

		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>0043646</u></p> <p>Facility Name: <u>PITTSFIELD HEALTHCARE CENTER</u></p> <p>Address: <u>1400 EAST WASHINGTON STREET</u> <u>PITTSFIELD</u> <u>62363</u> <small>Number City Zip Code</small></p> <p>County: <u>PIKE</u></p> <p>Telephone Number: <u>(217) 285-4491</u> Fax # <u>(217) 285-4242</u></p> <p>IDPA ID Number: <u>830320180022</u></p> <p>Date of Initial License for Current Owners: <u>02/07/98</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></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 style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Larry Bonds</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>President</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(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																																					
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																					
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	(Print Name and Title) _____																																						
	(Firm Name & Address) _____																																						
	(Telephone) _____ Fax # () _____																																						

Facility Name & ID Number PITTSFIELD HEALTHCARE CENTER# 0043646 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	8	Skilled (SNF)	8	2,920	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	91	Intermediate (ICF)	91	33,215	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	99	TOTALS	99	36,135	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	251	11	
9	SNF/PED	0	0	0	0	9
10	ICF	20,538	6,315	0	26,853	10
11	ICF/DD	0	0	0	0	11
12	SC	0	0	0	0	12
13	DD 16 OR LESS	0	0	0	0	13
14	TOTALS	20,789	6,326	1,580	28,695	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 79.41%D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/A - NoneF. Does the facility maintain a daily midnight census? YESG. 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 02/07/98J. 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 8 and days of care provided 1,580Medicare Intermediary TRAILBLAZER HEALTH ENTERPRISES, LLC

IV. ACCOUNTING BASIS

ACCRAU 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

Page 3

Facility Name & ID Number PITTSFIELD HEALTHCARE CENTER # 0043646 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	126,424	7,048	8,347	141,819		141,819		141,819		1
2	Food Purchase		104,072		104,072		104,072		104,072		2
3	Housekeeping	89,284	9,308		98,592		98,592		98,592		3
4	Laundry	36,490	18,221		54,711		54,711		54,711		4
5	Heat and Other Utilities			75,857	75,857		75,857	70	75,927		5
6	Maintenance	21,863	7,181	28,223	57,267		57,267	189	57,456		6
7	Other (specify):* Waste Removal			3,263	3,263		3,263		3,263		7
8	TOTAL General Services	274,061	145,830	115,690	535,581		535,581	259	535,840		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	773,547	37,332	8,396	819,275		819,275		819,275		10
10a	Therapy		19,813	214,900	234,713		234,713	8	234,721		10a
11	Activities	32,540	797	2,636	35,973		35,973		35,973		11
12	Social Services	19,223		2,678	21,901		21,901		21,901		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	825,310	57,942	228,610	1,111,862		1,111,862	8	1,111,870		16
	C. General Administration										
17	Administrative	48,047			48,047		48,047		48,047		17
18	Directors Fees										18
19	Professional Services			77,022	77,022		77,022	141,709	218,731		19
20	Dues, Fees, Subscriptions & Promotions			10,384	10,384		10,384	523	10,907		20
21	Clerical & General Office Expenses	75,020	42,021	159,664	276,705		276,705	48,728	325,433		21
22	Employee Benefits & Payroll Taxes			234,704	234,704		234,704	9	234,713		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,628	5,628		5,628	5,698	11,326		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			125,499	125,499		125,499	59,454	184,953		26
27	Other (specify):*										27
28	TOTAL General Administration	123,067	42,021	612,901	777,989		777,989	256,121	1,034,110		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,222,438	245,793	957,201	2,425,432		2,425,432	256,388	2,681,820		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			102,877	102,877		102,877		102,877			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			517,005	517,005		517,005	2,527	519,532			32
33	Real Estate Taxes			50,230	50,230		50,230	88	50,318			33
34	Rent-Facility & Grounds							2,890	2,890			34
35	Rent-Equipment & Vehicles			4,844	4,844		4,844	549	5,393			35
36	Other (specify):* See Attached			173,676	173,676		173,676	(138,814)	34,862			36
37	TOTAL Ownership			848,632	848,632		848,632	(132,760)	715,872			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,875	2,875		2,875		2,875			38
39	Ancillary Service Centers		31,235	324	31,559		31,559		31,559			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,865	67,865		67,865		67,865			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		31,235	71,064	102,299		102,299		102,299			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,222,438	277,028	1,876,897	3,376,363		3,376,363	123,628	3,499,991			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
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
PITTSFIELD HEALTHCARE CENTER

ID# 0043646

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	(173,676)	36	30
31				31
32	Vending revenue	(980)	21	32
33				33
34				34
35				35
36				36
37				37
38				38
39	Subtotal Line 29	(174,656)	#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 PITTSFIELD HEALTHCARE CENTER# 0043646 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	70	0	0	0	0	0	0	0	0	0	70	5
6	Maintenance	0	189	0	0	0	0	0	0	0	0	0	189	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	259	0	0	0	0	0	0	0	0	0	259	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	8	0	0	0	0	0	0	0	0	0	8	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	8	0	0	0	0	0	0	0	0	0	8	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	141,709	0	0	0	0	0	0	0	0	0	141,709	19
20	Fees, Subscriptions & Promotions	0	523	0	0	0	0	0	0	0	0	0	523	20
21	Clerical & General Office Expenses	(980)	49,708	0	0	0	0	0	0	0	0	0	48,728	21
22	Employee Benefits & Payroll Taxes	0	9	0	0	0	0	0	0	0	0	0	9	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,698	0	0	0	0	0	0	0	0	0	5,698	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	59,454	0	0	0	0	0	0	0	0	0	59,454	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(980)	257,101	0	0	0	0	0	0	0	0	0	256,121	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(980)	257,368	0	0	0	0	0	0	0	0	0	256,388	29

Facility Name & ID Number **PITTSFIELD HEALTHCARE CENTER**

0043646

Report Period Beginning:

1/1/2001

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 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%	70	70	2	
3	V	6 Maintenance		Senior Living Properties, LLC	100.00%	189	189	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%	8	8	6	
7	V	19 Professional Services		Senior Living Properties, LLC	100.00%	141,709	141,709	7	
8	V	20 Dues, Fees, Subscriptions & Promotions		Senior Living Properties, LLC	100.00%	523	523	8	
9	V	21 Clerical & General Office Expenses		Senior Living Properties, LLC	100.00%	49,708	49,708	9	
10	V	22 Employee Benefits & Payroll Taxes		Senior Living Properties, LLC	100.00%	9	9	10	
11	V	24 Travel and Seminar		Senior Living Properties, LLC	100.00%	5,698	5,698	11	
12	V	26 Insurance - Prop Liab Malpractice		Senior Living Properties, LLC	100.00%	59,454	59,454	12	
13	V	32 Interest		Senior Living Properties, LLC	100.00%	2,527	2,527	13	
14	Total		\$			\$ 259,895	\$ *	259,895	14

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		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%	\$ 88	\$ 88		15	
16	V	34	Rent-Facility & Grounds		Senior Living Properties, LLC	100.00%	2,890	2,890		16	
17	V	35	Rent-Equipment & Vehicles		Senior Living Properties, LLC	100.00%	549	549		17	
18	V	36	Loss, Goodwill, & Depreciation		Senior Living Properties, LLC	100.00%	34,862	34,862		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			\$			\$ 38,389	\$ *	38,389	39	

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

Facility Name & ID Number PITTSFIELD HEALTHCARE CENTER # 0043646 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 PITTSFIELD HEALTHCARE CENTER # 0043646 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	70	2
3	6	Maintenance	See attachment	See attachment	10,713		See attachment	189	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	8	6
7	19	Professional Services	See attachment	See attachment	7,709,475		See attachment	141,709	7
8	20	Dues, Fees, Subscriptions & Prom	See attachment	See attachment	17,834		See attachment	523	8
9	21	Clerical & General Office Expens	See attachment	See attachment	2,749,973		See attachment	49,708	9
10	22	Employee Benefits & Payroll Tax	See attachment	See attachment	508		See attachment	9	10
11	24	Travel and Seminar	See attachment	See attachment	837,931		See attachment	5,698	11
12	26	Insurance - Prop Liab Malpractic	See attachment	See attachment	1,271,868		See attachment	59,454	12
13	32	Interest	See attachment	See attachment	53,649		See attachment	2,527	13
14	33	Real Estate Taxes	See attachment	See attachment	4,962		See attachment	88	14
15	34	Rent-Facility & Grounds	See attachment	See attachment	162,698		See attachment	2,890	15
16	35	Rent-Equipment & Vehicles	See attachment	See attachment	31,048		See attachment	549	16
17	36	Loss, Goodwill, & Depreciation	See attachment	See attachment	1,962,703		See attachment	34,862	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 14,815,849	\$		\$ 298,284	25

Facility Name & ID Number **PITTSFIELD HEALTHCARE CENTER** # **0043646** 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	\$32,620.00	02/06/98	\$ 4,652,436	\$ 4,662,725	02/01/08	0.0681	\$ 339,229	1	
2	Complete Care Services	X	Acquisition	\$1,201.00	02/06/98	205,860	217,496	02/06/08	N/A - None	N/A - None	2	
3	Manager Note	X	Acquisition	\$1,201.00	02/06/98	205,860	217,496	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	1,253,355	Demand	Prime + 2%	121,958	6	
7	Other Interest									58,345	7	
8											8	
9	TOTAL Facility Related			\$35,022.00		\$ 5,064,156	\$ 6,351,072			\$ 519,532	9	
B. Non-Facility Related*												
10											10	
11											11	
12											12	
13											13	
14	TOTAL Non-Facility Related					\$	\$			\$	14	
15	TOTALS (line 9+line14)					\$ 5,064,156	\$ 6,351,072			\$ 519,532	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 PITTSFIELD HEALTHCARE CENTER COUNTY PIKE

FACILITY IDPH LICENSE NUMBER 0043646

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>53-033-05</u>	<u>See Attached</u>	<u>\$ 49,004.70</u>	<u>\$ 49,004.70</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		<u>\$ 49,004.70</u>	<u>\$ 49,004.70</u>

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: 30,894 B. General Construction Type: Exterior BRICK 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	242,194	1998	\$ 137,500	1
2					2
3	TOTALS	242,194		\$ 137,500	3

Facility Name & ID Number PITTSFIELD HEALTHCARE CENTER

0043646

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	99	1998	1970	\$ 2,020,231	\$ 67,341	30	\$ 67,341	\$ 0	\$ 263,752	4
5						-				5
6						-				6
7						-				7
8						-				8
Improvement Type**										
9	carpet	1998		764	153	5	153	(0)	484	9
10	replace sink	1998		5,913	296	20	296	(0)	912	10
11	signage	1998		464	46	10	46	0	166	11
12	seal, coat, patch parking lot	1998		6,338	792	8	792	0	2,509	12
13	replacement doors	1999		6,619	441	15	441	0	1,324	13
14	steel door	1999		566	38	15	38	(0)	113	14
15	carpet install	1999		2,000	400	5	400		1,200	15
16	generator	1999		1,031	52	20	52	(0)	147	16
17	met / glass door	1999		1,779	89	20	89	(0)	252	17
18	repairs to nurse call system	1999		817	82	10	82	(0)	225	18
19	install a/c	1998		1,746	175	10	175	(0)	582	19
20	install a/c unit	1998		5,200	520	10	520		1,647	20
21	boiler repair	1999		1,100	55	20	55		119	21
22	shower tile	1999		680	34	20	34		74	22
23	compressors (2)	1999		1,732	115	15	115	0	240	23
24	a/c unit / airhandler	2000		6,980	465	15	465	0	620	24
25	floor and piping repairs	2000		2,089	209	10	209	(0)	261	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

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)		\$ 2,066,049	\$ 71,303		\$ 71,303	\$ (0)	\$ 274,627	70

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

Facility Name & ID Number **PITTSFIELD HEALTHCARE CENTER** # **0043646** 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	\$ 215,486	\$ 30,744	\$ 30,744	\$	Various	\$ 114,996	71
72	Current Year Purchases	5,690	830	830		Various	830	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 221,176	\$ 31,574	\$ 31,574	\$		\$ 115,826	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			-							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)	\$	2,424,725	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	102,877	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	102,877	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)	\$	390,453	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: \$ 4,844 Description: Nursing - 829, Central Supply - 2232, Dietary - 898, Plant - 506, Administrative - 379
 (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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a, 3	hrs	\$	1,420	\$ 87,910	\$ 125	1,420	\$ 88,035	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		178	9,055	-	178	9,055	2
3	Licensed Recreational Therapist	10a, 3	hrs		32	1,576	19,688	32	21,264	3
4	Licensed Physical Therapist	10a, 3	hrs		1,964	116,360	-	1,964	116,360	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			\$	3,594	\$ 214,901	\$ 19,813	3,594	\$ 234,714	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

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Facility Name & ID Number PITTSFIELD HEALTHCARE CENTER

0043646

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	\$ 42,356	\$	1
2	Cash-Patient Deposits	1,623		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	343,968		3
4	Supply Inventory (priced at)	4,134		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)	\$ 392,081	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	137,500		13
14	Buildings, at Historical Cost	2,157,022		14
15	Leasehold Improvements, at Historical Cost	6,802		15
16	Equipment, at Historical Cost	218,089		16
17	Accumulated Depreciation (book methods)	(390,453)		17
18	Deferred Charges	2,007,805		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>	782,606		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,919,371	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,311,452	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 225,836	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,912		28
29	Short-Term Notes Payable	619,258		29
30	Accrued Salaries Payable	115,479		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>	16,550		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 987,035	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	4,997,427		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)	\$ 4,997,427	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,984,462	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (673,010)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,311,452	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (979,410)	1
2	Restatements (describe):		2
3	Restatements of Prior Year to allow rollforward	1,067,922	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 88,512	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(761,522)	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)	\$ (761,522)	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)	\$ (673,010)	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number PITTSFIELD HEALTHCARE CENTER

0043646

Report Period Beginning: 1/1/2001

Ending:

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12/31/2001

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,699,402	1
2	Discounts and Allowances for all Levels	(617,884)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,081,518	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	383,806	6
7	Oxygen	41,647	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 425,453	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	425	13
14	Non-Patient Meals	60	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	58,467	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,001	19
20	Radiology and X-Ray		20
21	Other Medical Services	18,937	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 106,890	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	980	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 980	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,614,841	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	535,581	31
32	Health Care	1,111,862	32
33	General Administration	777,989	33
B. Capital Expense			
34	Ownership	848,632	34
C. Ancillary Expense			
35	Special Cost Centers	34,434	35
36	Provider Participation Fee	67,865	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,376,363	40
41	Income before Income Taxes (line 30 minus line 40)**	(761,522)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (761,522)	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 **PITTSFIELD HEALTHCARE CENTER**

0043646

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	2,076	2,267	\$ 40,817	\$ 18.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,017	6,190	88,792	14.34	3
4	Licensed Practical Nurses	24,784	25,388	267,481	10.54	4
5	Nurse Aides & Orderlies	38,914	41,129	370,770	9.01	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,954	2,028	16,102	7.94	9
10	Activity Assistants	2,043	2,106	16,439	7.81	10
11	Social Service Workers	1,933	2,034	19,223	9.45	11
12	Dietician	4,072	4,072	33,012	8.11	12
13	Food Service Supervisor	1,291	1,371	13,783	10.05	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,397	11,096	79,629	7.18	15
16	Dishwashers					16
17	Maintenance Workers	1,875	1,941	21,863	11.26	17
18	Housekeepers	11,336	12,093	89,284	7.38	18
19	Laundry	2,938	3,204	36,490	11.39	19
20	Administrator	1,812	1,956	48,047	24.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,481	5,619	75,020	13.35	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	619	663	5,686	8.58	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	117,542	123,157	\$ 1,222,438 *	\$ 9.93	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	192	\$ 5,760	1, 3	35
36	Medical Director				36
37	Medical Records Consultant	16	654	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	480	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	48	2,676	11, 3	44
45	Social Service Consultant	48	2,676	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	400	\$ 12,246		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	120	\$ 4,192	10, 3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	120	\$ 4,192		53

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. \$ 15,256 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. \$ 67,865
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? Yes Indicate the amount. \$ 60
- (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.