

		FOR BHF USE			

LL2

Supportive Living Facility

**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2011)**

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>1000084</u></p> <p>Facility Name: <u>Legacy Estates of Monmouth</u></p> <hr/> <p>Address: <u>1200 W. Broadway</u> <u>Monmouth</u> <u>61462</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Warren</u></p> <p>Telephone Number: (<u>309</u>) <u>734-0909</u> Fax # (<u>309</u>) <u>734-0910</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>8/16/2007</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact:</p> <p>Name: <u>Larry Templin</u> Telephone Number: <u>(309) 691-8113</u></p> <p>Email Address: _____</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 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>1/1/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Mark B. Petersen</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> <td></td> </tr> </table> <table border="1" style="width:100%"> <tr> <td style="width:20%;">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) (_____)</td> <td>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) (_____)	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																																												
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 _____																																													
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) (_____)	Fax # (_____)																																												

Facility Name Legacy Estates of Monmouth

Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	59	Single Unit Apartment	59	21,535	1
2		Double Unit Apartment			2
3		Other			3
4	59	TOTALS	59	21,535	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	9,001	8,480		17,481	5
6	Double Unit					6
7	Other					7
8	TOTALS	9,001	8,480		17,481	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 81.17%

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 Non-allowable costs have been eliminated in Schedule IV, Column 5

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: 12/31/2011 Fiscal Year: 12/31/2011

* 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: Legacy Estates of Monmouth

Report Period Beginning:

1/1/2011

Ending: 12/31/2011

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	76,030	98,398		174,428	(2,523)	171,905	1
2	Housekeeping, Laundry and Maintenance	63,966	27,958	18,058	109,982		109,982	2
3	Heat and Other Utilities			63,839	63,839		63,839	3
4	Other (specify):							4
5	TOTAL General Services	139,996	126,356	81,897	348,249	(2,523)	345,726	5
B. Health Care and Programs								
6	Health Care/ Personal Care	312,506	2,154		314,660		314,660	6
7	Activities and Social Services	22,757	277	237	23,271	(478)	22,793	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	335,263	2,431	237	337,931	(478)	337,453	9
C. General Administration								
10	Administrative and Clerical	17,111	1,681	74,154	92,946	(11,667)	81,279	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			95,963	95,963		95,963	12
13	Insurance-Property, Liability and Malpractice			8,409	8,409		8,409	13
14	Other (specify):		198	14,737	14,935	(14,935)		14
15	TOTAL General Administration	17,111	1,879	193,263	212,253	(26,602)	185,651	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	492,370	130,666	275,397	898,433	(29,603)	868,830	16
Capital Expenses								
D. Ownership								
17	Depreciation			126,947	126,947	(13,863)	113,084	17
18	Interest			245,026	245,026	(2,627)	242,399	18
19	Real Estate Taxes			62,760	62,760		62,760	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			951	951		951	21
22	Other (specify):							22
23	TOTAL Ownership			435,684	435,684	(16,490)	419,194	23
24	GRAND TOTAL (Sum of lines 16 and 23)	492,370	130,666	711,081	1,334,117	(46,093)	1,288,024	24

Facility Name: Legacy Estates of Monmouth

Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 17.28	1
2	Licensed Practical Nurses	2	16.65	2
3	Certified Nurse Assistants	10	8.93	3
4	Activity Director & Assistants	1	9.40	4
5	Social Service Workers			5
6	Head Cook	1	9.87	6
7	Cook Helpers/Assistants	3	9.41	7
8	Dishwashers			8
9	Maintenance Workers	1	16.04	9
10	Housekeepers	2	8.50	10
11	Laundry			11
12	Managers	1	23.82	12
13	Other Administrative			13
14	Clerical	1	10.07	14
15	Marketing			15
16	Other	1	9.40	16
17	Total (lines 1 thru 16)	25	\$	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
See Attached Schedule 4B		

OTHER RELATED BUSINESS ENTITIES		
Name	3	City

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, Inc. If yes, what is the value of those services? \$ 61,200
 (Please attach a separate schedule itemizing those services.) The services were for management and administrative functions.

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: Legacy Estates of Monmouth

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

VIII. OWNERSHIP COSTS

A. Purchase price of land 127,000 Year land was acquired 2005

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	59			2007	3,548,140	96,850	39	90,978	\$(5,872)	\$ 409,401	1
2				2009	10,000	401	25	400	(1)	1,000	2
3											3
4											4
5											5
Improvement Type											
6		Roof Repair		2008	3,015	201	15	201		705	6
7		Wall Remodeling between Rooms 308 & 310		2008	4,105	274	15	274		959	7
8		Shower Installation		2009	16,200	1,080	15	1,080		2,700	8
9		Carpet in 3 Halls		2009	18,927	1,262	15	1,262		3,786	9
10		Pool Repair		2009	6,522	435	15	435		1,087	10
11		Curb Replacement		2010	8,800	586	15	586		879	11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 3,615,709	\$ 101,089		\$ 95,216	\$ (5,873)	\$ 420,517	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	\$ 181,009	25,858	17,868	(7,990)	10 yrs.	78,373	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 181,009	\$ 25,858	\$ 17,868	(7,990)		\$ 78,373	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	N/A	\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: Legacy Estates of Monmouth

Report Period Beginning: 1/1/2011

Ending: 2/31/2011

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 \$ -

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		Midwest Bank of Western IL		X	Mortgage	5/1/09	2,800,000	Refinanced	4/30/12	0.0850	79,752	1
2		Midwest Bank of Western IL		X	Mortgage	6/1/11	4,237,500	4,211,546	5/31/12	0.0700	158,548	2
3						/ /			/ /			3
		Working Capital										
4		Midwest Bank of Western IL		X	Line of Credit	11/1/11	150,000	150,000	5/30/12	0.0500	719	4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 7,187,500	\$ 4,361,546			\$ 239,019	7
		B. Non-Facility Related										
8						/ /		Amortization Exp.	/ /		6,007	8
9						/ /		Interest Offset	/ /		-2,627	9
10		TOTALS (lines 7, 8 and 9)					\$ 7,187,500	\$ 4,361,546			\$ 242,399	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: Legacy Estates of Monmouth

Report Period Beginning: 1/1/2011

Ending:

12/31/2011

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,483,727	\$ 1,483,727	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	228,748	228,748	3
4	Supply Inventory (priced <u>Cost</u>)	5,086	5,086	4
5	Short-Term Investments			5
6	Prepaid Insurance	16,216	16,216	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)	\$ 1,733,777	\$ 1,733,777	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	150,800	127,000	13
14	Buildings, at Historical Cost	2,762,532	3,558,140	14
15	Leasehold Improvements, at Historical Cost	829,377	57,569	15
16	Equipment, at Historical Cost	181,009	181,009	16
17	Accumulated Depreciation (book methods)	(543,424)	(498,890)	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 Loan Costs	54,066	54,066	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,434,360	\$ 3,478,894	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,168,137	\$ 5,212,671	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 252,069	\$ 252,069	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	150,000	150,000	29
30	Accrued Salaries Payable	26,974	26,974	30
31	Accrued Taxes Payable	69,810	69,810	31
32	Accrued Interest Payable	12,669	12,669	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Payroll Withholdings	25,034	25,034	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 536,556	\$ 536,556	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,211,546	4,211,546	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Security Deposit	34,300	34,300	42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 4,245,846	\$ 4,245,846	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 4,782,402	\$ 4,782,402	45
46	TOTAL EQUITY	\$ 385,735	\$ 430,269	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,168,137	\$ 5,212,671	47

*(See instructions.)

Facility Name: Legacy Estates of Monmouth

Report Period Beginning: 1/1/2011

Ending:

12/31/2011

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

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 1,604,800	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,604,800	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	2,523	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 2,523	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	2,627	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 2,627	14
D. Other Revenue (specify):			
15	Cable Television Revenue	12,338	15
16	Transportation & Miscellaneous Income	486	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 12,824	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,622,774	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	348,249	19
20	Health Care/ Personal Care	337,931	20
21	General Administration	212,253	21
B. Capital Expense			
22	Ownership	435,684	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)	\$ 1,334,117	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 288,657	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 288,657	31

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	76,030	6,788	0	82,818	0	82,818	0	82,818
2. Food Purchase	0	91,610	0	91,610	0	91,610	-2,523	89,087
3. Housekeeping	30,586	16,669	365	47,620	0	47,620	0	47,620
4. Laundry	0	2,456	0	2,456	0	2,456	0	2,456
5. Heat and Other Utilities	0	0	63,839	63,839	0	63,839	0	63,839
6. Maintenance	33,380	8,833	17,693	59,906	0	59,906	0	59,906
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	139,996	126,356	81,897	348,249	0	348,249	-2,523	345,726
9. Medical Director	0	0	0	0	0	0	0	0
10. Nursing & Medical Records	312,506	2,154	0	314,660	0	314,660	0	314,660
10a. Therapy	0	0	0	0	0	0	0	0
11. Activities	22,757	169	237	23,163	0	23,163	-478	22,685
12. Social Services	0	108	0	108	0	108	0	108
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	335,263	2,431	237	337,931	0	337,931	-478	337,453
17. Administrative	0	0	61,200	61,200	0	61,200	-11,659	49,541
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	1,103	1,103	0	1,103	0	1,103
20. Fees, Subscriptions & Promotion	0	0	3,533	3,533	0	3,533	0	3,533
21. Clerical & General Office	17,111	1,681	5,234	24,026	0	24,026	-8	24,018
22. Employee Benefits & Payroll	0	0	95,963	95,963	0	95,963	0	95,963
23. Inservice Training & Education	0	0	85	85	0	85	0	85
24. Travel and Seminar	0	0	0	0	0	0	0	0
25. Other Admin. Staff Trans	0	0	2,999	2,999	0	2,999	0	2,999
26. Insurance-Prop.Liab.Malpractice	0	0	8,409	8,409	0	8,409	0	8,409
27. Other (specify)*	0	198	14,737	14,935	0	14,935	-14,935	0
28. Total General Adminis	17,111	1,879	193,263	212,253	0	212,253	-26,602	185,651
29. Total General Administrative	492,370	130,666	275,397	898,433	0	898,433	-29,603	868,830
30. Depreciation	0	0	126,947	126,947	0	126,947	-13,863	113,084
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	245,026	245,026	0	245,026	-2,627	242,399
33. Real Estate	0	0	62,760	62,760	0	62,760	0	62,760
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	951	951	0	951	0	951
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	435,684	435,684	0	435,684	-16,490	419,194
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	0	0	0	0	0	0
43. Other (specify):*	0	0	0	0	0	0	0	0
44. Total Special Cost Ce	0	0	0	0	0	0	0	0
45. Grand Total	492,370	130,666	711,081	1,334,117	0	1,334,117	-46,093	1,288,024

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,483,727	1,483,727
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	228,748	228,748
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	16,216	16,216
7. Other Prepaid Expenses	5,086	5,086
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	1,733,777	1,733,777
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	150,800	127,000
14. Buildings, at Historical Cost	2,762,532	3,558,140
15. Leasehold Improvements, Historical Cost	829,377	57,569
16. Equipment, at Historical Cost	181,009	181,009
17. Accumulated Depreciation (book methods)	-543,424	-498,890
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):	54,066	54,066
23. other (specify):	0	0
24. Total Long-Term Assets	3,434,360	3,478,894
25. Total Assets	5,168,137	5,212,671
CURRENT LIABILITIES		
26. Accounts Payable	252,069	252,069
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	150,000	150,000
30. Accrued Salaries Payable	26,974	26,974
31. Accrued Taxes Payable	2,670	2,670
32. Accrued Real Estate Taxes	67,140	67,140
33. Accrued Interest Payable	12,669	12,669
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	25,034	25,034
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	536,556	536,556
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	4,211,546	4,211,546
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	34,300	34,300
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	4,245,846	4,245,846
46. Total Liabilities	4,782,402	4,782,402
47. Total Equity	385,735	430,269
48. Total Liabilities and Equity	5,168,137	5,212,671

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,604,800
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	1,604,800
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Ancillary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	2,523
15. Telephone, Television, and Radio	12,338
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	14,861
24. Contributions	0
25. Interest and Other Investments Income	2,627
Subtotal - Non-Operating Revenue	2,627
27. Other Revenue (specify):	0
28. Other Revenue (specify):	486
Subtotal - Other Revenue	486
30. Total Revenue	1,622,774
31. General Services	348,249
32. Health Care	337,931
33. General Administration	197,318
34. Ownership	435,684
35. Special Cost Centers	14,935
35. Provider Participation Fee	0
37. Other	0
40. Total Expenses	1,334,117
41. Income Before Income Taxes	288,657
42. Income Taxes	0
43. Net Income or Loss for the Year	288,657