165,092		\$ 32,300	3

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER

0043513

Report Period Beginning:

1/1/2001

Ending:

12/31/2001

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	97	1998	1970	\$ 846,074	\$ 28,202	30	\$ 28,202	\$ 0	\$ 110,459	4
5						-				5
6						-				6
7						-				7
8						-				8
Improvement Type**										
9	Alum slider	1998		560	37	15	37	0	130	9
10	concrete	1998		722	36	20	36	0	120	10
11	pavilion material	1998		2,506	125	20	125	0	417	11
12	water heater	1998		3,795	380	10	380	(1)	1,329	12
13	signage	1998		464	46	10	46	0	166	13
14	land improvement (purchase price)	1998		13,478	899	15	899	(0)	3,520	14
15	install gas range	1999		3,147	315	10	315	(0)	944	15
16	2 fire doors	1999		1,031	52	20	52	(0)	142	16
17	exterior door	1999		1,634	163	10	163	0	449	17
18	thermostat for water heater	1999		572	57	10	57	0	157	18
19	repped part of kitchen	1999		595	24	25	24	(0)	66	19
20	power control unit	1999		581	29	20	29	0	70	20
21	laundry room concrete slab	1999		1,210	61	20	61	(1)	126	21
22	5 sprinkler heads	1999		1,256	50	25	50	0	104	22
23	carpeting	1999		2,859	572	5	572	(0)	1,191	23
24	windows	2000		613	88	7	88	(0)	95	24
25	replaced plumbing	2000		3,564	509	7	509	0	721	25
26	freezer repairs	2000		1,014	145	7	145	(0)	266	26
27	water tank repair	2000		2,851	285	10	285	0	475	27
28	garbage disposer	2000		1,000	200	5	200		267	28
29						-				29
30	drapery & hardware	2001		940	39	10	39		39	30
31						-				31
32						-				32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

	1	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	(DON'T ENTER BELOW THIS LINE)				-				63
64	Total (This Page)								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 890,466	\$ 32,314		\$ 32,314	\$ (0)	\$ 121,253	70

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

Facility Name & ID Number **COTTONWOOD HEALTH CARE CENTER** # **0043513** Report Period Beginning: **1/1/2001** Ending: **12/31/2001**

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	\$ 122,686	\$ 15,613	\$ 15,613	\$	Various	\$ 56,700	71
72	Current Year Purchases	7,471	911	911		Various	911	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 130,157	\$ 16,524	\$ 16,524	\$		\$ 57,611	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	Resident Transport	1992 Ford Econoline	2,000	\$ 12,750	\$ 2,550	\$ 2,550	\$	5	\$ 3,400	76
77			-							77
78			-							78
79			-							79
80	TOTALS			\$ 12,750	\$ 2,550	\$ 2,550	\$		\$ 3,400	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 1,065,673	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 51,388	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 51,388	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 182,264	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?
 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>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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.	<u>/2002</u>	\$ _____
13.	<u>/2003</u>	\$ _____
14.	<u>/2004</u>	\$ _____

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: 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: \$ 2,523 Description: Central Supply - 617, Dietary - 539, Plant - 617, Laundry - 640, Administrative - 110
 (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	<u>N/A</u>		\$	\$	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.

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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>Training was not necessary for aides, as the facility only hired aides who were already trained. 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)	\$			

- (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.

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	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)							
					Units	Cost								
1	Licensed Occupational Therapist	10a, 3	hrs	\$	-	\$	-	\$	73		\$	73	1	
2	Licensed Speech and Language Development Therapist		hrs		-		-		-				2	
3	Licensed Recreational Therapist	10a, 3	hrs		11		574		2,744		11	3,318	3	
4	Licensed Physical Therapist	10a, 3	hrs		-		-		12			12	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy		# of prescripts		-		-		-				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			\$	11	\$	574	\$	2,829		11	\$	3,403	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.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER

0043513

Report Period Beginning: 1/1/2001

Ending:

12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001

(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	\$ 36,031	\$	1
2	Cash-Patient Deposits	55		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	356,002		3
4	Supply Inventory (priced at)	6,323		4
5	Short-Term Investments			5
6	Prepaid Insurance			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)	\$ 398,411	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,300		13
14	Buildings, at Historical Cost	877,464		14
15	Leasehold Improvements, at Historical Cost	13,942		15
16	Equipment, at Historical Cost	145,941		16
17	Accumulated Depreciation (book methods)	(182,264)		17
18	Deferred Charges	60,745		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): <u>Intercompany Rec / (Pay)</u>	(172,158)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 775,970	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,174,381	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 124,705	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,554		28
29	Short-Term Notes Payable	472,316		29
30	Accrued Salaries Payable	152,434		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other accrued expenses</u>	(33,602)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 733,407	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,813,193		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,813,193	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,546,600	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,372,219)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,174,381	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (860,699)	1
2	Restatements (describe):		2
3	Restatements of Prior Year to allow rollforward	825,634	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (35,065)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(3,337,154)	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)	\$ (3,337,154)	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)	\$ (3,372,219)	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Page 19

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER # 0043513 Report Period Beginning: 1/1/2001

Ending: 12/31/2001

VII. 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	\$ 2,872,371	1
2	Discounts and Allowances for all Levels	(669,368)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,203,003	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(121)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ (121)	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			28
28a	Vending	557	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 557	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,203,439	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	595,150	31
32	Health Care	1,225,756	32
33	General Administration	877,477	33
B. Capital Expense			
34	Ownership	2,777,128	34
C. Ancillary Expense			
35	Special Cost Centers	1,428	35
36	Provider Participation Fee	63,654	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,540,593	40
41	Income before Income Taxes (line 30 minus line 40)**	(3,337,154)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (3,337,154)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER

0043513

Report Period Beginning: 1/1/2001

Ending: 12/31/2001

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	2,663	2,965	\$ 55,054	\$ 18.57	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,197	7,482	134,353	17.96	3
4	Licensed Practical Nurses	24,958	25,859	356,828	13.80	4
5	Nurse Aides & Orderlies	37,262	40,752	444,912	10.92	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,397	2,487	26,328	10.59	9
10	Activity Assistants	5,355	5,694	50,877	8.94	10
11	Social Service Workers	6,399	6,823	88,312	12.94	11
12	Dietician	4,962	4,962	43,410	8.75	12
13	Food Service Supervisor	1,193	1,386	18,062	13.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,733	11,482	90,574	7.89	15
16	Dishwashers					16
17	Maintenance Workers	2,897	3,044	34,035	11.18	17
18	Housekeepers	14,475	15,184	123,634	8.14	18
19	Laundry	3,938	4,342	48,056	11.07	19
20	Administrator	2,754	2,842	60,657	21.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,357	4,909	73,755	15.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	707	707	10,067	14.24	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	841	897	12,433	13.86	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	133,088	141,817	\$ 1,671,347 *	\$ 11.79	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	85	\$ 3,390	1, 3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	600	10, 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	32	1,734	11, 3	44
45	Social Service Consultant	32	1,734	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	173	\$ 7,458		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	264	\$ 7,934	10, 3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	264	\$ 7,934		53

A. Administrative Salaries	Function	Ownership %	Amount
Sharon DeGroot	Admin.	0%	\$
Thelma Wesle	Admin.	0%	
Kathryn E. Langan	Admin.	0%	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			
			\$ <u>60,657</u>

B. Administrative - Other	Description	Amount
N/A		\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		
		\$

C. Professional Services	Vendor/Payee	Type	Amount
Legal Fees	Various		\$ 12,331
Patient Litigation	Various		55,736
Payroll Processing	Various		11,068
Accounting	Various		
EDP Services	Various		3,899
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			
			\$ <u>83,034</u>

D. Employee Benefits and Payroll Taxes	Description	Amount
Workers' Compensation Insurance		\$ 13,982
Unemployment Compensation Insurance		-
FICA Taxes		156,254
Employee Health Insurance		146,199
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Home Office Allocation		10
TOTAL (agree to Schedule V, line 22, col.8)		
		\$ <u>316,445</u>

E. Schedule of Non-Cash Compensation Paid to Owners or Employees	Description	Line #	Amount
N/A			\$
TOTAL			
			\$

F. Dues, Fees, Subscriptions and Promotions	Description	Amount
IDPH License Fee		\$
Advertising: Employee Recruitment		986
Health Care Worker Background Check (Indicate # of checks performed <u>9</u>)		
Dues & Subscriptions		300
Advertising & Public Relations		
Home Office Allocation		582
Less: Public Relations Expense		
Non-allowable advertising		#VALUE!
Yellow page advertising		#VALUE!
TOTAL (agree to Sch. V, line 20, col. 8)		
		\$ <u>#VALUE!</u>

G. Schedule of Travel and Seminar**	Description	Amount
Out-of-State Travel		\$
In-State Travel		22,715
Seminar Expense		496
Business Meals		
Home Office Allocation		6,343
Less: Entertainment Expense (agree to Sch. V, line 24, col. 8)		#VALUE!
TOTAL		
		\$ <u>#VALUE!</u>

* Attach copy of IMRF notifications **See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (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. \$ 63,654
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 benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ None
- (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? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
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? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.