

		FOR BHF USE			

LL2

Supportive Living Facility

**2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2016)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

<p>I. Facility ID Number: <u>1000133</u></p> <p>Facility Name: <u>Courtyard Estates of Peoria</u></p> <hr/> <p>Address: <u>117 N Western Avenue</u> <u>Peoria</u> <u>61604</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Peoria</u></p> <p>Telephone Number: <u>(309)674-2400</u> Fax # <u>(309)621-4860</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>8/24/11</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 Charitable Corp.</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY Individual</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL 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 checked="" type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input 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>Mike Kocher</u> Telephone Number: <u>(309)691-8113</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp.	<input checked="" type="checkbox"/> PROPRIETARY Individual	<input type="checkbox"/> GOVERNMENTAL State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2016</u> to <u>12/31/2016</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 align="center">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) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Mark B. Petersen</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Title) <u>Chief Executive Officer</u></td> </tr> </table> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) <u>()</u></td> <td style="border: none;">Fax # ()</td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE IL DEPT OF HEALTHCARE AND FAMILY SERVICES 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>Mark B. Petersen</u>			(Title) <u>Chief Executive Officer</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) <u>()</u>	Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp.	<input checked="" type="checkbox"/> PROPRIETARY Individual	<input type="checkbox"/> GOVERNMENTAL State																																									
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	(Telephone) <u>()</u>	Fax # ()																																									

Facility Name Courtyard Estates of Peoria

Report Period Beginning: 1/1/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units N/A

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	100	Single Unit Apartment	100	36,500	1
2		Double Unit Apartment			2
3		Other			3
4	100	TOTALS	100	36,500	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	20,001	13,372		33,373	5
6	Double Unit					6
7	Other					7
8	TOTALS	20,001	13,372		33,373	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 91.43%

D. Indicate the number of paid bed-hold days the SLF had during this year

None Also, indicate the number of unpaid bed-hold days the SLF had during this year. None (Do not include bed-hold days in Section B.)

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES NO

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES NO

G. List all services provided by your facility for non-residents.

(E.g., day care, "meals on wheels", outpatient therapy)
N/A

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

J. Does the facility have any Illinois Housing Development Authority Loans outstanding?

No If yes, did the facility make all of the required payments of interest and principle? _____
If no, explain. _____

K. Does the facility have any loans from the Federal Home Loan Bank outstanding?

No If yes, did the facility make all of the required payments of interest and principle? _____
If no, explain. _____

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding?

No If yes, did the facility make all of the required payments of interest and principle? _____
If no, explain. _____

Facility Name: Courtyard Estates of Peoria

Report Period Beginning:

1/1/2016

Ending: 12/31/2016

IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	242,964	186,202		429,166	(2,095)	427,071	1
2	Housekeeping, Laundry and Maintenance	288,641	61,106	4,112	353,859		353,859	2
3	Heat and Other Utilities			186,769	186,769		186,769	3
4	Other (specify):							4
5	TOTAL General Services	531,605	247,308	190,881	969,794	(2,095)	967,699	5
B. Health Care and Programs								
6	Health Care/ Personal Care	692,535	(863)	9,202	700,874	(6,658)	694,216	6
7	Activities and Social Services	65,257	1,615	3,711	70,583	(3,530)	67,053	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	757,792	752	12,913	771,457	(10,188)	761,269	9
C. General Administration								
10	Administrative and Clerical	73,769	3,208	286,094	363,071	(167,750)	195,321	10
11	Marketing Materials, Promotions and Advertising	47,070	2,420		49,490	(49,490)		11
12	Employee Benefits and Payroll Taxes			181,250	181,250		181,250	12
13	Insurance-Property, Liability and Malpractice			32,082	32,082		32,082	13
14	Other (specify):			48,695	48,695	(48,695)		14
15	TOTAL General Administration	120,839	5,628	548,121	674,588	(265,935)	408,653	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,410,236	253,688	751,915	2,415,839	(278,218)	2,137,621	16
Capital Expenses								
D. Ownership								
17	Depreciation			306,126	306,126	3,565	309,691	17
18	Interest			5,543	5,543	(112)	5,431	18
19	Real Estate Taxes			280,508	280,508		280,508	19
20	Rent -- Facility and Grounds			79,499	79,499		79,499	20
21	Rent -- Equipment							21
22	Other (specify):			6,153	6,153		6,153	22
23	TOTAL Ownership			677,829	677,829	3,453	681,282	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,410,236	253,688	1,429,744	3,093,668	(274,765)	2,818,903	24

Facility Name: Courtyard Estates of Peoria

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

V. STAFFING AND SALARY COSTS (Please report each line separately.)

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 23.39	1
2	Licensed Practical Nurses	9	19.46	2
3	Certified Nurse Assistants	10	10.52	3
4	Activity Director & Assistants	2	15.69	4
5	Social Service Workers			5
6	Head Cook	1	23.13	6
7	Cook Helpers/Assistants	9	10.41	7
8	Dishwashers			8
9	Maintenance Workers	2	15.46	9
10	Housekeepers	7	14.21	10
11	Laundry			11
12	Managers	1	32.69	12
13	Other Administrative			13
14	Clerical	2	17.73	14
15	Marketing	1	22.63	15
16	Other			16
17	Total (lines 1 thru 16)	46	\$	17

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1	N/A			\$	1
2					2
3					3
4					4
5					5
				Total	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	N/A	\$ 1
2		\$ 2
		Total
		\$ 3

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES

Name	1	City	2
See Attached Schedule 4A			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES NO

Name of related entity: Petersen Health Care Management, Inc. If yes, what is the value of those services? \$ 198,200

(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES NO

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

Facility Name: Courtyard Estates of Peoria

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VIII. OWNERSHIP COSTS

A. Purchase price of land 470,000 Year land was acquired 2009

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar. *Total units on this schedule must agree with page 2.

	1 Units*	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	
1	100		2011	2011	\$ 5,537,053	\$ 221,482	25	\$ 221,482	\$	\$ 1,218,151	1
2											2
3											3
4											4
5											5
Improvement Type											
6		2012 Repairs		2012	38,128	3,943	7 & 15	3,946	3	17,757	6
7		Wall Air Conditioners (20)		2013	26,079	3,724	7	3,726	2	13,041	7
8		2014 Repairs		2014	27,602	3,943	7	3,943		11,139	8
9		Dry Pipe Valve Repair		2015	6,708	952	7	958	6	1,437	9
10		Elevator Repair		2016	4,895	700	7	350	(350)	350	10
11		Air Conditioner for Lounge		2016	4,617	308	15	154	(154)	154	11
12		Water Heater		2016	6,535	934	7	467	(467)	467	12
13		Carpeting for 7 Rooms		2016	5,283	755	7	377	(378)	377	13
14											14
15											15
16											16
17		TOTAL (lines 1 thru 16)			\$ 5,656,900	\$ 236,741		\$ 235,403	\$ (1,338)	\$ 1,262,873	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 468,512	\$ 67,095	\$ 66,930	(165)	7 yrs.	\$ 234,365	18
19	Vehicles	36,788	2,290	7,358	5,068	5 yrs.	29,432	19
20	TOTAL (lines 18 and 19)	\$ 505,300	\$ 69,385	\$ 74,288	4,903		\$ 263,797	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21	House on Arthur Street	\$ 61,800	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$ 61,800	\$	\$	24

Facility Name: Courtyard Estates of Peoria

Report Period Beginning: 1/1/2016

Ending: 2/31/2016

IX. RENTAL COSTS

A. Building and Fixed Equipment

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? YES NO

		1	2	3	4	5	6	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*	
3	Original Building			/ /	\$			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL				\$			7

8. Is movable equipment rental included in building rental? YES NO

9. Rental amount for movable equipment \$ 6,153

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

X. INTEREST EXPENSE

	1	Name of Lender	2		3	4	6		7	8	9	
			Related**	YES			NO	Purpose of Loan				
							Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1		1st Mid-Illinois Bank & Trust		X	Mortgage	1/1/11	\$ 5,249,269	\$ 4,506,915	3/4/36	5.0000	\$ 276,047	1
2						/ /			/ /			2
3						/ /			/ /			3
		Working Capital										
4		1st Mid-Illinois Bank & Trust		X	Line of Credit	/ /	244,274	113,932	/ /		4,461	4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 5,493,543	\$ 4,620,847			\$ 280,508	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 5,493,543	\$ 4,620,847			\$ 280,508	10

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

** If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

Facility Name: Courtyard Estates of Peoria

Report Period Beginning: 1/1/2016

Ending:

12/31/2016

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (170,273)	\$ (170,273)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>6,506</u>)	826,273	826,273	3
4	Supply Inventory (priced <u>Cost</u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,892	30,892	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	55,864	55,864	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 742,756	\$ 742,756	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	470,000	470,000	13
14	Buildings, at Historical Cost	5,537,053	5,537,053	14
15	Leasehold Improvements, at Historical Cost	119,848	119,848	15
16	Equipment, at Historical Cost	505,300	505,300	16
17	Accumulated Depreciation (book methods)	(1,588,096)	(1,526,670)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Non-Care Asset</u>	61,800	61,800	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,105,905	\$ 5,167,331	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,848,661	\$ 5,910,087	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 153,016	\$ 153,016	26
27	Officer's Accounts Payable	33,000	33,000	27
28	Accounts Payable-Patient Deposits	57,024	57,024	28
29	Short-Term Notes Payable	113,932	113,932	29
30	Accrued Salaries Payable	47,246	47,246	30
31	Accrued Taxes Payable	134,916	134,916	31
32	Accrued Interest Payable	23,240	23,240	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>Payroll Withholdings</u>	16,702	16,702	35
36	<u>Accrued Management Fees</u>	1,011,327	1,011,327	36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,590,403	\$ 1,590,403	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,506,915	4,506,915	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	<u>Intercompany Loans</u>	297,894	297,894	42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 4,804,809	\$ 4,804,809	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 6,395,212	\$ 6,395,212	45
46	TOTAL EQUITY	\$ (546,551)	\$ (485,125)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,848,661	\$ 5,910,087	47

*(See instructions.)

Facility Name: Courtyard Estates of Peoria

Report Period Beginning: 1/1/2016

Ending:

12/31/2016

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
I. Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 3,085,488	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,085,488	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals	2,095	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 2,095	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	112	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 112	14
D. Other Revenue (specify):			
15	Transportation Revenue	3,530	15
16	Miscellaneous Income	7,595	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 11,125	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,098,820	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	969,794	19
20	Health Care/ Personal Care	771,457	20
21	General Administration	674,588	21
B. Capital Expense			
22	Ownership	677,829	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 3,093,668	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 5,152	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 5,152	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 1,816,393	32
33	Private Pay - Net Inpatient Revenue	1,269,095	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 3,085,488	37

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Total
1. Dietary	242,964	13,990	0	256,954	0	256,954	0	256,954
2. Food Pt	0	172,212	0	172,212	0	172,212	-2,095	170,117
3. Housek	206,893	31,751	0	238,644	0	238,644	0	238,644
4. Laundry	17,448	4,818	0	22,266	0	22,266	0	22,266
5. Heat an	0	0	186,769	186,769	0	186,769	0	186,769
6. Mainter	64,300	24,537	4,112	92,949	0	92,949	0	92,949
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	531,605	247,308	190,881	969,794	0	969,794	-2,095	967,699
9. Medical	0	0	0	0	0	0	0	0
10. Nursin	692,535	-863	9,202	700,874	0	700,874	-6,658	694,216
10a. Therz	0	0	0	0	0	0	0	0
11. Activi	65,257	1,615	3,679	70,551	0	70,551	-3,530	67,021
12. Social	0	0	0	0	0	0	0	0
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total I	757,792	752	12,881	771,425	0	771,425	-10,188	761,237
17. Admir	0	0	236,400	236,400	0	236,400	-166,813	69,587
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	7,114	7,114	0	7,114	0	7,114
20. Fees, f	0	0	10,689	10,689	0	10,689	0	10,689
21. Cleric:	73,769	3,208	20,747	97,724	0	97,724	-937	96,787
22. Emplo	0	0	181,250	181,250	0	181,250	0	181,250
23. Inserv:	0	0	0	0	0	0	0	0
24. Travel	0	0	0	0	0	0	0	0
25. Other	0	0	11,144	11,144	0	11,144	0	11,144
26. Insura	0	0	32,082	32,082	0	32,082	0	32,082
27. Other	47,070	2,420	48,695	98,185	0	98,185	-98,185	0
28. Total C	120,839	5,628	548,121	674,588	0	674,588	-265,935	408,653
29. Total C	1,410,236	253,688	751,883	2,415,807	0	2,415,807	-278,218	2,137,589
30. Deprec	0	0	306,126	306,126	0	306,126	3,565	309,691
31. Amort	0	0	5,543	5,543	0	5,543	0	5,543
32. Interes	0	0	280,508	280,508	0	280,508	-112	280,396
33. Real E	0	0	79,499	79,499	0	79,499	0	79,499
34. Rent -	0	0	0	0	0	0	0	0
35. Rent -	0	0	6,153	6,153	0	6,153	0	6,153
36. Other	0	0	0	0	0	0	0	0
37. Total C	0	0	677,829	677,829	0	677,829	3,453	681,282
38. Medic	0	0	0	0	0	0	0	0
39. Ancill.	0	0	0	0	0	0	0	0
40. Barber	0	0	0	0	0	0	0	0
41. Coffee	0	0	32	32	0	32	0	32
42	0	0	0	0	0	0	0	0
43. Other	0	0	0	0	0	0	0	0
44. Total S	0	0	32	32	0	32	0	32
45. Grand	1,410,236	253,688	1,429,744	3,093,668	0	3,093,668	-274,765	2,818,903

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-170,273	-170,273
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	826,273	826,273
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	30,892	30,892
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	55,864	55,864
9. Other (specify):	0	0
10. Total current assets	742,756	742,756
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	470,000	470,000
14. Buildings, at Historical Cost	5,537,053	5,537,053
15. Leasehold Improvements, Historical Cost	119,848	119,848
16. Equipment, at Historical Cost	505,300	505,300
17. Accumulated Depreciation (book methods)	-1,588,096	-1,526,670
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	61,800	61,800
24. Total Long-Term Assets	5,105,905	5,167,331
25. Total Assets	5,848,661	5,910,087
CURRENT LIABILITIES		
26. Accounts Payable	153,016	153,016
27. Officer's Accounts Payable	33,000	33,000
28. Accounts Payable-Patients Deposits	57,024	57,024
29. Short-Term Notes Payable	113,932	113,932
30. Accrued Salaries Payable	47,246	47,246
31. Accrued Taxes Payable	134,916	134,916
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	23,240	23,240
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	16,702	16,702
37. Other Current Liabilities (specify):	1,011,327	1,011,327
38. Total Current Liabilities	1,590,403	1,590,403
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	4,506,915	4,506,915
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	297,894	297,894
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	4,804,809	4,804,809
46.Total Liabilities	6,395,212	6,395,212
47.Total Equity	-546,551	-485,125
48.Total Liabilities and Equity	5,848,661	5,910,087

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,085,488
2. Discounts and Allowances for all Level	0
Subtotal - Inpatient Care	3,085,488
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursement	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	2,095
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	2,095
24. Contributions	0
25. Interest and Other Investments Income	112
Subtotal - Non-Operating Revenue	112
27. Other Revenue (specify):	3,530
28. Other Revenue (specify):	7,595
Subtotal - Other Revenue	11,125
30. Total Revenue	3,098,820
31. General Services	1,001,045
32. Health Care	777,918
33. General Administration	630,981
34. Ownership	746,282
35. Special Cost Centers	0
35. Provider Participation Fee	0
37. Other	0
40. Total Expenses	3,156,226
41. Income Before Income Taxes	-57,406
42. Income Taxes	0
43. Net Income or Loss for the Year	-57,406