

		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>0042820</u></p> <p>Facility Name: <u>Coulterville Care Center</u></p> <p>Address: <u>13138 State Route 13</u> <u>Coulterville</u> <u>62237</u> Number City Zip Code</p> <p>County: <u>Randolph</u></p> <p>Telephone Number: <u>(618) 758-2256</u> Fax # <u>(618) 758-3407</u></p> <p>IDPA ID Number: <u>364137587001</u></p> <p>Date of Initial License for Current Owners: <u>11/12/99</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" 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 <u>501(c)(3)</u></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 type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael G. Kaplan</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" 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 <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2001</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 data-bbox="1155 738 1291 820"></td> <td data-bbox="1291 738 1950 803">(Type or Print Name) _____</td> </tr> <tr> <td data-bbox="1155 803 1291 820"></td> <td data-bbox="1291 803 1950 868">(Title) _____</td> </tr> <tr> <td data-bbox="1155 820 1291 1031">Paid Preparer</td> <td data-bbox="1291 820 1950 885">(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____</td> </tr> <tr> <td data-bbox="1155 885 1291 1031"></td> <td data-bbox="1291 885 1950 950">(Print Name and Title) _____</td> </tr> <tr> <td data-bbox="1155 950 1291 1031"></td> <td data-bbox="1291 950 1950 1015">(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td data-bbox="1155 1015 1291 1031"></td> <td data-bbox="1291 1015 1950 1031">(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Coulterville Care Center

0042820 Report Period Beginning: 01/01/2001 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 7/1/01

	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	59	Skilled (SNF)	69	23,375	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	16	Sheltered Care (SC)	6	4,000	5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	27,375	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				5
		2 Public Aid Recipient	3 Private Pay	4 Other	5 Total	
		8	SNF	9,270	7,812	
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	626	1,390		2,016	12
13	DD 16 OR LESS					13
14	TOTALS	9,896	9,202	1,803	20,901	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.35%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/12/99

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/1999 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 12 and days of care provided 1,803

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Coulterville Care Center # 0042820 Report Period Beginning: 01/01/2001 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	93,826	8,455	4,652	106,933		106,933		106,933		1
2	Food Purchase		68,202		68,202		68,202	(16)	68,186		2
3	Housekeeping	72,505	10,233		82,738		82,738		82,738		3
4	Laundry	47,635	11,225		58,860		58,860		58,860		4
5	Heat and Other Utilities			70,005	70,005		70,005		70,005		5
6	Maintenance	7,394	7,961	32,088	47,443		47,443		47,443		6
7	Other (specify):*										7
8	TOTAL General Services	221,360	106,076	106,745	434,181		434,181	(16)	434,165		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	578,851	31,153	5,888	615,892		615,892		615,892		10
10a	Therapy		1,279	587,907	589,186		589,186		589,186		10a
11	Activities	21,513	758	2,273	24,544		24,544		24,544		11
12	Social Services	20,011		2,063	22,074		22,074		22,074		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	620,375	33,190	604,131	1,257,696		1,257,696		1,257,696		16
	C. General Administration										
17	Administrative	48,829		145,470	194,299		194,299		194,299		17
18	Directors Fees										18
19	Professional Services			52,486	52,486		52,486		52,486		19
20	Dues, Fees, Subscriptions & Promotions			3,618	3,618		3,618		3,618		20
21	Clerical & General Office Expenses	44,307	4,879	17,324	66,510		66,510	(2,874)	63,636		21
22	Employee Benefits & Payroll Taxes			121,479	121,479		121,479		121,479		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,026	2,026		2,026		2,026		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			60,264	60,264		60,264		60,264		26
27	Other (specify):*										27
28	TOTAL General Administration	93,136	4,879	402,667	500,682		500,682	(2,874)	497,808		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	934,871	144,145	1,113,543	2,192,559		2,192,559	(2,890)	2,189,669		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

Coulterville Care Center

#0042820

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

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			118,608	118,608		118,608	118,608				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			333,635	333,635		333,635	333,635				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,483	5,483		5,483	5,483				35
36	Other (specify):*											36
37	TOTAL Ownership			457,726	457,726		457,726	457,726				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		68,595	2,548	71,143		71,143	71,143				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,303	32,303		32,303	32,303				42
43	Other (specify):* Nonallowable costs			10,973	10,973		10,973	(10,973)				43
44	TOTAL Special Cost Centers		68,595	45,824	114,419		114,419	(10,973)	103,446			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	934,871	212,740	1,617,093	2,764,704		2,764,704	(13,863)	2,750,841			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	(16)	02		4
5	Telephone, TV & Radio in Resident Rooms	(2,874)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8)	43		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	(7,724)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(784)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(2,457)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (13,863)		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (13,863)		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

Coulterville Care, Inc.
Provider # 0042820
12/31/2001

Schedule 5A

VI. Adjustment Detail
Non-allowable Expenses
Line 29 - Other

<u>Description</u>	<u>Amount</u>	<u>Reference</u>
Disallow Late Payment Charges	(720)	43
Disallow Gifts & Flowers	(1,737)	43
Total	<u><u>(2,457)</u></u>	

See Accountants' Compilation Report

Coulterville Care Center

ID# 0042820

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	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 Coulterville Care Center# 0042820

Report Period Beginning:

01/01/2001

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	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(16)	0	0	0	0	0	0	0	0	0	0	(16)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(16)	0	0	0	0	0	0	0	0	0	0	(16)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16)	0	0	0	0	0	0	0	0	0	0	(16)	29

Facility Name & ID Number Coulterville Care Center

0042820

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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 Schedule 7A						

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V			N/A				3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Coulterville Care Center # 0042820 Report Period Beginning: 01/01/2001 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									\$	1
2										2
3			N/A							3
4										4
5										5
6										6
7			See attached Schedule 7A for Board of Directors.							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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Coulterville Care Center

0042820 Report Period Beginning: 01/01/2001

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6			N/A						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 Coulterville Care Center # 0042820 Report Period Beginning: 01/01/2001 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	Bonds payable - Series A		X	Construction of facility	\$11,000.00	10/15/99	\$ 3,615,000	\$ 3,615,000	10/15/28	0.0616	\$ 269,719	1
2	Bonds payable - Series B		X	Construction of facility	\$667.00	10/15/99	245,000	165,592	10/15/28	0.0850	22,911	2
3	Bonds payable - Series C		X	Construction of facility	\$400.00	10/15/99	140,000	140,000	10/15/28	0.0800	11,200	3
4												4
5												5
Working Capital												
6	Community Bank & Trust		X	Working Capital	Demand	02/18/00	125,150	152,184	09/18/02	0.1500	19,668	6
7	Lakeland Health Care, Inc.		X	Working Capital	Various	11/01/99	70,000	70,000	11/01/04	0.0800	None	7
8	Lakeland Health Care, Inc.		X	Working Capital	Demand	Various	50,000	49,198	12/31/01	None	None	8
9	TOTAL Facility Related				\$12,067.00		\$ 4,245,150	\$ 4,191,974			\$ 323,498	9
B. Non-Facility Related*												
10												10
11										Amortization of bond costs	10,137	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 10,137	14
15	TOTALS (line 9+line14)						\$ 4,245,150	\$ 4,191,974			\$ 333,635	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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2000 report.		\$	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.)	2000	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (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.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996 _____	8	
	1997 _____	9	
	1998 _____	10	
	1999 _____	11	
	2000 _____	12	
			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,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Coulterville Care Center COUNTY Randolph

FACILITY IDPH LICENSE NUMBER 0042820

CONTACT PERSON REGARDING THIS REPORT F. Micheal Bridges

TELEPHONE (618) 758-2256 FAX #: (618) 758-3407

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 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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	N/A	\$ _____	\$ _____
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 directly used for nursing home services? YES 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,606 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

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)

None

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

Nature 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	Facility	212,112	1999	\$ 98,450	1
2					2
3	TOTALS	212,112		\$ 98,450	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Coulterville Care Center

0042820

Report Period Beginning:

01/01/2001 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	75	1999	1999	\$ 3,409,916	\$ 85,248	40	\$ 85,248	\$	\$ 177,600	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Alarm System		1999	32,465	3,247	10	3,247		6,764	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

*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

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)		\$ 3,442,381	\$ 88,495		\$ 88,495	\$	\$ 184,364		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Coulterville Care Center

0042820

Report Period Beginning:

01/01/2001

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	\$ 337,739	\$ 30,113	\$ 30,113	\$	15	\$ 62,548	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 337,739	\$ 30,113	\$ 30,113	\$		\$ 62,548	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				\$	\$	\$	\$		\$	76
77				N/A						77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 3,878,570	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 118,608	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 118,608	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 246,912	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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:			\$			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: _____ *

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: \$ 5,483 Description: Copier \$5,483
 (Attach a schedule detailing the breakdown of movable equipment)

* 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.

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			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

SEE ACCOUNTANTS' COMPILATION REPORT

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO It is the policy of this facility to only hire certified nurses aides If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> 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.
- 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 of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	3,927	\$	77,061	\$		3,927	\$	77,061	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,522		52,852			1,522		52,852	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	L10A, C2 & 3	hrs		11,425		457,994		1,279	11,425		459,273	4
5	Physician Care		visits										5
6	Dental Care		visits										6
7	Work Related Program		hrs										7
8	Habilitation		hrs										8
9	Pharmacy	L39, C2	# of prescripts						68,595			68,595	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Exceptional Care Program												12
13	Other (specify): See attached Schedule 16A						2,548					2,548	13
14	TOTAL			\$	16,874	\$	590,455	\$	69,874	16,874	\$	660,329	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

Coulerville Care, Inc.
Provider # 0042820
12/31/2001

Schedule 16A

XIV. Special Services (Direct Cost)
Line 13 - Other

<u>Service</u>	<u>Schedule V Line & Column Reference</u>	<u>Outside Practitioner Cost</u>	<u>Supplies (Actual or Allocated)</u>	<u>Total Cost</u>
Laboratory	L39, C3	2,230.00		2,230.00
Radiology	L39, C3	<u>318.00</u>	<u> </u>	<u>318.00</u>
		<u>2,548.00</u>	-	<u>2,548.00</u>

See Accountants' Compilation Report

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Coulterville Care Center

0042820

Report Period Beginning: 01/01/2001

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	\$ 234,176	\$ 234,176	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 91,500)	686,997	686,997	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	19,067	19,067	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 940,240	\$ 940,240	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	98,450	98,450	13
14	Buildings, at Historical Cost	3,442,381	3,442,381	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	337,739	337,739	16
17	Accumulated Depreciation (book methods)	(246,912)	(246,912)	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): Bond Issue Cost, net	271,573	271,573	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,903,231	\$ 3,903,231	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,843,471	\$ 4,843,471	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 457,693	\$ 457,693	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	87,687	87,687	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,051	10,051	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	372,387	372,387	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	219,091	219,091	36
37	Accrued Assesment Fees	23,788	23,788	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,170,697	\$ 1,170,697	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,191,974	4,191,974	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Related Parties	62,159	62,159	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,254,133	\$ 4,254,133	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,424,830	\$ 5,424,830	46
47	TOTAL EQUITY(page 18, line 24)	\$ (581,359)	\$ (581,359)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,843,471	\$ 4,843,471	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (523,092)	1
2	Restatements (describe):		2
3			3
4	Prior Period Adjustments	(126,128)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (649,220)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	67,861	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)	\$ 67,861	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)	\$ (581,359)	24 *

Operating entity only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Coulterville Care Center

0042820

Report Period Beginning: 01/01/2001

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	\$ 2,368,880	1
2	Discounts and Allowances for all Levels	(498,969)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,869,911	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	901,224	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 901,224	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	16	14
15	Telephone, Television and Radio	2,874	15
16	Rental of Facility Space		16
17	Sale of Drugs	53,497	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,043	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 61,430	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			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,832,565	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	434,181	31
32	Health Care	1,257,696	32
33	General Administration	500,682	33
B. Capital Expense			
34	Ownership	457,726	34
C. Ancillary Expense			
35	Special Cost Centers	82,116	35
36	Provider Participation Fee	32,303	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,764,704	40
41	Income before Income Taxes (line 30 minus line 40)**	67,861	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 67,861	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Coulterville Care Center

0042820

Report Period Beginning: 01/01/2001

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	1,907	1,994	\$ 37,373	\$ 18.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	464	558	9,958	17.85	3
4	Licensed Practical Nurses	16,902	16,675	205,918	12.35	4
5	Nurse Aides & Orderlies	31,544	32,926	277,625	8.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,041	2,128	21,513	10.11	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,167	20,011	9.23	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,167	21,369	9.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,891	11,351	72,457	6.38	15
16	Dishwashers					16
17	Maintenance Workers	997	1,041	7,394	7.10	17
18	Housekeepers	9,718	10,196	72,505	7.11	18
19	Laundry	5,982	6,285	47,635	7.58	19
20	Administrator	2,080	2,167	48,829	22.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,963	2,050	20,608	10.05	23
24	Clerical	2,336	2,416	23,699	9.81	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	1,933	2,020	25,568	12.66	31
32	Other Health Care Plan Coordina	1,628	1,715	22,409	13.07	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	94,546	97,856	\$ 934,871 *	\$ 9.55	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	150	\$ 4,652	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant	18	738	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,650	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	58	2,063	L11, C3	44
45	Social Service Consultant	58	2,063	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	284	\$ 20,166		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Coulterville Care Center

0042820

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Chris Haake	Administrator	0%	\$ 38,242	Workers' Compensation Insurance	\$ 16,783	IDPH License Fee	\$ 2,389	
James Ritchie	Administrator	0%	10,587	Unemployment Compensation Insurance	32,640	Advertising: Employee Recruitment	2,389	
				FICA Taxes	65,379	Health Care Worker Background Check (Indicate # of checks performed <u>17</u>)	204	
				Employee Health Insurance	6,677	Illinois Charity Bureau	1,025	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 48,829			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Lakeland Health Care			\$ 145,470					
See Attached Schedule 21A for Management Agreement								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 145,470	TOTAL (agree to Schedule V, line 22, col.8)	\$ 121,479	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,618	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Altschuler, Melvoin & Glasser LLP	Accounting		\$ 21,908				Out-of-State Travel	\$
American Express Tax & Bus. Serv.	Accounting		23,255					
Kerber, Eck & Braeckel LLP	Payroll		2,976	N/A			In-State Travel	1,324
Melyx	Computer Services		1,957					
Grueninger & Assoc.	Legal		1,890				Seminar Expense	702
Mark Atkins	Legal		500					
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 2,026
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 52,486	TOTAL		\$		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
3														
4			N/A											
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Coulterville Care Center# 0042820Report Period Beginning: 01/01/2001Ending: 12/31/2001**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? N/A
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,290 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 32,303
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. \$ None Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (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? 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? Yes
Firm Name: Altschuler, Melvoin & Glasser 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 is currently in progress.
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	93,826	8,455	4,652	106,933	0	106,933	0	106,933
2. Food P	0	68,202	0	68,202	0	68,202	-16	68,186
3. Housek	72,505	10,233	0	82,738	0	82,738	0	82,738
4. Laundry	47,635	11,225	0	58,860	0	58,860	0	58,860
5. Heat ar	0	0	70,005	70,005	0	70,005	0	70,005
6. Mainte	7,394	7,961	32,088	47,443	0	47,443	0	47,443
7. Other (0	0	0	0	0	0	0	0
8. Total G	221,360	106,076	106,745	434,181	0	434,181	-16	434,165
9. Medical	0	0	6,000	6,000	0	6,000	0	6,000
10. Nursin	578,851	31,153	5,888	615,892	0	615,892	0	615,892
10a. Ther	0	1,279	587,907	589,186	0	589,186	0	589,186
11. Activit	21,513	758	2,273	24,544	0	24,544	0	24,544
12. Social	20,011	0	2,063	22,074	0	22,074	0	22,074
13. Nurse	0	0	0	0	0	0	0	0
14. Progr	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	620,375	33,190	604,131	1,257,696	0	1,257,696	0	1,257,696
17. Admin	48,829	0	145,470	194,299	0	194,299	0	194,299
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	52,486	52,486	0	52,486	0	52,486
20. Fees,	0	0	3,618	3,618	0	3,618	0	3,618
21. Cleric	44,307	4,879	17,324	66,510	0	66,510	-2,874	63,636
22. Empl	0	0	121,479	121,479	0	121,479	0	121,479
23. Inserv	0	0	0	0	0	0	0	0
24. Travel	0	0	2,026	2,026	0	2,026	0	2,026
25. Other	0	0	0	0	0	0	0	0
26. Insura	0	0	60,264	60,264	0	60,264	0	60,264
27. Other	0	0	0	0	0	0	0	0
28. Total I	93,136	4,879	402,667	500,682	0	500,682	-2,874	497,808
29. Total C	934,871	144,145	1,113,543	2,192,559	0	2,192,559	-2,890	2,189,669
30. Depre	0	0	118,608	118,608	0	118,608	0	118,608
31. Amort	0	0	0	0	0	0	0	0
32. Intere	0	0	333,635	333,635	0	333,635	0	333,635
33. Real E	0	0	0	0	0	0	0	0
34. Rent -	0	0	0	0	0	0	0	0
35. Rent -	0	0	5,483	5,483	0	5,483	0	5,483
36. Other	0	0	0	0	0	0	0	0
37. Total J	0	0	457,726	457,726	0	457,726	0	457,726
38. Medic	0	0	0	0	0	0	0	0
39. Ancill	0	68,595	2,548	71,143	0	71,143	0	71,143
40. Barbe	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42. Provid	0	0	32,303	32,303	0	32,303	0	32,303
43. Other	0	0	10,973	10,973	0	10,973	-10,973	0
44. Total K	0	68,595	45,824	114,419	0	114,419	-10,973	103,446
45. Grand	934,871	212,740	1,617,093	2,764,704	0	2,764,704	-13,863	2,750,841

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	234,176	234,176
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	686,997	686,997
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	19,067	19,067
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	940,240	940,240
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	98,450	98,450
14. Buildings, at Historical Cost	3,442,381	3,442,381
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	337,739	337,739
17. Accumulated Depreciation (book methods)	-246,912	-246,912
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	271,573	271,573
24. Total Long-Term Assets	3,903,231	3,903,231
25. Total Assets	4,843,471	4,843,471
CURRENT LIABILITIES		
26. Accounts Payable	457,693	457,693
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	87,687	87,687
31. Accrued Taxes Payable	10,051	10,051
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	372,387	372,387
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	242,879	242,879
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,170,697	1,170,697
LONG TERM LIABILITES		
39. Long-Term Notes Payable	4,191,974	4,191,974
40. Mortgage Payable	0	0
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	62,159	62,159
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	4,254,133	4,254,133
46. Total Liabilities	5,424,830	5,424,830
47. Total Equity	-581,359	-581,359
48. Total Liabilities and Equity	4,843,471	4,843,471

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,368,880
2. Discounts and Allowances for all Levels	-498,969
Subtotal - Inpatient Care	1,869,911
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	901,224
7. Oxygen	0
Subtotal - Ancillary Revenue	901,224
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	16
15. Telephone, Television, and Radio	2,874
16. Rental of Facility Space	0
17. Sale of Drugs	53,497
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	5,043
22. Laundry	0
Subtotal - Other Operating Revenue	61,430
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	0
28. Other Revenue (specify):	0
Subtotal - Other Revenue	-
30. Total Revenue	2,832,565
31. General Services	434,181
32. Health Care	1,257,696
33. General Administration	500,682
34. Ownership	457,726
35. Special Cost Centers	82,116
35. Provider Participation Fee	32,303
37. Other	0
40. Total Expenses	2,764,704
41. Income Before Income Taxes	67,861
42. Income Taxes	0
43. Net Income or Loss for the Year	67,861

Page

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10 Attachment of Real Estate Bill and fill out form

11

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

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

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23

RECONCILIATION REPORT

Coulterville Care Center

02:26 PM 11/07/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CELL
Adjustment Detail	-13,863	equal to	-13,863	0	O.K.	Pg5 Z22
Interest Expense	333,635	equal to	333,635	0	O.K.	Pg9 P34
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33
Ownership Costs-Depreciation	118,608	equal to	118,608	0	O.K.	Pg13 Y28
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22
Rental Costs B	5,483	equal to	5,483	0	O.K.	Pg14 J30+N40
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32
Therapy Services	589,186	equal to	589,186	0	O.K.	Pg16 Z12+Z14..Z16 & Pg 20 X17..X20
Special Serv.- Supplies	69,874	equal to	69,874	0	O.K.	Pg16 V32
Income Stat. General Serv.	434,181	equal to	434,181	0	O.K.	Pg19 P11
Income Stat. Health Care	1,257,696	equal to	1,257,696	0	O.K.	Pg19 P12
Income Stat. Administration	500,682	equal to	500,682	0	O.K.	Pg19 P13
Income Stat. Ownership	457,726	equal to	457,726	0	O.K.	Pg19 P15
Income Stat. Special Cost Ctr	82,116	equal to	82,116	0	O.K.	Pg19 P17
Income Stat. Prov. Partic.	32,303	equal to	32,303	0	O.K.	Pg19 P18
Staff- Nursing	556,442	equal to	578,851	-22,409	FAILED	Pg20 K11..K15+K35+K36+K38..K44
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17
Staff- Activities	21,513	equal to	21,513	0	O.K.	Pg20 K19+K20
Staff- Social Serv. Workers	20,011	equal to	20,011	0	O.K.	Pg20 K21
Staff- Dietary	93,826	equal to	93,826	0	O.K.	Pg20 K22..K26
Staff- Maintenance	7,394	equal to	7,394	0	O.K.	Pg20 K27
Staff- Housekeeping	72,505	equal to	72,505	0	O.K.	Pg20 K28
Staff- Laundry	47,635	equal to	47,635	0	O.K.	Pg20 K29
Staff- Administrative	48,829	equal to	48,829	0	O.K.	Pg20 K30..K32
Staff- Clerical	44,307	equal to	44,307	0	O.K.	Pg20 K33..K34
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37
Total Salaries And Wages	934,871	equal to	934,871	0	O.K.	Pg20 K44
Dietary Consultant	4,652	< or = to	4,652	0	O.K.	Pg20 X12
Medical Director	6,000	< or = to	6,000	0	O.K.	Pg20 X13
Consultants & contractors	5,388	< or = to	5,888	-500	O.K.	Pg20 X14..X16+X37..X39
Activity Consultant	2,063	< or = to	2,273	-210	O.K.	Pg20 X21
Social Service Consultant	2,063	< or = to	2,063	0	O.K.	Pg20 X22
Supp. Sched.- Admin. Salar.	48,829	equal to	48,829	0	O.K.	Pg21 I16
Supp. Sched.- Admin. Other	145,470	equal to	145,470	0	O.K.	Pg21 I24
Supp. Sched.- Prof. Serv.	52,486	equal to	52,486	0	O.K.	Pg21 I41
Supp. Sched.- Benefit/Taxes	121,479	equal to	121,479	0	O.K.	Pg21 P22
Supp. Sched.- Sched of dues..	3,618	equal to	3,618	0	O.K.	Pg21 V22
Supp. Sched.- Sched. of trav	2,026	equal to	2,026	0	O.K.	Pg21 V41
Gen. Info - Particip. Fees	32,303	equal to	32,303	0	O.K.	Pg23 I38
Gen. Info - Employee Meals	None	< or = to		0	O.K.	Pg23 S16
Gen. Info - Employee Meals	None	equal to	0	#VALUE!	#VALUE!	Pg23 S16
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31
Days of medicare provided	1,803	equal to	1,803	0	O.K.	Pg2 AB29
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18
Total loan balance	4,191,974	equal to	4,191,974	0	O.K.	Pg9 L34
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15
Land	98,450	equal to	98,450	0	O.K.	Pg11 T43
Building cost	3,442,381	equal to	3,442,381	0	O.K.	Pg12 to 121 L43
Equipment and vehicle cost	337,739	equal to	337,739	0	O.K.	Pg13 O22+L13
Accumulated depr.	246,912	equal to	246,912	0	O.K.	Pg13 Y30
End of year equity	-581,359	equal to	-581,359	0	O.K.	Pg18 I33
Net income (loss)	67,861	equal to	67,861	0	O.K.	Pg18 I15
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S31
Balance Sheet	4,843,471	equal to	4,843,471	0	O.K.	Pg17:H41