		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0036749

Facility Name: Aviston, Terrace

Address: 349 West First Avenue (Number) Aviston (City) 62216 (Zip Code)

County: Clinton

Telephone Number: (618) 228-7040 **Fax #** (618) 228-7002

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1991

Type of Ownership:

[X] VOLUNTARY,NON-PROFIT		[ ] PROPRIETARY		[ ] GOVERNMENTAL	
	[X] Charitable Corp.		[ ] Individual		[ ] State
	[ ] Trust		[ ] Partnership		[ ] County
IRS Exemption Code 501 C (3)			[ ] Corporation		[ ] Other
			[ ] "Sub-S" Corp.		
			[ ] Limited Liability Co.		
			[ ] Trust		
			[ ] Other		

In the event there are further questions about this report, please contact:
Name: Jerry Johnson **Telephone Number:** (309) 685-0595 ext 304
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 7/1/2010 to 6/30/2011 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) Jerry Johnson
(Title) Controller

Paid Preparer
(Signed) (Date)
(Print Name and Title) Lisa Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, PO Box 9, Dunlap, IL 61525
(Telephone) 309-265-3630 Fax # ( )

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 Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,628			5,628	13
14	TOTALS	5,628			5,628	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.37%

D. How many bed-hold days during this year were paid by the Department?
63 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 01/01/1991

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/1991 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2011 Fiscal Year: 6/30/2011

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

Facility Name & ID Number Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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	20,700	1,987	1,921	24,608		24,608		24,608			1
2	Food Purchase		29,524		29,524		29,524	(2,223)	27,301			2
3	Housekeeping		2,388	40	2,428		2,428	370	2,798			3
4	Laundry		1,504	155	1,659		1,659		1,659			4
5	Heat and Other Utilities			15,682	15,682		15,682	555	16,237			5
6	Maintenance	7,430		5,875	13,305		13,305	437	13,742			6
7	Other (specify):*											7
8	**TOTAL General Services**	28,130	35,403	23,673	87,206		87,206	(861)	86,345			8
	B. Health Care and Programs											
9	Medical Director			1,800	1,800		1,800		1,800			9
10	Nursing and Medical Records	193,752	6,945	2,596	203,293		203,293		203,293			10
10a	Therapy			1,182	1,182		1,182		1,182			10a
11	Activities		2,163		2,163		2,163	482	2,645			11
12	Social Services			2,405	2,405		2,405		2,405			12
13	CNA Training											13
14	Program Transportation			2,927	2,927		2,927		2,927			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	193,752	9,108	10,910	213,770		213,770	482	214,252			16
	C. General Administration											
17	Administrative	1,504			1,504		1,504		1,504			17
18	Directors Fees			2,393	2,393		2,393		2,393			18
19	Professional Services			10,735	10,735		10,735	4,141	14,876			19
20	Dues, Fees, Subscriptions & Promotions			2,257	2,257		2,257	452	2,709			20
21	Clerical & General Office Expenses		3,410	7,421	10,831		10,831	49,541	60,372			21
22	Employee Benefits & Payroll Taxes			72,360	72,360		72,360	10,525	82,885			22
23	Inservice Training & Education			88	88		88		88			23
24	Travel and Seminar			2,900	2,900		2,900	561	3,461			24
25	Other Admin. Staff Transportation			1,420	1,420		1,420	261	1,681			25
26	Insurance-Prop.Liab.Malpractice			3,838	3,838		3,838	633	4,471			26
27	Other (specify):*											27
28	**TOTAL General Administration**	1,504	3,410	103,412	108,326		108,326	66,114	174,440			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	223,386	47,921	137,995	409,302		409,302	65,735	475,037			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 Aviston, Terrace #0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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			20,259	20,259		20,259	2,226	22,485			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,906	43,906		43,906	(12,403)	31,503			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							142	142			35
36	Other (specify):*											36
37	**TOTAL Ownership**			64,165	64,165		64,165	(10,035)	54,130			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,456	36,456		36,456		36,456			42
43	Other (specify):* Non-allowable Costs			211,950	211,950		211,950	(211,950)				43
44	**TOTAL Special Cost Centers**			248,406	248,406		248,406	(211,950)	36,456			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	223,386	47,921	450,566	721,873		721,873	(156,250)	565,623			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 Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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	$ (211,950)	43	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				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	(12,767)	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				24
25	Fund Raising, Advertising and Promotional				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 See Pg 5A	(2,261)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (226,978)		$	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)	70,728		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 70,728		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (156,250)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Aviston, Terrace

ID# 0036749

Report Period Beginning: 7/1/2010

Ending: 6/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Miscellaneous Income	$ (38)	21	1
2	Offset Vending Income	(2,223)	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**	(2,261)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aviston, Terrace # 0036749 **Report Period Beginning:** 7/1/2010 **Ending:** 6/30/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,223)	0	0	0	0	0	0	0	0	0	0	(2,223)	2
3	Housekeeping	0	0	370	0	0	0	0	0	0	0	0	370	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	555	0	0	0	0	0	0	0	0	555	5
6	Maintenance	0	0	437	0	0	0	0	0	0	0	0	437	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,223)	0	1,362	0	0	0	0	0	0	0	0	(861)	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	482	0	0	0	0	0	0	0	0	482	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	482	0	0	0	0	0	0	0	0	482	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	4,141	0	0	0	0	0	0	0	0	4,141	19
20	Fees, Subscriptions & Promotions	0	0	452	0	0	0	0	0	0	0	0	452	20
21	Clerical & General Office Expenses	(38)	0	49,579	0	0	0	0	0	0	0	0	49,541	21
22	Employee Benefits & Payroll Taxes	0	0	10,525	0	0	0	0	0	0	0	0	10,525	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	561	0	0	0	0	0	0	0	0	561	24
25	Other Admin. Staff Transportation	0	0	261	0	0	0	0	0	0	0	0	261	25
26	Insurance-Prop.Liab.Malpractice	0	0	633	0	0	0	0	0	0	0	0	633	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(38)	0	66,152	0	0	0	0	0	0	0	0	66,114	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,261)	0	67,996	0	0	0	0	0	0	0	0	65,735	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aviston, Terrace **#** 0036749 **Report Period Beginning:** 7/1/2010 **Ending:** 6/30/2011

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	0	2,226	0	0	0	0	0	0	0	0	2,226	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,767)	0	364	0	0	0	0	0	0	0	0	(12,403)	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	142	0	0	0	0	0	0	0	0	142	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(12,767)	0	2,732	0	0	0	0	0	0	0	0	(10,035)	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):*	(211,950)	0	0	0	0	0	0	0	0	0	0	(211,950)	43
44	**TOTAL Special Cost Centers**	(211,950)	0	0	0	0	0	0	0	0	0	0	(211,950)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(226,978)	0	70,728	0	0	0	0	0	0	0	0	(156,250)	45

Facility Name & ID Number Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Progressive Housing, Inc	100	See Pg 6-Supp		See Pg 6-Supp		

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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	6	Maintenance	$ 1,035	Progressive Housing, Inc.	100.00%	$ 1,035	$	1
2	V	11	Activities	296	Progressive Housing, Inc.	100.00%	296		2
3	V	18	Director Fees	2,393	Progressive Housing, Inc.	100.00%	2,393		3
4	V	19	Professional Services	10,745	Progressive Housing, Inc.	100.00%	10,745		4
5	V	20	Dues, Fees, Subs and Promotions	724	Progressive Housing, Inc.	100.00%	724		5
6	V	21	Clerical and General Office	3,034	Progressive Housing, Inc.	100.00%	3,034		6
7	V	24	Travel and Seminar	524	Progressive Housing, Inc.	100.00%	524		7
8	V	32	Interest	157	Progressive Housing, Inc.	100.00%	157		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 18,908			$ 18,908	$ *	14

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

Facility Name & ID Number Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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)	
15	V	3	Housekeeping	$	Center For Residential Management	Parent Co.	$ 370	$ 370	15
16	V	5	Utilities		Center For Residential Management	Parent Co.	555	555	16
17	V	6	Maintenance		Center For Residential Management	Parent Co.	437	437	17
18	V	11	Activities		Center For Residential Management	Parent Co.	482	482	18
19	V	19	Professional Services		Center For Residential Management	Parent Co.	4,141	4,141	19
20	V	20	Dues, Fees, Subs & Promotions		Center For Residential Management	Parent Co.	452	452	20
21	V	21	Clerical and General Office		Center For Residential Management	Parent Co.	49,579	49,579	21
22	V	22	Employee Benefits & Payroll		Center For Residential Management	Parent Co.	10,525	10,525	22
23	V	23	Inservice Training & Education		Center For Residential Management	Parent Co.	0		23
24	V	24	Travel and Seminar		Center For Residential Management	Parent Co.	561	561	24
25	V	25	Other Admin. Staff Transport.		Center For Residential Management	Parent Co.	261	261	25
26	V	26	Insurance-Prop./Liab./Malprac.		Center For Residential Management	Parent Co.	633	633	26
27	V	30	Depreciation		Center For Residential Management	Parent Co.	2,226	2,226	27
28	V	32	Interest		Center For Residential Management	Parent Co.	364	364	28
29	V	35	Rent-Equipment & Vehicles		Center For Residential Management	Parent Co.	142	142	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 70,728	$ * 70,728	39

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

Facility Name & ID Number Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Sparta Terrace	Sparta	Center for Residential			1
2			Ellner Terrace	Evansville	Management	Peoria	Management Co.	2
3			Taylorville Terrace	Taylorville	Progressive			3
4			Briarbrook Place	East Peoria	Housing, Inc.	Peoria	ICF/DD Provider	4
5			Harris Place	East Peoria	Progressive Careers			5
6			Joshua Manor	Hoyleton	& Housing	Steger	Workshop	6
7			Terra Estates	Hoyleton	Progressive Careers			7
8			Park Place	Pana	& Housing	Waltonville	Workshop	8
9			Cardinal	Woodlawn	Perfection			9
10			Western Gardens	MT. Vernon	Cleaning	Olympia Fields	Housekeeping	10
11			Galaxy	Woodlawn				11
12			Bill Goat Hill	MT. Vernon				12
13			Country Club Hill	Country Club Hills				13
14			Lee street	Country Club Hills				14
15			Baker Street	Country Club Hills				15
16			182nd Street	Country Club Hills				16
17			Osage	Park Forest				17
18			Oakwood	Park Forest				18
19			Blair	Park Forest				19
20			Lowell	Hazelcrest				20
21			Marquette	Park Forest				21
22			Cherry	Park Forest				22
23			Luella	Sauk Village				23
24			Olivia	Sauk Village				24
25			Huron	Park Forest				25
26			Wilshire	Park Forest				26
27			Constance	Sauk Village				27
28			175th Place	Country Club Hills				28
29			Sauganash	Park Forest				29
30								30

Facility Name & ID Number Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Childers	Chairman	Board Member	None	8,989	3Hrs/MTG	1.00	Dir. Fees	$ 611	L18,C3	1
2	Orland Bauer	Treasurer	Board Member	None	8,989	3Hrs/MTG	1.00	Dir. Fees	611	L18,C3	2
3	Robert Bauer	Secretary	Board Member	None	8,989	3Hrs/MTG	1.00	Dir. Fees	611	L18,C3	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	8,240	3Hrs/MTG	1.00	Dir. Fees	560	L18,C3	4
5	Lawrence Manson	President	Board Memb/CEO	None	151,354	1.18	2.95	Salary	8,734	L21,C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 11,127		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

Aviston, Terrace
0036749
6/30/2011

SCHEDULE 7A

	BOARD OF DIRECTOR FEES					SALARY
	Progressive Housing, Inc.					Center for Residential Management
	Edward Childers	Orland Bauer	Robert Bauer	Shawn Jeffers	Total	Larry Manson
Lakeview Living Center						4,603
Sparta Terrace	555	555	555	509	2,174	8,156
Ellner Terrace	564	564	563	517	2,208	7,950
Taylorville Terrace	525	525	526	482	2,058	8,624
Aviston Terrace	611	611	611	560	2,393	8,734
Briarbrook Place	579	579	578	531	2,267	9,284
Harris Place	554	554	555	509	2,172	7,972
Joshua Manor	606	606	606	557	2,375	8,283
Terra Estates	646	646	645	592	2,529	8,910
Park Place	471	471	472	433	1,847	7,269
Western Gardens	229	229	229	211	898	3,263
Galaxy	232	232	232	212	908	4,557
Cardinal	204	204	204	187	799	3,545
Bill Goat Hill	234	234	234	215	917	4,328
Country Club Hill	181	181	182	167	711	3,482
Lee Street	199	199	198	182	778	3,576
Baker Street	193	193	192	177	755	3,644
182nd Street	202	202	202	186	792	3,684
Osage	212	212	213	195	832	3,683
Oakwood	206	206	205	189	806	3,779
Blair	210	210	211	193	824	3,847
Lowell	251	251	252	231	985	3,904
Marquette	208	208	207	191	814	4,037
Cherry	223	223	222	204	872	4,170
Luella	238	238	238	219	933	4,125
Olivia	240	240	241	222	943	4,464
Huron	217	217	217	199	850	4,039
Wilshire	213	213	213	195	834	4,239
Constance	166	166	166	145	643	1,417
175th Place	211	211	212	189	823	3,094
Sauganash						177
Steger						1,913
Waltonville	220	220	219	201	860	3,174
Perfection Cleaning						162
Total PHI	9,600	9,600	9,600	8,800	37,600	160,088

Facility Name & ID Number Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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 [X] NO [ ]

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

Name of Related Organization: Progressive Housing, Inc.
Street Address: PO Box 10528
City / State / Zip Code: Peoria, IL. 61612
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	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	6	Maintenance	Budgeted Revenue	14,012,681	30	$ 16,403	$	877,113	$ 1,035	1
2	11	Activities	Budgeted Revenue	14,012,681	30	4,740		877,113	296	2
3	18	Director Fees	Budgeted Revenue	14,012,681	30	37,600		877,113	2,393	3
4	19	Professional Services	Budgeted Revenue	14,012,681	30	170,531		877,113	10,745	4
5	20	Dues, Fees, Subs and Promotions	Budgeted Revenue	14,012,681	30	11,434		877,113	724	5
6	21	Clerical and General Office	Budgeted Revenue	14,012,681	30	48,267		877,113	3,034	6
7	24	Travel and Seminar	Budgeted Revenue	14,012,681	30	8,382		877,113	524	7
8	32	Interest	Budgeted Revenue	14,012,681	30	2,492		877,113	157	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					$ 299,849	$		$ 18,908	25

Facility Name & ID Number Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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 [X] NO [ ]

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

Name of Related Organization: Center For Residential Management
Street Address: PO Box 10528
City / State / Zip Code: Peoria, IL. 61612
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	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	3	Housekeeping	Revenue	12,359,018	34	$ 6,784	$	674,258	$ 370	1
2	5	Utilities	Revenue	12,359,018	34	10,175		674,258	555	2
3	6	Maintenance	Revenue	12,359,018	34	8,009		674,258	437	3
4	11	Activities	Revenue	12,359,018	34	8,842		674,258	482	4
5	19	Professional Services	Revenue	12,359,018	34	75,898		674,258	4,141	5
6	20	Dues, Fees, Subs & Promotions	Revenue	12,359,018	34	8,284		674,258	452	6
7	21	Clerical and General Office	Revenue	12,359,018	34	908,778	829,663	674,258	49,579	7
8	22	Employee Benefits & Payroll	Revenue	12,359,018	34	192,921		674,258	10,525	8
9	23	Inservice Training & Education	Revenue	12,359,018	34	8		674,258		9
10	24	Travel and Seminar	Revenue	12,359,018	34	10,280		674,258	561	10
11	25	Other Admin. Staff Transport.	Revenue	12,359,018	34	4,786		674,258	261	11
12	26	Insurance-Prop./Liab./Malprac.	Revenue	12,359,018	34	11,606		674,258	633	12
13	30	Depreciation	Revenue	12,359,018	34	40,795		674,258	2,226	13
14	32	Interest	Revenue	12,359,018	34	6,672		674,258	364	14
15	35	Rent-Equipment & Vehicles	Revenue	12,359,018	34	2,604		674,258	142	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,296,442	$ 829,663		$ 70,728	25

Facility Name & ID Number Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	$ 679,192	$ 610,063	08/15/26	6.7500	$ 42,370	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Vendor Finance Charge		X	Working Capital							45	6
7	Allocation from Parent Co.	X		Working Capital							489	7
8	Amort of Loan Cost		X	Line of Credit Fee							1,366	8
9	TOTAL Facility Related						$ 679,192	$ 610,063			$ 44,270	9
	B. Non-Facility Related*											
10												10
11	Offset Interest Income										(12,767)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (12,767)	14
15	TOTALS (line 9+line14)						$ 679,192	$ 610,063			$ 31,503	15

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

* 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 Aviston, Terrace # 0036749 **Report Period Beginning:** 7/1/2010 **Ending:** 6/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)	**2010**	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006		**8**
	2007		**9**
	2008		**10**
	2009		**11**
	2010		**12**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	**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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aviston, Terrace COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0036749

CONTACT PERSON REGARDING THIS REPORT N/A

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,900 B. General Construction Type: Exterior Brick/Siding Frame Wood Number of Stories One

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. [ ] (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: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	26,400	1991	$ 20,000	1
2					2
3	TOTALS	26,400		$ 20,000	3

Facility Name & ID Number Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	16		1991	1986	$ 432,500	$ 10,813	40	$ 10,813	$	$ 221,659	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Expand Bedroom			1991	1,862		15			1,862	9
10	Celing Light Fixtures			1993	536		15			536	10
11	Allocated from Company										11
12	Sprinkler System			1996	936	63	15	63		905	12
13	Sprinkler System			1998	1,274	85	15	85		1,062	13
14	Bathroom Toilets			2001	1,349	90	15	90		944	14
15	Bathroom Tiles			2001	2,720	181	15	181		1,904	15
16	Bathroom Tiles and Drywall			2001	2,540	169	15	169		1,679	16
17	Sprinkler System			2004	4,614	308	15	308		2,333	17
18	Sprinkler System			2004	900	60	15	60		400	18
19	Furanace Upgrade			2005	1,623	108	15	108		685	19
20	Ohio Valley Sprinkler Air Compressor			2005	1,994	133	15	133		765	20
21	New A/C			2006	1,014	68	15	68		344	21
22	Living Room Carpet			2007	1,185	79	15	79		349	22
23	Gazebo			2007	1,796	120	15	120		429	23
24	Alarm System Upgrade			2008	1,529	102	15	102		348	24
25	Concrete Sidewalk			2008	2,000	133	15	133		322	25
26	Flooring - Zickel			2010	3,731	249	15	249		332	26
27											27
28											28
29											29
30											30
31											31
32	Allocated from Center for Residential Management							712	712		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 Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)		$ 464,103	$ 12,761		$ 13,473	$ 712	$ 236,858	70

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

Facility Name & ID Number Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 23,942	$ 2,536	$ 2,536	$	5-10Yrs	$ 12,515	71
72	Current Year Purchases	1,700	246	246		5-10Yrs	246	72
73	Fully Depreciated Assets	16,413				5-10Yrs	16,413	73
74	Allocated From Parent Co.			1,514	1,514			74
75	TOTALS	$ 42,055	$ 2,782	$ 4,296	$ 1,514		$ 29,174	75

D. Vehicle Costs. (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 Use	2005 Forf Taurus	2005	$ 17,283	$ 863	$ 863	$	5	$ 17,283	76
77	Facility Use	1998 Astro Van	2005	4,000				5	4,000	77
78	Facility Use	Fuel Pump	2008	934	187	187		5	607	78
79	Facility Use	2008 Chrysler Van	2008	18,328	3,666	3,666		5	10,997	79
80	TOTALS			$ 40,545	$ 4,716	$ 4,716	$		$ 32,887	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)	$ 566,703	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 20,259	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 22,485	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,226	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 298,919	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	N/A				88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		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 Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:							3
4	Additions	N/A						4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☒ X NO Terms: N/A *

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.	/2012	$ N/A
13.	/2013	$ N/A
14.	/2014	$ N/A

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: $ 142 Description: Allocated from Parent Co - postage machine, copier
(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		N/A			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 Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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

It is the policy of this facility to only hire certified nurses aides.

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

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 Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	10(3)	visits		30	2,323		30	2,323	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			$	30	$ 2,323	$	30	$ 2,323	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 Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2011 (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	$ 607	$ 607	1
2	Cash-Patient Deposits	10,063	10,063	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,255)	218,381	218,381	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	115	115	6
7	Other Prepaid Expenses	1,456	1,456	7
8	Accounts Receivable (owners or related parties)	2,036,049	2,036,049	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,266,671	$ 2,266,671	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	20,000	13
14	Buildings, at Historical Cost	464,103	464,103	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	82,600	82,600	16
17	Accumulated Depreciation (book methods)	(298,919)	(298,919)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	100,144	100,144	21
22	Other Long-Term Assets (spe Loan costs	12,298	12,298	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 380,226	$ 380,226	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,646,897	$ 2,646,897	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 69,295	$ 69,295	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,063	10,063	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	19,191	19,191	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	16,334	16,334	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Workshop	84,425	84,425	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 199,308	$ 199,308	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	610,063	610,063	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)**	$ 610,063	$ 610,063	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 809,371	$ 809,371	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,837,526	$ 1,837,526	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,646,897	$ 2,646,897	48

***(See instructions.)**

Facility Name & ID Number Aviston, Terrace # 0036749 **Report Period Beginning:** 7/1/2010 **Ending:** 6/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,648,826	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,648,826	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	188,700	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)**	$ 188,700	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)**	$ 1,837,526	24	*

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

Facility Name & ID Number Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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	$ 674,258	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 674,258	3
	B. Ancillary Revenue		
4	Day Care	211,950	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 211,950	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services **Transportion, DSP training**	7,651	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 7,651	23
	D. Non-Operating Revenue		
24	Contributions	1,686	24
25	Interest and Other Investment Income***	12,767	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,453	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Vending Income**	2,223	28
28a	**Miscellaneous Income**	38	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,261	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 910,573	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	87,206	31
32	Health Care	213,770	32
33	General Administration	108,326	33
	B. Capital Expense		
34	Ownership	64,165	34
	C. Ancillary Expense		
35	Special Cost Centers	211,950	35
36	Provider Participation Fee	36,456	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 721,873	40
41	**Income before Income Taxes (line 30 minus line 40)****	188,700	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 188,700	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No 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 Aviston, Terrace
ID# 0036749
FYE 6/30/2011

SCH 19A

Schedule XVII
Page 19

This facility is a Not-For-Profit Under IRC 501C(3)
and is part of a Consolidated Entity Tax Return.
Therefore, the Income or Loss cannot be
traced to the Federal Income Tax Return.

Facility Name & ID Number Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	466	521	11,613	22.29	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,626	2,080	20,700	9.95	15
16	Dishwashers					16
17	Maintenance Workers	814	814	7,430	9.13	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	43	74	1,504	20.32	20
21	Assistant Administrator					21
22	Other Administrative					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	1,848	1,871	28,196	15.07	29
30	Habilitation Aides (DD Homes)	14,825	16,176	153,943	9.52	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	19,622	21,536	$ 223,386 *	$ 10.37	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	24	$ 1,921	L1, C3	35
36	Medical Director	Monthly	1,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant			L10, C3	38
39	Pharmacist Consultant	Monthly	273	L10, C3	39
40	Physical Therapy Consultant	3	72	L10A, C3	40
41	Occupational Therapy Consultant	28	574	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	8	536	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	37	2,405	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	100	$ 7,581		49

C. CONTRACT NURSES

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

Facility Name & ID Number Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patty Ming	Administrator	0	$ 1,504
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 1,504

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Schuyler Roche	Legal	$ 883
Wells Fargo	Bond Trustee	291
Mike Kaplan	Financial Consulting	172
Personnel Planners	UC Consultant	413
Heinold-Banwart, LTD	Accounting	5,542
Barbara Weiner	Legal	63
Wildman, Harrold, Allen	Legal	2,990
Dean Group Consulting	HR Consultant	225
Ice Miller	Legal	156
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 10,735

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 5,523
Unemployment Compensation Insurance	7,866
FICA Taxes	16,390
Employee Health Insurance	41,772
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Moral	340
403B Retirement Contribution	400
Drug Tests	69
Allocation from Parent Co.	10,525
TOTAL (agree to Schedule V, line 22, col.8)	$ 82,885

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	24
Health Care Worker Background Check	
(Indicate # of checks performed 10)	362
Patient Background Checks	
Misc. Licenses	92
IHCA Dues	368
Miscellaneous Dues & Fees	941
Therapy License	470
Allocation from Parent Co.	452
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,709

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,958
Allocation from Parent Co.	500
Seminar Expense	942
Allocation from Parent Co.	61
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,461

**See instructions.

Aviston, Terrace
0036749
Period Beginning 7/1/2010
Period End 6/30/2011

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	**Type**	**Amount**
Total (agree to Schedule V, line 19, column 3)		10,735

CRM Management Allocation

National Hotline Services	Employee Hotline	98
Mike Kaplan	Finanacial Consultant	3,289
Klancic Architect PC	Architect	75
Title Professionals	Loan Settlement fees	679
Total (agree to Schedule V, line 19, column 8)		14,876

Facility Name & ID Number Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Aviston, Terrace # 0036749 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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. **IHCA $368**

(3) Did the nursing home make political contributions or payments to a politica
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? **N/A** 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? **5-10 Yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **2,280** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **36,456**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **0** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **0**

(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 fo
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? **90**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all othe
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? **Yes**
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: **Heinold- Banwart, LTD**

(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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	20,700	1,987	1,921	24,608	0	24,608	0	24,608
2. Food Purchase	0	29,524	0	29,524	0	29,524	-2,223	27,301
3. Housekeeping	0	2,388	40	2,428	0	2,428	370	2,798
4. Laundry	0	1,504	155	1,659	0	1,659	0	1,659
5. Heat and Other Utilities	0	0	15,682	15,682	0	15,682	555	16,237
6. Maintenance	7,430	0	5,875	13,305	0	13,305	437	13,742
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	28,130	35,403	23,673	87,206	0	87,206	-861	86,345
9. Medical Director	0	0	1,800	1,800	0	1,800	0	1,800
10. Nursing & Medical Records	193,752	6,945	2,596	203,293	0	203,293	0	203,293
10a. Therapy	0	0	1,182	1,182	0	1,182	0	1,182
11. Activities	0	2,163	0	2,163	0	2,163	482	2,645
12. Social Services	0	0	2,405	2,405	0	2,405	0	2,405
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	2,927	2,927	0	2,927	0	2,927
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	193,752	9,108	10,910	213,770	0	213,770	482	214,252
17. Administrative	1,504	0	0	1,504	0	1,504	0	1,504
18. Directors Fees	0	0	2,393	2,393	0	2,393	0	2,393
19. Professional Services	0	0	10,735	10,735	0	10,735	4,141	14,876
20. Fees, Subscriptions & Promotion	0	0	2,257	2,257	0	2,257	452	2,709
21. Clerical & General Office	0	3,410	7,421	10,831	0	10,831	49,541	60,372
22. Employee Benefits & Payroll	0	0	72,360	72,360	0	72,360	10,525	82,885
23. Inservice Training & Education	0	0	88	88	0	88	0	88
24. Travel and Seminar	0	0	2,900	2,900	0	2,900	561	3,461
25. Other Admin. Staff Trans	0	0	1,420	1,420	0	1,420	261	1,681
26. Insurance-Prop.Liab.Malpractice	0	0	3,838	3,838	0	3,838	633	4,471
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	1,504	3,410	103,412	108,326	0	108,326	66,114	174,440
29. Total General Administrative	223,386	47,921	137,995	409,302	0	409,302	65,735	475,037
30. Depreciation	0	0	20,259	20,259	0	20,259	2,226	22,485
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	43,906	43,906	0	43,906	-12,403	31,503
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	142	142
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	64,165	64,165	0	64,165	-10,035	54,130
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	36,456	36,456	0	36,456	0	36,456
43. Other (specify):*	0	0	211,950	211,950	0	211,950	-211,950	0
44. Total Special Cost Ce	0	0	248,406	248,406	0	248,406	-211,950	36,456
45. Grand Total	223,386	47,921	450,566	721,873	0	721,873	-156,250	565,623

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	607	607
2. Cash - Patient Deposits	10,063	10,063
3. Accounts & Notes Recievable	218,381	218,381
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	115	115
7. Other Prepaid Expenses	1,456	1,456
8. Accounts Receivable-Owner/Related Party	2,036,049	2,036,049
9. Other (specify):	0	0
10. Total current assets	2,266,671	2,266,671
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	20,000	20,000
14. Buildings, at Historical Cost	464,103	464,103
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	82,600	82,600
17. Accumulated Depreciation (book methods)	-298,919	-298,919
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	100,144	100,144
22. Other Long-Term Assets (specify):	12,298	12,298
23. other (specify):	0	0
24. Total Long-Term Assets	380,226	380,226
25. Total Assets	2,646,897	2,646,897
CURRENT LIABILITIES		
26. Accounts Payable	69,295	69,295
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	10,063	10,063
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	19,191	19,191
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	16,334	16,334
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	84,425	84,425
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	199,308	199,308
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	610,063	610,063
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	610,063	610,063
46.Total Liabilities	809,371	809,371
47.Total Equity	1,837,526	1,837,526
48.Total Liabilities and Equity	2,646,897	2,646,897

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	674,258
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	674,258
4. Day Care	211,950
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	211,950
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	0
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. Radiologyand X-Ray	0
21. Other Medical Services	7,651
22. Laundry	0
Subtotal - Other Operating Revenue	7,651
24. Contributions	1,686
25. Interest and Other Investments Income	12,767
Subtotal - Non-Operating Revenue	14,453
27. Other Revenue (specify):	0
28. Other Revenue (specify):	2,261
Subtotal - Other Revenue	2,261
30. Total Revenue	910,573
31. General Services	87,206
32. Health Care	213,770
33. General Administration	108,326
34. Ownership	64,165
35. Special Cost Centers	211,950
35. Provider Participation Fee	36,456
37. Other	0
40. Total Expenses	721,873
41. Income Before Income Taxes	188,700
42. Income Taxes	0
43. Net Income or Loss for the Year	188,700