		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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.

I. IDPH License ID Number: 0042820

Facility Name: COULTERVILLE CARE CENTER

Address: 13138 STATE ROUTE 13 (Number) COULTERVILLE (City) 62237 (Zip Code)

County: RANDOLPH

Telephone Number: 618-758-2256 **Fax #** 618-758-3407

HFS ID Number: 364137587001

Date of Initial License for Current Owners: 11/12/1999

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: KEN MARX **Telephone Number:** 314-231-5544
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/09 to 12/31/09 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	KEN MARX PARTNER
	(Firm Name & Address)	BKD, LLP 211 N BROADWAY, STE 600 ST. LOUIS, MO 63102
	(Telephone)	314-231-5544 Fax # 314-231-9731

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

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

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	11,271	7,973	4,543	23,787	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,271	7,973	4,543	23,787	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.89%

D. How many bed-hold days during this year were paid by the Department?
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

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 11/12/1999

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/12/1999 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 75 and days of care provided 4,543

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	150,162	16,201	4,558	170,921		170,921		170,921			1
2	Food Purchase		166,752		166,752		166,752	(2,765)	163,987			2
3	Housekeeping	107,738	10,253	2,114	120,105		120,105		120,105			3
4	Laundry	66,285	4,751	4,162	75,198		75,198		75,198			4
5	Heat and Other Utilities			103,577	103,577		103,577		103,577			5
6	Maintenance	27,191	3,881	57,977	89,049		89,049	(8,115)	80,934			6
7	Other (specify):*											7
8	**TOTAL General Services**	351,376	201,838	172,388	725,602		725,602	(10,880)	714,722			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	976,209	59,619	232	1,036,060		1,036,060		1,036,060			10
10a	Therapy			544,942	544,942		544,942		544,942			10a
11	Activities	35,499	2,173	74	37,746		37,746		37,746			11
12	Social Services	26,557	122		26,679		26,679		26,679			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,038,265	61,914	551,248	1,651,427		1,651,427		1,651,427			16
	C. General Administration											
17	Administrative	119,120	2,171	231,123	352,414		352,414	(6,876)	345,538			17
18	Directors Fees											18
19	Professional Services			174,944	174,944		174,944		174,944			19
20	Dues, Fees, Subscriptions & Promotions			29,635	29,635		29,635	(8,665)	20,970			20
21	Clerical & General Office Expenses		10,311	33,283	43,594		43,594		43,594			21
22	Employee Benefits & Payroll Taxes			357,651	357,651		357,651		357,651			22
23	Inservice Training & Education			4,213	4,213		4,213		4,213			23
24	Travel and Seminar			11,873	11,873		11,873		11,873			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			90,870	90,870		90,870		90,870			26
27	Other (specify):*											27
28	**TOTAL General Administration**	119,120	12,482	933,592	1,065,194		1,065,194	(15,541)	1,049,653			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,508,761	276,234	1,657,228	3,442,223		3,442,223	(26,421)	3,415,802			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.

Facility Name & ID Number COULTERVILLE CARE CENTER #0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			174,521	174,521		174,521		174,521			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			307,535	307,535		307,535	(3,819)	303,716			32
33	Real Estate Taxes			66,109	66,109		66,109		66,109			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,486	5,486		5,486		5,486			35
36	Other (specify):*											36
37	TOTAL Ownership			553,651	553,651		553,651	(3,819)	549,832			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			6	6		6		6			38
39	Ancillary Service Centers		105,487	44,034	149,521		149,521		149,521			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,063	41,063		41,063		41,063			42
43	Other (specify):* BAD DEBT RECOVERY			36,541	36,541		36,541	(36,541)				43
44	TOTAL Special Cost Centers		105,487	121,644	227,131		227,131	(36,541)	190,590			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,508,761	381,721	2,332,523	4,223,005		4,223,005	(66,781)	4,156,224			45

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

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,765)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,115)	6		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	(3,819)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,541)	43		24
25	Fund Raising, Advertising and Promotional	(8,665)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(6,876)	17		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (66,781)		$	30

BHF 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 Amount	2 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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (66,781)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

COULTERVILLE CARE CENTER

ID# 0042820

Report Period Beginning: 1/1/09

Ending: 12/31/09

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	OTHER INCOME	$ (6,876)	17	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**	(6,876)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	(2,765)	0	0	0	0	0	0	0	0	0	0	(2,765)	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	(8,115)	0	0	0	0	0	0	0	0	0	0	(8,115)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,880)	0	0	0	0	0	0	0	0	0	0	(10,880)	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	CNA 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	(6,876)	0	0	0	0	0	0	0	0	0	0	(6,876)	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	(8,665)	0	0	0	0	0	0	0	0	0	0	(8,665)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(15,541)	0	0	0	0	0	0	0	0	0	0	(15,541)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(26,421)	0	0	0	0	0	0	0	0	0	0	(26,421)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,819)	0	0	0	0	0	0	0	0	0	0	(3,819)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,819)	0	0	0	0	0	0	0	0	0	0	(3,819)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(36,541)	0	0	0	0	0	0	0	0	0	0	(36,541)	43
44	TOTAL Special Cost Centers	(36,541)	0	0	0	0	0	0	0	0	0	0	(36,541)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(66,781)	0	0	0	0	0	0	0	0	0	0	(66,781)	45

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

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

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 [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								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.

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column 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								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 COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	BANK OF NEW YORK		X	CONSTRUCTION FINANCING			$ 4,000,000	$ 3,260,000			$ 294,818	1
2	AMORTIZATION		X	BOND ISSUANCE COSTS							10,139	2
3												3
4												4
5												5
	Working Capital											
6	RICKEL		X	START UP EXPENSE			25,000	36,198		3.5000	1,289	6
7	FRIAR		X	START UP EXPENSE			25,000	36,198		3.5000	1,289	7
8												8
9	TOTAL Facility Related						$ 4,050,000	$ 3,332,396			$ 307,535	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,050,000	$ 3,332,396			$ 307,535	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* 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.)

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 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.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 66,109	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 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.	$ 66,109	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2004		8
2005		9
2006		10
2007	61,408	11
2008	66,109	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2008	$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COULTERVILLE CARE CENTER COUNTY RANDOLPH

FACILITY IDPH LICENSE NUMBER 0042820

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2008 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 2008.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		NURSING FACILITY	$ 66,109.22	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 66,109.22	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and 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 original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA 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 [X] 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				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	75		1999	1999	$ 3,409,916	$ 85,248	40	$ 85,248	$	$ 859,583	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ALARM SYSTEM			1999	32,465	3,245	10	3,245		32,735	9
10	CONCRETE FLOOR- STORAGE BUILDING			2005	2,450	164	15	164		722	10
11	REMOVAL OF DINING ROOM WALL & MINOR REPAINTING			2007	7,960	531	5	531		1,327	11
12	PARKING LOT			2007	9,587	1,916	15	1,916		4,633	12
13	FRONT DOOR OF BUILDING			2008	5,556	556	10	556		1,112	13
14	OUTDOOR KEYPAD			2008	1,083	217	5	217		397	14
15	SMOKER'S PAVILLION			2008	2,011	402	5	402		502	15
16	CABLING FOR VOICE & INTERNET			2009	9,072	1663	5	1,663		1,663	16
17	EXTERIOR LIGHTING			2009	1,060	212	5	212		212	17
18	NEW SLIDE DOOR PACKAGE			2009	7,044	235	10	235		235	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

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		$ 3,488,204	$ 94,389		$ 94,389	$	$ 903,121	70

**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: 1/1/09 Ending: 12/31/09

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	$ 587,972	$ 68,439	$ 68,439	$ (0)		$ 376,384	71
72	Current Year Purchases	106,455	11,693	11,693	0		11,692	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 694,427	$ 80,132	$ 80,132	$ 0		$ 388,076	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	94 WHEELCHAIR VAN	2002	$ 1,000	$	$	$		$ 1,000	76
77										77
78										78
79										79
80	TOTALS			$ 1,000	$	$	$		$ 1,000	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,183,631	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 174,521	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 174,521	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)	$ 1,292,197	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.

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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 [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	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

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: *

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.	/2010	$
13.	/2011	$
14.	/2012	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 5,486 Description: COPIER & OXYGEN
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA 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 CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs 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 CNAs.

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

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

		1	2	3	4	5	6	7	8	
	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		hrs	$	3,193	$ 189,973	$	3,193	$ 189,973	1
2	Licensed Speech and Language Development Therapist		hrs		1,136	71,308		1,136	71,308	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		5,362	283,661		5,362	283,661	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	9,692	$ 544,941	$	9,692	$ 544,941	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 CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/09 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,042,002	$	1
2	Cash-Patient Deposits	13,465		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (247,488))	554,455		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,356		6
7	Other Prepaid Expenses	6,007		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,671,285	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	98,450		13
14	Buildings, at Historical Cost	3,409,916		14
15	Leasehold Improvements, at Historical Cost	83,287		15
16	Equipment, at Historical Cost	694,427		16
17	Accumulated Depreciation (book methods)	(1,291,197)		17
18	Deferred Charges	304,123		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(113,649)		20
21	Restricted Funds	195,570		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,380,927	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,052,212	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 564,309	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,465		28
29	Short-Term Notes Payable	225,000		29
30	Accrued Salaries Payable	52,784		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,277		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	176,645		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	OTHER ACCRUED EXPENSES	3,291		36
37	OTHER CURRENT LIABILITIES	15,165		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,053,936	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,332,396		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,332,396	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,386,332	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 665,880	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,052,212	$	48

*(See instructions.)

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 543,614	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 543,614	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	122,266	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)**	$ 122,266	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)**	$ 665,880	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,864,154	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,864,154	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,270,850	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,270,850	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,085	13
14	Non-Patient Meals	2,765	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	131,921	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,118	19
20	Radiology and X-Ray	998	20
21	Other Medical Services	53,685	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 199,572	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,373	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,373	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER INCOME	7,322	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,322	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,345,271	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	725,602	31
32	Health Care	1,651,427	32
33	General Administration	1,065,194	33
	B. Capital Expense		
34	Ownership	553,651	34
	C. Ancillary Expense		
35	Special Cost Centers	186,068	35
36	Provider Participation Fee	41,063	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,223,005	40
41	**Income before Income Taxes (line 30 minus line 40)****	122,266	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 122,266	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 COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	6,449	6,449	$ 149,884	$ 23.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,232	4,232	100,359	23.71	3
4	Licensed Practical Nurses	14,660	14,660	231,516	15.79	4
5	CNAs & Orderlies	49,948	49,948	481,794	9.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,282	3,282	35,499	10.82	10
11	Social Service Workers	2,112	2,112	26,557	12.57	11
12	Dietician	16,290	16,290	150,162	9.22	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,400	2,400	27,191	11.33	17
18	Housekeepers	11,713	11,713	107,738	9.20	18
19	Laundry	7,867	7,867	66,285	8.43	19
20	Administrator	2,080	2,080	64,818	31.16	20
21	Assistant Administrator					21
22	Other Administrative	4,199	4,199	54,302	12.93	22
23	Office Manager					23
24	Clerical					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	1,418	1,418	12,656	8.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	126,650	126,650	$ 1,508,761 *	$ 11.91	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		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

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

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ANDREA MCFADDEN	ADMINISTRATOR		$ 64,818
OTHER ADMIN SAL			54,302
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 119,120

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
PLEASE SEE ATTACHED	PURCHASED SERVICES	$ 41,674
PLEASE SEE ATTACHED	LEGAL	70,882
PLEASE SEE ATTACHED	AUDIT	33,388
PLEASE SEE ATTACHED	PROFESSIONAL FEES	29,000
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 174,944

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 145,811
Unemployment Compensation Insurance	26,168
FICA Taxes	113,742
Employee Health Insurance	64,381
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OTHER BENEFITS	7,549
TOTAL (agree to Schedule V, line 22, col.8)	$ 357,651

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,380
Advertising: Employee Recruitment	8,463
Health Care Worker Background Check (Indicate # of checks performed ____)	
Patient Background Checks	
FINES/ PENALITIES	0
DUES & SUBSCRIPTIONS	4,781
ADVERTISING & MARKETING	10,170
BACKGROUND CHECK FEES	2,467
PRINTING	374
Less: Public Relations Expense	( )
Non-allowable advertising	(8,665)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,970

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,548
Seminar Expense	5,325
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,873

**See instructions.

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number COULTERVILLE CARE CENTER # 0042820 Report Period Beginning: 1/1/09 Ending: 12/31/09

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **$2,864.57 (LSN) AND $1,468.39 (AAHSA)**

(3) Did the nursing home make political contributions or payments to a political action 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**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,174** Line _____

(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 during this cost report period. $ **41,063**
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, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **2,765**

(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? **0**
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? **NO**
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: **BKD, LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.